



AGREEMENT

Between

BROWARD COUNTY

and

VISTA HEALTHPLAN, INC.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

For

GROUP HEALTH INSURANCE COVERAGE

For

Broward County Employees

Contract Year - January 1, 2010 - December 31, 2010

RLI #R0713904R1



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AGREEMENT

Between

BROWARD COUNTY

And

VISTA HEALTHPLAN, INC.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

For

**HEALTH INSURANCE COVERAGE AND BENEFITS
INSURING BROWARD COUNTY EMPLOYEES**

FOR CONTRACT YEAR JANUARY 1, 2010 - DECEMBER 31, 2010

RLI #R0713904R1

This is an Agreement made and entered into by and between BROWARD COUNTY, a political subdivision of the State of Florida, hereinafter referred to as "COUNTY,"

AND

VISTA HEALTHPLAN, INC., licensed to do business in the State of Florida, its successors and assigns, hereinafter collectively referred to as "VISTA."

AND

COVENTRY HEALTH AND LIFE INSURANCE COMPANY, licensed to do business in the State of Florida, its successors and assigns, hereinafter collectively referred to as "CHLIC." VISTA and CHLIC shall collectively be referred to as "PLAN."

IN CONSIDERATION of the mutual terms, conditions, promises, covenants and payments hereinafter set forth, COUNTY and PLAN agree as follows:

ARTICLE 1

DEFINITIONS AND IDENTIFICATIONS

For the purposes of this Agreement, reference to one gender shall include the other, use of the plural shall include the singular, and use of the singular shall include

the plural. The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement. Terms such as "herein," "hereof," "hereunder," and "hereinafter" refer to this Agreement as a whole and not to any particular sentence, paragraph, or section where they appear, unless the context otherwise requires. The following definitions apply unless the context in which the word or phrase is used requires a different definition:

- 1.1 Agreement: This document, Articles 1 through 35 inclusive. Other terms and conditions are included in the exhibits and documents that are expressly incorporated by reference.
- 1.2 Benefit Eligible: An employee, retiree, dependent deemed by COUNTY to be eligible to receive county benefits and designated as "Benefit Eligible." Notwithstanding the foregoing, an eligible employee is an employee who works full time, having a normal work week of twenty (20) or more hours, and who has met any applicable waiting period or other requirements and, if covered, retired employees as of the January 1, 2010 ("Effective Date"). Subject to any eligibility exceptions noted herein, an employee becomes eligible for coverage on the Effective Date. The waiting period is the length of time an employee must wait before becoming eligible for coverage.
- 1.3 Board: The Board of County Commissioners of Broward County, Florida, which is the governing body of Broward County, Florida.
- 1.4 Calendar Quarter: Each calendar quarter of the contract year divided as follows: first quarter being January 1 through March 31; the second quarter being April 1 through June 30; the third quarter being July 1 through September 30 and; the fourth quarter being October 1 through December 31.
- 1.5 CHLIC: COVENTRY HEALTH AND LIFE INSURANCE COMPANY, selected by the Board to provide health insurance coverage and benefits pursuant to the terms of this Agreement, the RLI, and the Offer.
- 1.6 Consumer Driven Health Plan (CDH): Refers collectively to the CDH HMO and CDH PPO plans described below:
 - 1.6.1 CDH Health Maintenance Organization Plan (CDH HMO). An open access health maintenance organization offered by Vista Healthplan, Inc, which benefits are described in the Certificate of Coverage, Schedule of Benefits. The COUNTY funds a Health Reimbursement Account (HRA) which can be used by the insured to pay for specified care per the guidelines established by the COUNTY.
 - 1.6.2 CDH Preferred Provider Organization Plan (CDH PPO). A preferred provider organization plan offered by Coventry Health and Life Insurance Company, which benefits are described in the Certificate of Coverage, Schedule of Benefits. The COUNTY funds a Health Reimbursement

Account (HRA) which can be used by the insured to pay for specified care per the guidelines established by the COUNTY.

- 1.7 Contract Administrator: Whenever the term Contract Administrator is used herein, it is intended to mean the Broward County Human Resources Division Director or the Director's designee. In the administration of this Agreement, as contrasted with matters of policy, all parties may rely on the instructions or determinations made by the Contract Administrator; provided, however, that such instructions and determinations do not change the Scope of Services as described in Article 3 herein.
- 1.8 COUNTY: Broward County, Florida, a body corporate and politic pursuant to Article I of the Broward County Charter, and a political subdivision of the State of Florida pursuant to Article VIII, § 1, of the Florida state Constitution.
- 1.9 County Administrator: The administrative head of COUNTY pursuant to Sections 3.02 and 3.03 of the Broward County Charter.
- 1.10 County Attorney: The chief legal counsel for COUNTY who directs and supervises the Office of the County Attorney pursuant to Section 2.10 of the Broward County Charter, or the designee of the County Attorney.
- 1.11 HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended and the corresponding regulations thereof.
- 1.12 Mailing Time: Pursuant to this Agreement, performance deadlines have been established including an allowance for correspondence sent by United States mail. Mailing time is defined as six (6) calendar days except in the case of a performance deadline which falls on a Sunday or legal holiday. In such cases, delivery by mail shall be deemed to have occurred on the following calendar day.
- 1.13 Member: A COUNTY employee, COBRA or Domestic Partner Continuation beneficiary, Retiree or Covered dependent(s) of these groups, who has elected to participate in health benefits plan offered by PLAN.
- 1.14 Offer: Offer prepared by PLAN for the Board and submitted in response to **RLI #R0713904R1** as amended through subsequent negotiations with COUNTY Staff and the Insurance Selection Committee.
- 1.15 Performance Standard Penalties: The assessment of penalties for PLAN's failure to meet performance guarantees as set forth in Exhibit "C," attached hereto and incorporated herein, entitled "General Provisions/Performance Standards."
- 1.16 Primary Care Physician: A licensed practitioner of medicine under the CDH HMO Plan which is designated for each subscriber and is responsible for

coordinating the health care of the subscriber. For the CDH PPO plan the subscriber is not required to obtain a referral from their Primary Care Physician to have access to other network providers.

- 1.17 Provider: A physician or facility providing health related services pursuant to the terms of this Agreement, the RLI, and the Offer.
- 1.18 RLI: Request for Letter of Interest for group medical benefits for the Broward County Board of County Commissioners **RLI #R0713904R1**.
- 1.19 VISTA: VISTA HEALTHPLAN, INC., selected by the Board to provide health maintenance organization plan coverage and benefits, pursuant to the terms of this Agreement, the RLI and the Offer.

ARTICLE 2

BACKGROUND

In order to establish the background, context and frame of reference for this Agreement and to generally express the objectives and intentions of the respective parties herein, the following statements, representations and explanations shall be accepted as predicates for the undertakings and commitments included within the provisions which follow and may be relied upon by the parties as essential elements of the mutual considerations upon which this Agreement is based, to wit: Negotiations pertaining to the health insurance coverage and benefits to be provided by PLAN were undertaken between PLAN and a committee selected by the Board and this Agreement incorporates the results of such negotiations.

ARTICLE 3

SCOPE OF SERVICES/SELECTED POLICIES AND BENEFITS

- 3.1 PLAN shall provide group health insurance benefits to COUNTY employees under the Consumer Driven Health (CDH) Group Policy and the Certificate of Coverage in Exhibit "A," attached hereto and incorporated herein, entitled "Certificate of Coverage." The Certificate of Coverage describes the benefits provided and the limitations of this Agreement. Nothing in the Certificate of Coverage is intended to change or void the terms of this Agreement. COUNTY shall distribute to Member the Certificate of Coverage and any amendments or endorsements to it, other coverage materials, and notices applicable to all or any Member. Except as otherwise agreed by the parties, Members will be required to obtain a copy of the Certificate of Coverage through the PLAN website, by contacting the Contract Administrator, or by calling the PLAN Customer Service Department and requesting a hard copy be mailed via U.S. regular mail. COUNTY shall provide a copy of the Certificate of Coverage to all Members upon request.

- 3.2 PLAN shall notify COUNTY of any judgment or final order rendered by the Florida Department of Financial Services, Florida Office of Insurance Regulations, any federal or other state agency, and any court of law, finding that any of the specific plans or programs PLAN is providing to COUNTY, pursuant to this Agreement, are inconsistent or fail to comply with any applicable federal or state law requirements or regulations. PLAN shall also notify COUNTY of any corrective action plan, regarding its health insurance or managed care products or business that is imposed by any state or federal agency including any corrective action plan imposed by the Florida Department of Financial Services, Florida Office of Insurance Regulations, specifically concerning the plan or program PLAN provides to COUNTY under this Agreement. The notification required by this section shall be provided within thirty (30) days after the judgment or final order is rendered, or the corrective action plan is imposed.
- 3.3 PLAN shall provide specific de-identifiable data to COUNTY's third party vendor, Edify, or its designee, in compliance with HIPAA and all other applicable state and federal law and regulations as described in Exhibit "C," attached hereto and incorporated herein, entitled "General Provisions/Performance Standards."
- 3.4 PLAN's entire response to RLI # R0713904R1 shall be relied upon and incorporated herein as additional terms and conditions that PLAN agrees to for the duration of this contract unless otherwise noted in this Agreement or the incorporated and attached Exhibits.
- 3.4 COUNTY agrees to:
- 3.4.1 Collect member enrollment information.
- 3.4.2 Collect any required Member contribution.
- 3.4.3 Deliver notice of termination to the Members.

ARTICLE 4

TERM OF AGREEMENT

- 4.1 TERM: This Agreement shall commence on January 1, 2010 and terminate December 31, 2010.
- 4.2 RENEWAL: COUNTY has the option to renew this Agreement annually for four (4) one-year periods, upon mutual consent of both COUNTY and PLAN. At least two hundred seventy (270) days prior to the expiration of the initial term of this Agreement and any renewal term, PLAN shall notify COUNTY of its intent to enter into renewal negotiations. Notwithstanding the above, COUNTY shall have the right to, by and through its Contract Administrator and at his/her sole discretion, extend the term of this Agreement on a month to month basis, for a maximum of six (6) months, due to ongoing negotiations and/or to allow time for

transition to a new vendor on the same benefits and pricing terms as existed during the preceding term. If the terms and conditions are not the same, any extension would have to be approved by the Board.

ARTICLE 5

PREMIUM RATES

- 5.1 The premium rates charged by PLAN are set forth in Exhibit "B" attached hereto and incorporated, entitled "Premium Rates". These rates reflect maximum monthly premium rates charged by PLAN and do not include pharmacy coverage. The first premium covers the period starting on the Effective Date and is due on the Effective Date. Each following premium payment is due the first day of each month, unless COUNTY and PLAN agree on some other method and/or frequency of payment. Premium payments should be sent to PLAN's address indicated on the premium notice statement.
- 5.2 PLAN has provided a 24 month "Administrative Services Only" (ASO) rate guarantee to COUNTY valid from January 1, 2011 through December 31, 2012 should COUNTY change from fully insured to self insured.
- 5.3 In no event shall the premium rates charged under this Agreement exceed the guaranteed maximum rates as listed in Exhibit "B" for a 12-month period commencing January 1, 2010, through December 31, 2010 and ASO rates under any Agreement between COUNTY and PLAN shall not exceed the guaranteed maximum as listed in Exhibit "B" for up to a 24-month period commencing January 1, 2011 through December 31, 2012. For any proposed increase in premium rates for the subsequent calendar years, PLAN must provide a preliminary statement of any proposed premium increase to COUNTY two hundred ten (210) days prior to the effective date of the proposed premium increase, i.e., January 1.
- 5.4 This Agreement has a thirty (30) 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. The Agreement will stay in force during the grace period. Premiums must be paid and received directly by PLAN by the end of the grace period. The grace period does not apply to the premium due on the premium due date if COUNTY gave PLAN timely written notice that the Agreement is to be terminated prior to such premium due date. If the premiums are not paid and received directly by PLAN by the end of the grace period, coverage will terminate back to the last day of the month for which the premium payment was made. PLAN must receive all applicable premium payments prior to the expiration of the grace period to ensure continuation of coverage. In the event of termination of this Agreement due to non-payment, PLAN shall provide the COUNTY with fifteen (15) day prior written notice by certified mail of such termination.

- 5.5 COUNTY recognizes that changes to federal and state laws may mandate coverage changes resulting in PLAN's adjustments to the premium rates set forth in Section 5.1 for the initial term of this Agreement or any renewal period. Therefore, if an adjustment to these premium rates is required due to mandated changes in federal or state laws, COUNTY shall reconvene a committee selected by the Board to address these proposed adjustments to the premium rates. Until such adjustments are approved by the Board and the committee convened by the Board, COUNTY shall continue to pay premiums at the rates set forth in this Agreement. COUNTY reserves the right to terminate this Agreement if the parties are unable to agree on adjustments to this Agreement.

ARTICLE 6

GENERAL PROVISIONS/SERVICE STANDARDS

PLAN agrees to meet the performance standards as set forth in Exhibit "C," attached hereto and incorporated herein, entitled "General Provisions/Performance Standards."

- 6.1 PLAN may request an extension of any service standard deadline established pursuant to this article. Such request shall be submitted to the Contract Administrator no less than five (5) business days before the deadline, unless the need for an extension could not reasonably be foreseen by PLAN, or happened for a reason beyond PLAN's control, as determined by COUNTY. In the case of a need for an extension that could not be reasonably foreseen by PLAN, PLAN shall submit any request for an extension as soon as reasonably possible. If the request for an extension is based upon extenuating circumstances or other causes beyond PLAN's control, as determined by COUNTY, approval of the request shall not be unreasonably withheld. PLAN's written request must identify the section of this Article to which the request applies and the reasons why the established deadline could not be met. COUNTY may approve the extension request for such period as COUNTY deems appropriate. COUNTY shall notify PLAN of its decision in writing within three (3) business days after receipt of PLAN's extension request.
- 6.2 Force Majeure

If the performance of this Agreement, or any obligation hereunder is prevented by reason of hurricane, earthquake, or other casualty caused by nature, or by labor strike, war, or by a law, order, proclamation, regulation, ordinance of any governmental agency, the party so affected, upon giving prompt notice to the other party, shall be excused from such performance to the extent of such prevention, provided that the party so affected shall first have taken reasonable steps to avoid and remove such cause of non-performance and shall continue to take reasonable steps to avoid and remove such cause, and shall promptly notify the other party in writing and resume performance hereunder whenever such

causes are removed; provided, however, that if such non-performance exceeds sixty (60) days, the party that is not prevented from performance by the force majeure event shall have the right to terminate this Agreement upon written notice to the party so affected. This section shall not supersede or prevent the exercise of any right the parties may otherwise have to terminate this Agreement.

ARTICLE 7

PAYMENT OF PENALTIES

- 7.1 **PENALTY INVOICES:** If COUNTY, through its Contract Administrator, finds PLAN has incurred penalties pursuant to the terms of this Agreement, COUNTY will submit a written invoice to PLAN detailing the dates, Members' names and identification numbers, if applicable, and alleged performance failures.
- 7.2 **AGREED PENALTIES:** Any time penalties are incurred by PLAN pursuant to the terms of this Agreement, COUNTY will submit an invoice to PLAN for payment of these penalties no later than the end of the month following the period for which penalties were assessed. Unless PLAN files a dispute pursuant to Section 7.3 herein, PLAN must pay these penalties within twenty (20) days from the date of invoice. If a penalty is not paid by PLAN pursuant to the terms of this Agreement, COUNTY may automatically deduct the penalty amounts from COUNTY's monthly premium payment.
- 7.3 **DISPUTED PENALTIES:** Any time penalties are assessed by the Contract Administrator against PLAN pursuant to the terms of this Agreement, PLAN may appeal the assessment of such penalties to the Director of Purchasing within ten (10) days after notice of the assessment pursuant to Article 9 of this Agreement. The appeal shall be in writing and PLAN shall state the reasons why the penalties should be reduced or not assessed. If the appeal is not resolved by mutual agreement, the Director of Purchasing shall promptly issue a decision in writing, after consulting with the County Attorney's Office. The decision shall state the reasons for the action taken, and inform PLAN of its right to administrative review. If PLAN disagrees with the decision of the Director of Purchasing, it may seek administrative review by filing notice with the Director of Purchasing not later than ten (10) days after the decision of the Director of Purchasing. COUNTY and PLAN agree that the hearing procedures shall be in accordance with the provisions of Section 21.120 of the Broward County Procurement Code, as may be amended from time to time.

ARTICLE 8

TERMINATION

- 8.1 This Agreement may be terminated for convenience by the Board. Termination for convenience by the Board shall be effective on the termination date stated in written notice provided by the COUNTY, which termination date shall be not less than thirty (30) days after the date of such written notice. This Agreement may also be terminated by the County Administrator upon such notice as the County Administrator deems appropriate under the circumstances in the event the County Administrator determines that termination is necessary to protect the public health or safety. The parties agree that if the COUNTY erroneously, improperly or unjustifiably terminates this Agreement for cause, such termination shall be deemed a termination for convenience, which shall be effective thirty (30) days after such notice of termination for cause is provided.
- 8.2 This Agreement may be terminated for cause for reasons including, but not limited to, PLAN's repeated (whether negligent or intentional) submission for payment of false or incorrect bills or invoices, failure to suitably perform its obligations under this Agreement; or failure to continuously perform its obligations under this Agreement in a manner calculated to meet or accomplish the objectives as set forth in this Agreement.
- 8.3 **TERMINATION OF THIS AGREEMENT BY PLAN:** In accordance with applicable Florida law, PLAN may non-renew or terminate this Agreement only for one or more of the following reasons upon such notice as provided by Florida law:
- 8.3.1 COUNTY failed to pay premiums in accordance with the terms of this Agreement or PLAN has not received timely premium payments and PLAN provided COUNTY with notice in accordance with this Agreement and Florida law.
- 8.3.2 COUNTY performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Agreement.
- 8.3.3 There is no longer any Member who lives or works in the PLAN service area.
- 8.3.4 PLAN may terminate this Agreement for cause as set forth by applicable federal and state law, as amended from time to time.
- 8.4 In the event that PLAN files a petition seeking bankruptcy protection, or enters into an arrangement with creditors because of its insolvency, then upon thirty (30) days' notice, COUNTY may declare this Agreement cancelled.
- 8.5 Notice of termination shall be provided in accordance with Article 9 of this Agreement, entitled "Notices," except that notice of termination by the County Administrator, which the County Administrator deems necessary to protect the public health, safety, or welfare may be made by verbal notice that shall be promptly confirmed in writing in accordance with Article 9 of this Agreement.

- 8.6 In the event this Agreement is terminated by COUNTY for convenience, PLAN shall be paid for any services performed in accordance with the Agreement through the termination date specified in the written notice of termination. PLAN acknowledges and agrees that it has received good, valuable and sufficient consideration from COUNTY, the receipt and adequacy of which are, hereby acknowledged by PLAN, for COUNTY's right to terminate this Agreement for convenience.
- 8.5 In the event this Agreement is terminated for any reason, any amounts due PLAN shall be withheld by COUNTY until all documents are provided to COUNTY pursuant to Article 10 of this Agreement.

ARTICLE 9

NOTICES

Whenever either party desires to give notice unto the other, except for notice relating to the performance of service provisions set forth in Exhibit "C" of this Agreement, such notice must be in writing, sent by certified United States mail, postage prepaid, return receipt requested, or sent by commercial express carrier with acknowledgement of delivery, or by hand delivery with a request for a written receipt of acknowledgement of delivery, addressed to the party for whom it is intended, at the place last specified in Article 9. The place for giving notice shall remain the same as set forth herein until changed by giving notice in writing to the other party in the manner provided in this section. For the present, the parties designate the following:

COUNTY:

Human Resource Director
Broward County Human Resources Division
Governmental Center, Room 508
115 South Andrews Avenue
Fort Lauderdale, Florida 33301

PLAN HEALTHPLAN, INC.:

Catherine Aguirre, Vice President, Account Services
PLAN HEALTHPLAN, INC.
1340 Concord Terrace
Sunrise, Florida 33323

ARTICLE 10

OWNERSHIP OF DOCUMENTS

Pursuant to federal and state privacy regulations, any and all reports, photographs, surveys, and other data and documents provided or created in connection with this Agreement are and shall remain the property of PLAN. Notwithstanding the foregoing, to the extent permitted under HIPAA, in the event of termination of this Agreement, COUNTY shall have access to any reports, photographs, surveys, and other data and documents prepared by PLAN, whether finished or unfinished, and such documents shall be delivered by PLAN to the Contract Administrator within seven (7) days of termination of this Agreement by either party. Any compensation due to PLAN shall be withheld until all documents are received as provided herein. Nothing herein is intended to require that PLAN release to COUNTY any claims or medical records or protected health information of COUNTY employees and/or their dependents without appropriate releases by such individuals.

ARTICLE 11

AUDIT RIGHT AND RETENTION OF RECORDS

- 11.1 To the extent permitted under HIPAA, COUNTY shall have the right to audit the books, records, and accounts of PLAN that are related to this Agreement. PLAN shall keep such books, records, and accounts as may be necessary to record complete and correct entries related to PLAN's services under this Agreement. All books, records, and accounts of PLAN shall be kept in written form, or in a form capable of conversion into written form within a reasonable time, and upon request to do so, PLAN shall make same available in written form at no cost to COUNTY.
- 11.2 To the extent permitted under HIPAA, PLAN shall preserve and make available, at reasonable times for examination and audit by COUNTY, all financial records, supporting documents, statistical records, and any other documents pertinent to this Agreement for the required retention period of the Florida Public Records Act, Chapter 119, Florida Statutes, as may be amended from time to time, if applicable, or, if the Florida Public Records Act is not applicable, for the requisite time period set forth in any other applicable state and/or federal law including, but not limited to, HIPAA. If any audit has been initiated and audit findings have not been resolved at the end of the retention period, the books, records, and accounts shall be retained until resolution of the audit findings. If the Florida Public Records Act is determined by COUNTY to be applicable to PLAN's records, PLAN shall comply with all requirements thereof; however, no confidentiality or non-disclosure requirement of either federal or state law shall be violated by PLAN. Any incomplete or incorrect entry in such books, records, and accounts shall be a basis for COUNTY's disallowance and recovery of any payment upon such entry.

ARTICLE 12

INDEPENDENT CONTRACTOR

PLAN is an independent contractor under this Agreement. Services provided by PLAN pursuant to this Agreement shall be subject to the supervision of PLAN. In providing such services, neither PLAN nor its agents shall be officers, employees, or agents of COUNTY. No partnership, joint venture, or other joint relationship is created hereby. COUNTY does not extend to PLAN or PLAN's agents any authority of any kind to bind COUNTY in any respect whatsoever.

ARTICLE 13

ASSIGNMENT AND PERFORMANCE

- 13.1 Neither this Agreement nor any right or interest herein shall be assigned, transferred, or encumbered without the prior written consent by the other party. COUNTY may terminate this Agreement, effective immediately, if there is any assignment, or attempted assignment, transfer, or encumbrance, by PLAN of this Agreement or any right or interest herein without COUNTY's prior written consent.

Any purchase, sale, merger, consolidation, reorganization which may result in a change of control of PLAN shall not be deemed an assignment; however, it shall require written notice to COUNTY no later than when notice is provided to its shareholders. In the event PLAN, or any portion thereof, becomes the intended subject of a purchase, sale, merger, consolidation, reorganization, or other transaction which may result in a change of control of PLAN, PLAN shall provide notice to COUNTY pursuant to Article 9 of this Agreement no later than when notice is provided to its shareholders. Within ninety (90) days of receipt of such notice, COUNTY at COUNTY's sole discretion may terminate this Agreement. Upon COUNTY's notice to terminate under Article 13 of this Agreement, COUNTY shall have the right at the sole discretion of the Contract Administrator to continue this Agreement on a month to month basis for a maximum of six (6) months to allow time to transition to a new vendor.

PLAN agrees that any succeeding entity shall accept and agree to perform the continuing covenants of this Agreement and such entity shall further agree to continue to be responsible for compliance with and performance of the terms and conditions of this Agreement.

- 13.2 PLAN represents that each person who will render services pursuant to this Agreement is duly qualified to perform such services by all appropriate governmental authorities, where required, and that each person is reasonably

experienced and skilled in the area(s) for which he or she will render his or her services.

PLAN shall perform its duties, obligations, and services under this Agreement in a skillful and respectable manner. The quality of PLAN's performance and all interim and final product(s) provided to or on behalf of COUNTY shall be comparable to the best local and national standards.

ARTICLE 14

AMENDMENTS

No modification, amendment, or alteration of the terms or conditions contained herein shall be effective unless contained in a written document prepared with the same or similar formality as this Agreement and executed by the COUNTY and PLAN or others delegated authority to or otherwise authorized to execute same on their behalf.

ARTICLE 15

MATERIALITY AND WAIVER OF BREACH

- 15.1 COUNTY and PLAN agree that each requirement, duty, and obligation set forth herein was bargained for at arms-length and is agreed to by the parties in exchange for quid pro quo, that each is substantial and important to the formation of this Agreement and that each is, therefore, a material term hereof.
- 15.2 COUNTY's failure to enforce any provision of this Agreement shall not be deemed a waiver of such provision or modification of this Agreement. A waiver of any breach of a provision of this Agreement shall not be deemed a waiver of any subsequent breach and shall not be construed to be a modification of the terms of this Agreement.

ARTICLE 16

SEVERABILITY

In the event a portion of this Agreement is found by a court of competent jurisdiction or, if applicable, by a state regulatory agency with jurisdiction over such matters to be invalid, illegal, or unenforceable in any respect, the remaining provisions shall continue to be effective. If any portion of this Agreement is severed pursuant to this Article 16, COUNTY shall have the right to terminate this Agreement. An election to terminate this Agreement based upon this provision shall be made within seven (7) days after the finding by the court or state regulatory agency becomes final.

ARTICLE 17

COMPLIANCE WITH LAWS

COUNTY and PLAN shall comply with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations in performing its duties, responsibilities, and obligations pursuant to this Agreement. In the event any of the terms of this Agreement are inconsistent with such laws, codes, ordinances, rules, and regulations, this Agreement shall be construed to operate in conformity with the requirements of such laws, codes, ordinances, rules, and regulations.

ARTICLE 18

INDEMNIFICATION

PLAN shall at all times hereafter indemnify, hold harmless and, at County Attorney's option, defend or pay for an attorney selected by the County Attorney to defend COUNTY, its officers, agents, servants, and employees from and against any and all causes of action, demands, claims, losses, liabilities, and expenditures of any kind, including attorney fees, court costs, and expenses, caused or alleged to be caused by intentional or negligent act or omission of PLAN, its employees, agents, servants, subcontractors, and officers, or accruing, resulting from, or related to the subject matter of this Agreement including, without limitation, any and all claims, demands, losses, liabilities, expenditures or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property. In the event any lawsuit or other proceeding is brought against COUNTY by reason of any such claim, cause of action, or demand, PLAN shall, upon written notice from COUNTY, resist and defend such lawsuit or proceedings by counsel satisfactory to COUNTY or, at COUNTY's option, pay for an attorney selected by the County Attorney to defend COUNTY. The provisions and obligations of this section shall survive the expiration or earlier termination of this Agreement. To the extent considered necessary by the Contract Administrator and the County Attorney, any sums due PLAN under this Agreement may be retained by COUNTY until all of COUNTY's claims for indemnification pursuant to this Agreement have been settled or otherwise resolved; and any amount withheld shall not be subject to payment of interest by COUNTY. This indemnification provision shall not be construed as obligating PLAN to indemnify COUNTY for losses caused by the negligence or willful misconduct of COUNTY.

ARTICLE 19

INSURANCE

19.1 Insurance Coverage. In order to insure the indemnification obligation contained above, PLAN shall, at a minimum, provide, pay for, and maintain in force at all

times during the term of this Agreement (unless otherwise provided), the insurance coverages set forth in Subsections 19.1, through 19.7, in accordance with the terms and conditions required by this Article. Each insurance policy shall clearly identify the foregoing indemnification as insured.

19.2 Such policy or policies shall be without any deductible amount unless otherwise noted in this Agreement and shall be issued by approved companies authorized to do business in the State of Florida., and having agents upon whom service of process may be made in Broward County, Florida. PLAN shall pay all deductible amounts, if any. PLAN shall specifically protect COUNTY and the Broward County Board of County Commissioners by naming COUNTY and the Broward County Board of County Commissioners as additional insureds under the Commercial General Liability Policy. The official title of the certificate holder is Broward County Board of County Commissioners. This official title shall be used in all insurance documentation.

19.3 Commercial General Liability Insurance. A Commercial General Liability Insurance Policy shall be provided, which shall contain minimum limits of One Million Dollars (\$1,000,000) per occurrence, and shall contain minimum limits of Two Million Dollars (\$2,000,000) per aggregate. Coverage must be afforded on a form no more restrictive than the latest edition of the Commercial General Liability Policy, without restrictive endorsements, as filed by the Insurance Service Office ("ISO") and must include:

Premises and/or operations.

Independent contractors.

Products and /or Completed Operations for contracts.

Broad Form Contractual Liability Coverage applicable to this specific Agreement, including any hold harmless and/or indemnification Agreement.

Personal Injury Coverage with Employee and Contractual Exclusions removed, with minimum limits of coverage equal to those required for Bodily Injury Liability and Property Damage Liability.

19.4 Business Automobile Liability. A Business Automobile Liability Policy shall be provided, which shall contain minimum limits of One Million Dollars (\$1,000,000) per occurrence, combined single limit for Bodily Injury Liability and Property Damage Liability. Coverage must be afforded on a form no more restrictive than the latest edition of the Business Automobile Liability Policy, without restrictive endorsements, as filed by the ISO, and must include:

Owned Vehicles, if applicable.

Hired and Non-Owned Vehicles, if applicable.

Employers' Non-Ownership, if applicable.

- 19.5 Umbrella or Excess Liability. PLAN may satisfy the liability limits required above for Commercial General Liability or Business Auto Liability under an Umbrella or Excess Liability policy. There is no minimum Per Occurrence limit of liability under the Umbrella or Excess Liability; however, the Annual Aggregate limit shall not be less than the highest "Each Occurrence" limit for either Commercial General Liability or Business Auto Liability.
- 19.6 Workers' Compensation Insurance. Workers' Compensation insurance is to apply for all employees in compliance with Chapter 440, Florida Statutes, as may be amended from time to time, the "Workers' Compensation Law" of the State of Florida and all applicable federal laws. In addition, the policy(ies) must include:
- Employer's Liability with a minimum limit of One Hundred Thousand Dollars (\$100,000) each accident.
- 19.7 Professional Liability Insurance: PLAN shall maintain, for the term of this Agreement, Professional Liability Insurance, including coverage for errors and omissions, in the minimum amount of Five Million Dollars (\$5,000,000) per claim. If written with a deductible, PLAN shall be solely responsible for payment of that deductible. PLAN shall notify COUNTY in writing within thirty (30) calendar days of any claims filed or made against the Professional Liability Insurance Policy.
- 19.8 PLAN shall furnish to the COUNTY's Contract Administrator Certificate of Insurance or endorsements evidencing the insurance coverage specified by this Article within fifteen (15) calendar days after notification of award of this Agreement and attached hereto as Exhibit "D." The required Certificates of Insurance shall name the types of policies provided, refer specifically to this Agreement, and state that such insurance is as required by this Agreement. The Certificate of Insurance shall be in form similar to and contain the information set forth in Form 00708, to be provided by the COUNTY's Risk Management Division. PLAN's failure to provide to COUNTY the Certificates of Insurance or endorsements evidencing the insurance coverage within fifteen (15) calendar days shall provide the basis for the termination of the Agreement.
- 19.9 Coverage is not to cease and is to remain in force (subject to cancellation notice) until all performance required of PLAN is completed. All policies must be endorsed to provide COUNTY with at least thirty (30) days' notice of expiration, cancellation and /or restriction. If any of the insurance coverages will expire prior to the completion of the work, copies of renewal Certificate of Insurance shall be furnished at least thirty (30) days prior to the date of their expiration.

ARTICLE 20

NONDISCRIMINATION, EQUAL EMPLOYMENT OPPORTUNITY, AND AMERICANS WITH DISABILITIES ACT

- 20.1 PLAN shall not unlawfully discriminate on the basis of race, color, national origin, sex, religion, age, marital status, political affiliation, disability, or sexual orientation (including but not limited to any other protected category in Broward County Code, Chapter 16½) in the performance of this Agreement, the solicitation for or purchase of goods or services relating to this Agreement, or in subcontracting work (if authorized) in the performance of this Agreement. PLAN shall include the foregoing or similar language in its agreements with any subcontractors, except that any project assisted by the U.S. Department of Transportation funds shall comply with the non-discrimination requirements in 49 CFR Parts 23 and 26, as amended. Failure to comply with the foregoing requirements is a material breach of the Agreement, which may result in termination of this Agreement or such other remedy as COUNTY deems appropriate.
- 20.2 PLAN shall not unlawfully discriminate against any person in its operations and activities or in its use or expenditure of funds in fulfilling its obligations under this Agreement. PLAN shall affirmatively comply with all applicable provisions of the Americans with Disabilities Act (ADA) in the course of providing any services funded by COUNTY, including Titles I and II of the ADA (regarding nondiscrimination on the basis of disability), and all applicable regulations, guidelines, and standards. In addition, PLAN shall take affirmative steps to ensure nondiscrimination in employment against disabled persons.

ARTICLE 21

JURISDICTION, VENUE, GOVERNING LAW, AND WAIVER OF JURY TRIAL

This Agreement shall be interpreted and construed in accordance with and governed by the laws of the State of Florida and when applicable, federal law. All parties agree and accept that jurisdiction of any controversies or legal problems arising out of this Agreement and any action involving the enforcement or interpretation of any rights hereunder, shall be in the state courts of the Seventeenth Judicial Circuit in Broward County, Florida or in the United States District Court, Southern District of Florida, and venue for litigation arising out of this Agreement shall be in such courts, forsaking any other jurisdiction which either party may claim by virtue of its residency or other jurisdictional device. BY ENTERING INTO THIS AGREEMENT, PLAN AND COUNTY HEREBY EXPRESSLY WAIVE ANY RIGHTS EITHER PARTY MAY HAVE TO A TRIAL BY JURY OF ANY CIVIL LITIGATION RELATED TO THIS AGREEMENT.

ARTICLE 22

CONFLICT OF INTEREST

- 22.1 PLAN agrees that no employee or principal, in the course and scope of their employment or relationship with PLAN, shall, during the term of this Agreement, serve as an expert witness, or an adverse or hostile witness, against COUNTY in any legal or administrative proceeding, unless a party to such action is compelled to give testimony by court process. Further, PLAN agrees that neither PLAN, any principal, employee, nor agent shall give sworn testimony or issue a report or writing as an expression of his or her opinion which is adverse or prejudicial to the interests of COUNTY in connection with any such pending or threatened legal or administrative proceeding. The limitations of this section shall not preclude PLAN or any other persons from representing themselves in any action or in any administrative or legal proceeding.
- 22.2 PLAN agrees that neither PLAN, its principals, nor its employees shall have or hold any contractual or employment relationship with any of COUNTY's fringe benefit providers or any other entities competing to provide fringe benefits or related services to COUNTY or its employees in relation to COUNTY's employees benefits programs, have a material interest in such providers or entities during the term of this Agreement, including any renewal periods, or have a continuing or frequently recurring employment or contractual relationship that is substantially antagonistic or incompatible with PLAN's loyal and conscientious exercise of judgment related to its performance under this Agreement.
- 22.3 PLAN agrees that neither PLAN, its principals, nor its employees shall receive any fees, commissions or other compensation from any of the COUNTY's fringe benefit providers or any other entities competing to provide fringe benefits or related services to COUNTY or its employees in relation to the COUNTY's employee benefits programs.

ARTICLE 23

CONTINGENCY FEE

PLAN warrants that it has not employed or retained any company or person, other than a bona fide employee working solely for PLAN, to solicit or secure this Agreement and that it has not paid or agreed to pay any person, company, corporation, individual or firm, other than a bona fide employee working solely for PLAN, any fee, commission, percentage, gift, or other consideration contingent upon or resulting from the award or making of this Agreement. For a breach or violation of this provision, COUNTY shall have the right, at its discretion, to terminate this Agreement without liability, or to deduct from this Agreement price or otherwise recover the full amount of such fee, commission, percentage, gift, or consideration.

ARTICLE 24

JOINT PREPARATION

Each party and its counsel have participated fully in the review and revision of this Agreement and acknowledge that the preparation of this Agreement has been their joint effort. The language agreed to expresses their mutual intent and the resulting document shall not, solely as a matter of judicial construction, be construed more severely against one of the parties than the other. The language in this Agreement shall be interpreted as to its fair meaning and not strictly for or against any party.

ARTICLE 25

PRIORITY OF PROVISIONS

If there is a conflict or inconsistency between any term, statement, requirement, or provision of any exhibit attached hereto, any document or events referred to herein, or any document incorporated into this Agreement by reference, and a term, statement, requirement, or provision of this Agreement, the term, statement, requirement, or provision contained in this Agreement shall prevail and be given effect, except for such Articles in Exhibits "A" through "D," which describe the scope of services and performance standards particular to each exhibit. In that case, the specific scope of services and performance standards delineated in each exhibit will prevail over the corresponding scope of services and performance standards in this Agreement. Otherwise, any term, statement, or requirement which is severed from this Agreement pursuant to Article 16 herein because such term, statement, or requirement is held to be invalid, illegal, or unenforceable in any respect, then such term shall be considered severed from the attached and incorporated exhibits as well.

ARTICLE 26

PRIOR AGREEMENTS

This document incorporates and includes all prior negotiations, correspondence, conversations, agreements, and understandings applicable to the matters contained herein and the parties agree that there are no commitments, Agreements or understandings concerning the subject matter of this Agreement that are not contained in this document or otherwise incorporated herein. Accordingly, the parties agree that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written. It is further agreed that no modification, amendment or alteration in the terms or conditions contained herein shall be effective unless set forth in writing in accordance with Article 14 above.

ARTICLE 27

THIRD PARTY BENEFICIARIES

Neither PLAN nor COUNTY intends to directly or substantially benefit a third party by this Agreement. Therefore, the parties agree that there are no third party beneficiaries to this Agreement and that no third party shall be entitled to assert a claim against either of them based upon this Agreement.

ARTICLE 28

ADDITIONAL SERVICES AND CHANGES IN SCOPE OF SERVICES

COUNTY or PLAN may request changes that would increase, decrease, or otherwise modify the Scope of Services to be provided under Article 3 of this Agreement entitled "Scope of Services/Selected Policies and Benefits," Exhibit "C" of this Agreement entitled "General Provisions/Service Standards". Such changes must be contained in a written amendment, prepared and executed consistent with Article 14 of this Agreement entitled "Amendments," prior to any deviation from the terms of this Agreement, including the initiation of any additional services. COUNTY shall compensate PLAN for such additional services as mutually agreed to by the parties.

ARTICLE 29

PUBLIC ENTITY CRIME ACT

- 29.1 PLAN represents that the execution of this Agreement will not violate the Public Entity Crime Act, Section 287.133, Florida Statutes, as may be amended from time to time, which essentially provides that a person or affiliate who is a contractor, consultant or other provider and who has been placed on the convicted vendor list following a conviction for a Public Entity Crime may not submit a bid on a contract to provide any goods or services to COUNTY, may not submit a bid on a contract with COUNTY for the construction or repair of a public building or public work, may not submit bids on leases of real property to COUNTY, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with COUNTY, and may not transact any business with COUNTY in excess of the threshold amount provided in Section 287.017, Florida Statutes, as may be amended from time to time, for category two purchases for a period of thirty-six (36) months from the date of being placed on the convicted vendor list. Violation of this section shall result in termination of this Agreement and recovery of all monies paid hereto, and may result in debarment from COUNTY's competitive procurement activities.
- 29.2 In addition to the foregoing, PLAN further represents that there has been no determination, based on an audit, that it committed an act defined by

Section 287.133, Florida Statutes, as a “public entity crime” and that it has not been formally charged with committing an act defined as a “public entity crime” regardless of the amount of money involved or whether PLAN has been placed on the convicted vendor list.

ARTICLE 30

DRUG-FREE WORKPLACE

It is a requirement of COUNTY that it enter into contracts only with firms that certify the establishment of a drug-free workplace in accordance with Chapter 21.31(a)(2) of the Broward County Procurement Code. Execution of this Agreement by PLAN shall serve as PLAN’s required certification that it either has established or that it will establish a drug-free workplace in accordance with Section 287.087, Florida Statutes, as may be amended from time to time, and Chapter 21.31(a)(2) of the Broward County Procurement Code, as may be amended from time to time.

ARTICLE 31

LEGISLATIVE, REGULATORY, OR ADMINISTRATIVE CHANGE

In the event there shall be a change in the relevant federal or state statutes or regulations, the adoption of new federal or state legislation, or a change in any reimbursement system, any of which are reasonably likely to materially and adversely affect the manner in which either party may perform under this Agreement or which shall make this Agreement unlawful, the parties shall immediately enter into good faith negotiations regarding a new service agreement that complies with the law, regulation or policy and that approximates as closely as possible the position of the parties prior to the change.

ARTICLE 32

HIPAA COMPLIANCE

PLAN acknowledges that it must comply with the Rules and Regulations implementing HIPAA and PLAN agrees to abide by such Rules and Regulations upon their implementation, and abide by any other laws that evolve from HIPAA, either federal or state, upon their implementation. Where required PLAN shall handle and secure such PHI in compliance with HIPAA and its related regulations.

ARTICLE 33

INCORPORATION BY REFERENCE

The Exhibits "A," entitled "Certificate of Coverage", Exhibit "B," entitled "Premium Rates," Exhibit "C," entitled "General Provisions/Performance Standards," Exhibit "D," entitled "Certificate of Liability Insurance," and Exhibit "E," entitled "RLI," attached hereto and referenced in the respective articles of this Agreement, are incorporated into and made part of this Agreement.

ARTICLE 34

MULTIPLE ORIGINALS

This Agreement may be fully executed in four (4) copies by all parties, each of which, bearing original signatures, shall have the force and effect of an original document.

ARTICLE 35

PLAN REPRESENTATIONS AND WARRANTIES

- 35.1 PLAN warrants and guarantees that it is properly licensed and authorized to do business in Broward County as required by the laws of the State of Florida, and the administrative rules and regulations of the Florida Department of Financial Services.
- 35.2 PLAN agrees that the officer who signs this Agreement on its behalf, his or her name and signature appearing on the signature page corresponding to PLAN hereto, has full power and authority to execute this Agreement, and such officer's execution and PLAN's performance of the Agreement is a valid and binding obligation of PLAN which does not conflict with PLAN's respective articles of incorporation, by-laws, or any other Agreements to which PLAN is bound.

[THIS SECTION INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the parties have made and executed this Agreement on the respective dates under each signature: BROWARD COUNTY through its BOARD OF COUNTY COMMISSIONERS, signing by and through its Mayor or Vice Mayor, authorized to execute same by Board action on the ____ day of _____, 2009, and PLAN HEALTHPLAN INC., signing by and through its _____ on the ____ day of _____, 200__, and COVENTRY HEALTH AND LIFE INSURANCE COMPANY, signing by and through its _____, on the ____ day of _____, 200__.

COUNTY

ATTEST:

BROWARD COUNTY, through its
BOARD OF COUNTY COMMISSIONERS

County Administrator and, Chair

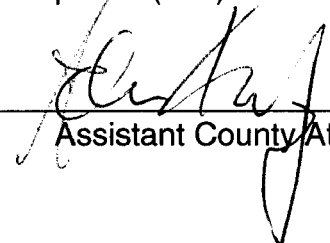
BY _____

Ex-Officio Clerk of the Board of County
Commissioners of Broward
County, Florida ____ day of _____, 200__.

Approved as to form by
Office of County Attorney
Broward County, Florida
Jeffrey J. Newton, County Attorney
Governmental Center, Suite #423
115 South Andrews Avenue
Fort Lauderdale, Florida 33301
Telephone: (954) 357-7600
Telecopier: (954) 357-7641

Insurance requirements
approved by Broward County
Risk Management Division

By  _____

By  _____
Assistant County Attorney

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Autism Spectrum Disorder

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

Effective date: April 1, 2009

The Certificate of Coverage is revised as follows:

The Certificate of Coverage has been revised to include Autism Spectrum Disorder and other Developmental Disability Therapies.

Eligibility

In order to be eligible to receive benefits, a Member is under eighteen (18) years of age or a Member is eighteen (18) years of age or older and in high school who has been diagnosed as having a developmental disability at eight (8) years of age or younger.

Definitions

Applied Behavior Analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

1. Autistic disorder.
2. Asperger's syndrome.
3. Pervasive developmental disorder not otherwise specified.

Covered Services

Autism Spectrum Disorder

Benefits are provided for the recognized services listed below when prescribed by the Member's treating physician in accordance with a treatment plan:

1. Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.
2. Speech therapy: treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly or Autism Spectrum Disorder.
3. Occupational therapy.
4. Physical therapy.
5. Applied Behavior Analysis shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

A treatment plan shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

Coverage may not be denied on the basis that provided services are habilitative in nature.

Exclusions and Limitations

Coverage is subject to a maximum benefit of \$36,000 per calendar year not to exceed \$200,000 in total individual lifetime benefits.

VISTA HEALTHPLAN™, INC.

A handwritten signature in black ink, appearing to read "Richard Weiss".

Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Bone Marrow Transplant

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Coverage is revised as follows:

The Transplantation benefit in the Covered Services section has been revised with the following language.

Covered Services Section

Transplantation

Bone Marrow Transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental in accordance with applicable Florida law. As used in this section, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, 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 chemotherapy.

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Dependent to Age 30

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Coverage is revised as follows:

Dependent Eligibility

To be eligible to enroll a Dependent, the Subscriber's Dependent must meet all the requirements as the Eligible Dependent as set forth below and be the Subscriber's s:

1. lawful spouse; or
2. a dependent child until the end of the Calendar Year in which the child turns twenty-five (25) years of age, if the child meets all of the following requirements:
 - a. the child is dependent on the Subscriber for support; and
 - b. the child is living in the Subscriber's household, or a Full Time or Part Time Student.
3. a dependent child until the end of the Calendar Year in which the child turns thirty (30) years of age, if the child meets all of the following requirements:
 - a. is unmarried and does not have a dependent of his or her own; and
 - b. is a resident of Florida or a Full Time or Part Time Student; and
 - c. is not provided coverage as a named subscriber, insured, enrollee, or a covered person under any other group or individual health benefit plan or is not entitled to benefits under Title XVIII of the Social Security Act.

If a Dependent child is provided coverage under the Subscriber's Certificate of Coverage after the child reaches age twenty-five (25) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Subscriber's Certificate of Coverage unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

The term child includes the Subscriber's natural born child, stepchild, or a foster or legally adopted child of the Subscriber upon placement in the residence, or at the birth of a newborn adopted child, where a written agreement to adopt such child had been entered into prior to the birth of the child, whether or not that agreement is enforceable. If the foster or adopted child is ultimately not placed in the residence of the Subscriber, no benefit will apply.

The term also includes any child for whom the Subscriber is the legal guardian or a child who is dependent on the Subscriber for health care coverage pursuant to a valid court order. VISTA has the right to request proof of any child's dependency status at any time.

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
Amendment to
HMO Open Access Certificate of Coverage
Broward County Board of County Commissioners

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

EFFECTIVE DATE: January 1, 2010

The HMO Open Access Certificate of Coverage is revised as follows:

INTRODUCTION

First paragraph is amended as follows:

This Certificate of Coverage provides Members with coverage for Medically Necessary Covered Services through a Health Maintenance Organization (“HMO”) provided by Vista Healthplan, Inc. (hereinafter referred to as “VISTA”). Coverage will only be provided for care that is rendered by Participating Providers for the Open Access Plan, except in the case of Emergency Medical Conditions or when, in Our sole judgment, the care required is not available from a Participating Provider.

Third paragraph is amended as follows:

To be seen by a Specialist, a Member will not be required to obtain a referral from his/her Primary Care Physician.

SECTION 1 ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

A. Eligibility

1. Subscriber
 - a. For a full-time employee: work twenty-five (25) hours or more during a normal work week and receive wages. For a part-time time employee: must work a minimum of twenty (20) hours during a normal work week and receive wages. Business owners must be noted on the Employers federal income tax Schedule C. Officers and/or Board Members of a company are not eligible for coverage unless they meet the same eligibility requirements specified herein for a full-time employee.
2. Eligible Dependents. Subject to the limitations set forth in this Certificate of Coverage, to be eligible to enroll as a Dependent and remain covered as a Dependent, a person must be:
 - a. The lawful spouse of the Subscriber,
 - b. The Subscriber’s Registered Domestic Partner;
 - c. Child(ren) shall include:
 1. an unmarried child of the Subscriber or
 2. Registered Domestic Partner (while the Registered Domestic Partnership is in-force)
 3. natural born child;
 4. stepchild(ren);
 5. legally adopted child(ren) or foster child(ren) upon placement in the Subscriber’s home;
 6. a child whom the Subscriber has legal guardianship;
 7. grandchild(ren); a dependent of a dependent (child born to an enrolled child dependent) may remain on the plan for up to eighteen (18) months from the newborn’s date of birth.

After the eighteen (18) months, the dependent of a dependent must meet criteria of foster child, adoption or legal guardianship by the Subscriber or spouse/domestic partner by a court of law;

- d. If a dependent child is provided coverage under the Subscriber's Certificate of Coverage after the child reaches age twenty-five (25) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Subscriber's Certificate of Coverage unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.
3. A Subscriber's unmarried child up to the age of nineteen (19) thru age twenty-one (21) if enrolled as a part-time or full-time student (earning a minimum of six (6) credit hours) at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school); age twenty-two (22) through the age of thirty (30) a full-time student (earning a minimum of twelve (12) credit hours) enrolled at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school). Subscriber will be required to provide proof of such student status. Coverage under this provision will remain in effect until the end of the calendar year.

A Subscriber's dependents who live or are enrolled as part-time or full-time students at schools outside the Service Area are covered under this Plan for Emergency Medical Conditions only. To receive full coverage under this Plan, the dependent must return to the Plan's Service Area.

4. Handicapped Child(ren); a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap incurred prior to age nineteen (19), or age 19 through age twenty-one (21) if a part-time or full-time student as defined herein, and age twenty-two through age twenty-five (25) if a full-time student. The child must be chiefly dependent on the Subscriber for support and maintenance. If a claim is denied, the Subscriber will be required to provide proof of mental retardation or handicap as well as from time to time upon request. Coverage will not terminate if the child continues to meet the criteria established herein.

B. Enrollment

6. **General Limitation Period.** If an Eligible Employee and his or her Eligible Dependents enroll for coverage under this Group Agreement during his or her Initial Enrollment Period, Annual Open Enrollment Period, or Special Enrollment Period, pre-existing conditions will be covered. If an Eligible Employee and his or her Dependents do not enroll for coverage during the Initial, Annual or Special Open Enrollment Period, they will be considered a Late Enrollee and subject to the delayed coverage rules as specified in the Late Enrollee Provision.
7. **Special Enrollment Period.** An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:
 - a. The Eligible Employee or Eligible Dependent was covered under other health coverage at the time coverage was previously offered to the Employee or Dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. The Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage.
 - (1) For an Eligible Employee, the previous coverage:
 - (a) Must have been under COBRA or State Continuation and the coverage was exhausted; or
 - (b) Was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.

- (2) For an Eligible Dependent, the coverage:
 - (a) Is newly made available to Dependents;
 - (b) Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;
 - (c) Is for a person who becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption.
- (3) New Dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:
 - (a) The date coverage is made available; or
 - (b) The date of marriage, birth, adoption, or placement for adoption.
- (4) In the case of a Dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if VISTA receives enrollment applications in the time frame specified herein. Other Dependent coverage is effective:
 - (a) In the case of marriage, as of the first of the following month, or
 - (b) In the case of a dependent's birth, as of the date of birth; or
 - (c) In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

8. Late Enrollees. (section shall read as follows): Unless otherwise prohibited by law, an Eligible Employee or Eligible Dependent who tries to enroll outside the Initial Enrollment Period or Annual Open Enrollment Period will be considered a Late Enrollee, unless that person is considered a Special Enrollee as described above. A Late Enrollee who wants to enroll for coverage under this Group Agreement must complete an Enrollment Application during the next Annual Open Enrollment Period, or if eligible, a Special Enrollment Period. Late Enrollees should contact his/her Benefits Department to determine when they are next eligible to enroll after his/her Initial Enrollment Period has expired.

9. Coverage for Retirees

- a. A covered Employee who is eligible for retiree health coverage under Group's eligibility rules, who retires prior to age 65 and who is not eligible for Medicare may remain covered under this Plan. His/her dependents will also remain covered under this Plan as long as they remain eligible for Dependent coverage. The retiree may also switch to the Consumer Driven Plan with Out-of-Network benefits offered by VISTA.
- b. A retiree who is eligible for Medicare shall have the same options described in paragraph 1 above. The retiree may also elect to discontinue coverage under this Plan and enroll in VISTA's Medicare HMO program. If the retiree makes such an election, his/her dependents may remain covered under this Plan as long as they remain eligible for Dependent coverage.

10. Dependent Survivor Benefit

When an employee or a retiree covered under this Plan dies, any of his Dependents who are then covered under this Plan, except those who are eligible for Medicare, will remain covered under this Plan without further payment of premiums, until the earliest of the following dates:

- a. The last day of the twelfth month after the employee's or retiree's death;
- b. The date of remarriage of a surviving spouse or new Domestic Partnership, if any;

- c. The date that Dependent qualifies for Medicare;
- d. The date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by the deceased employee or retiree.

Coverage under this provision shall be the same as that in effect at the employee's or retiree's death.

C. Effective Date of Coverage

2. Newly Eligible Employees: coverage will begin as of the first day of the calendar month following the date the employee becomes eligible, if written application is made on or before that date.
4. Late Enrollee. Coverage will begin as of the first day of the calendar month following the date application is received during an Annual Open Enrollment Period or Special Enrollment Period.

E. Member Status Change Form

2. Proof of Dependent Status
 - a. if a student, a letter from Registrar's Office certifying current hours enrolled; or
 - b. if disabled, a Healthcare Professional's certification stating date and degree of disability.

SECTION 3 COVERAGE PROVISIONS

C. Benefits and Services Excluded from Coverage

1. Members shall not be entitled to the benefits and services set forth in the Exclusions and Limitations Section, nor are Members entitled to benefits and services set forth in this Group Agreement:
 - a. If rendered by a Participating Physician without Prior Authorization for certain Covered Services; or
 - b. If rendered by a Non-Participating Provider without Prior Authorization in writing from VISTA with the exception of services rendered for Emergency Medical Conditions.
2. Copayment Responsibilities

Members may be required to pay Copayment amounts in connection with services and benefits covered under this Agreement. Such Copayments are set forth in the Schedule of Benefits. Copayments must be paid at the time of service unless alternate arrangements are made.

G. Prior Authorization (this section has been amended as follows)

In order to be eligible to receive benefits available under this Group Agreement, VISTA requires Prior Authorization by the Medical Management Department for certain services. If You fail to obtain Prior Authorization when it is required, benefits that may have otherwise been covered will be denied. The following treatment or services are examples, but not an inclusive list of treatments and services that must be authorized by Us as explained below:

1. Hospital confinements and Skilled Nursing Facility confinements;
2. Non-emergent transportation; air ambulance;
3. All non-emergency outpatient hospital services, including but not limited to, surgical, laboratory and diagnostic, except mammograms;
4. Non-emergency wound care procedures;
5. Inpatient rehabilitative services;
6. Outpatient rehabilitative services at a hospital;
7. DME (for North Florida only);
8. DME – customized/specialty items
9. Prosthetics, Braces, Hospice;
10. Pain Management;
11. C-PAP machine (see Sleep Studies benefit).

For a current list of all services requiring Prior Authorization, You may call Customer Service at 1-866-VISTA FL (1-866-847-8235), TDD #: 1-888-444-7352.

SECTION 4 COVERED SERVICES

A. Covered Services

1. Hospital Inpatient Services

- a. Semi-private room and board including special diets, as prescribed and Medically Necessary, use of operating room, anesthesia, intensive care or other special care units, oxygen, and general or private duty nursing when prescribed. If a Member signs a waiver assuming private room charges, the Member will be responsible for the cost. Private hospital room covered if Medically Necessary.

2. Outpatient Services

- d. Immunizations for pneumococcal and flu vaccinations, and immunizations and inoculations which are Medically Necessary in accordance with accepted medical practice and standards from time to time established by VISTA.
- h. Non-Surgical Spine and Back Disorder Treatment: Manual manipulation of the spine to correct subluxation and physiological therapeutic services deemed Medically Necessary.
- i. Rehabilitative Services: (this replaces the language in the COC) Medically Necessary services when ordered by a treating physician and approved by VISTA are limited to the therapy categories listed below. Therapy for a condition if in the determination of VISTA such therapy is expected to result in improvement in the Member's Condition. Therapy which is given to maintain a level of functioning, and which is not expected to result in improvement in the Member's Condition, shall be covered if authorized by VISTA on the basis that such treatment is necessary to prevent deterioration of the Member's Condition.
 1. Occupational Therapy – Services provided by a Healthcare Professional or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Covered Condition are covered.
 2. Speech Therapy – Services of a Healthcare Professional, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Covered Condition are covered.
 3. Physical Therapy – Services provided by a Healthcare Professional or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.
 4. Respiratory Therapy – Services provided for the purpose of aiding in the restoration of normal physical function of the lungs, due to injury, stroke or a surgical procedure while this coverage was in force.

Rehabilitative Therapy services are unlimited for modalities per day. They include:

1. Services of a licensed speech-language pathologist to aid in the restoration of speech loss or swallowing disorders or an impairment resulting from injury, stroke or a surgical procedure while this coverage was in force.
 2. Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to injury, stroke or a surgical procedure while this coverage was in force.
- j. Outpatient cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction, in accordance with a treatment plan written by the Member's Healthcare Provider and approved by VISTA.

- k. PCP office visits and Specialist office visits include services for cessation of smoking, nutritional and periodic health evaluations for preventive diagnostic and therapeutic care including dietary and stress reduction counseling.

3. Additional Services

Artificial Devices

Benefits are available for artificial heart devices.

Dental Services

Benefits are available for the treatment of an Accidental Dental injury to sound natural teeth if the services are rendered, and the treatment is received within:

- a. twelve (12) months from the date of injury
- b. the Member is continuously covered under this Certificate of Coverage from the date of injury to the date the care and treatment is received.

Family Planning:

Benefits are available for the following and may be, subject to Prior Authorization by VISTA:

- a. counseling;
- b. Voluntary sterilizations, tubal ligations and vasectomies.
- c. Services and care related to the termination of pregnancy.
- d. Intrauterine Devices (IUD), insertion and removal. (See Schedule of Benefits for Member Responsibility).
- e. Measurement and fitting for contraceptive diaphragms.

Home Health Care Services

Covered Home Health Care Services include:

- a. Part-time or intermittent nursing care by a registered nurse or licensed practical nurse is unlimited for hours in duration.

Newborns

Unlimited transportation costs.

Sleep Studies

Benefits are available for:

- a. sleep study for diagnostic purposes;
- b. treatment for obstructive sleep apnea (OSA) which includes continuous positive airway pressure (CPAP) machine if confirmed by a sleep study;
- c. treatment for insomnia and/or narcolepsy.

Transplantation

Coverage includes Medically Necessary services related to organ donation and harvesting if the Member is the recipient of the transplant and the donor has no other coverage for such procedures; however, the cost of purchasing an organ or tissue, and incidental services which are not Medically Necessary to the donation, harvesting or procurement, such as travel and lodging expenses of the Member and donor, are not covered. Donor patient costs will be covered to the same extent as costs associated with the Member for bone marrow transplants only, and limitations associated with such transplants that are determined to be scientifically acceptable and non-experimental for certain types of cancer. Testing to find a suitable donor is limited to the reasonable cost of searching for the donor from immediate family members and the National Bone Marrow Program.

B. Emergency Services and Care

Emergency Services and Care for Emergency Medical Conditions are covered. Following discharge from the Emergency Room, any after care or follow-up care, must be provided by the PCP or a Physician referred by the PCP or VISTA.

SECTION 5 EXCLUSIONS and LIMITATIONS

Cosmetic Surgery (language should read)

2. Any professional services and/or hospitalization in connection with elective Cosmetic Surgery, including but not limited to, body piercing and tattooing, tattoo removal, rhinoplasty, liposuction, abdominoplasty, breast reduction mammoplasty unless medically necessary, blepharoplasty, varicose vein injections, removal or injection of skin tags, of cherry angiomas, telangiectasias, spider angiomas.

Infertility Treatment: Benefits are not available unless elected by Rider.

Learning Disorders: Benefits are available through the Testing Learning Disabilities Amendment to the Certificate of Coverage if applicable.

Personal Comfort, Hygiene or Convenience Items: Benefits are not available for services and supplies deemed to be not Medically Necessary by the Member's PCP and not directly related to the care of the Member including, but not limited to personal care kits, guest meals and accommodations, television, telephone charges, photographs, complimentary meals, birth announcements, take-home supplies, and travel expenses (other than ambulance or other transportation services deemed to be Covered Services) unless medically necessary. The following items are excluded: beauty and barber services, radio, massages, allergenic pillows or mattresses or waterbeds, physical fitness equipment.

Sleep Disorders: See Covered Services for Sleep Studies.

Smoking Cessation: Benefits are available for health education services for cessation of smoking.

Transplantation: Artificial heart devices are covered. See Additional Services Section.

SECTION 6 CLAIMS

D. Reimbursement for Participating and Non-Participating Provider Services

VISTA will provide or arrange for services to be received from Participating Providers on a direct service basis. If a Member receives services from a Participating Provider, VISTA will pay the Healthcare Provider directly for all care received. The Member will not have to submit a claim for payment, and will be responsible only for any applicable Copayments, Deductibles and Coinsurance.

In the event the Member has an Emergency Medical Condition that requires services from a Non-Participating Provider while inside or outside the Service Area if a Member receives Covered Services in a foreign country as a result of an Emergency Medical Condition, the bill and supporting medical records must be in English and the amounts charged and paid must be in U.S. currency with the exchange rate attached for validation. It is the Member's responsibility for obtaining the necessary documents and translations.

The notice must be in writing, and any claim will be based on that written notice. The notice must be received by VISTA within twenty (20) days after the date of the injury or the first treatment date for the sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the twenty (20) day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

SECTION 9 TERMINATION OF COVERAGE

E. CONTINUATION OF COVERAGE during an approved leave under the FAMILY AND MEDICAL LEAVE ACT (FMLA)

Insured persons have the option to continue insurance during an approved leave under the Family and Medical Leave Act (FMLA) upon payment of the required contribution.

Continued insurance terminates when a required contribution is not made when due. Medical insurance under the Group Policy will be reinstated, as required under the Act, upon return to

Active Service for an Insured Person whose insurance terminated during an approved leave under FMLA.

SECTION 12 DEFINITIONS

Eligible Employee: an employee of the Group who works for the Group on a full-time basis, with a normal work week of twenty-five (25) hours or more, or a part-time employee who works a minimum of twenty (20) hours during a normal work week and is eligible based on the criteria established by the Group.

Full-Time Student: a Subscriber's unmarried child who is:

1. aged nineteen (19) through age twenty-one (21) earning a minimum of six (6) credit hours at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school), and;
2. aged twenty-two (22) through the age of twenty-five (25) earning a minimum of twelve (12) credit hours enrolled at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school).

Part-Time Student: a Subscriber's unmarried child aged nineteen (19) thru age twenty-one (21) earning a minimum of six (6) credit hours at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school).

Service Area: the geographic area in which VISTA is authorized to provide health services as approved the Agency for Health Care Administration.

VISTA HEALTHPLAN™, INC.

[signature
Name
Title]

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Qualifying Events

The Agreement between Vista Healthplan, Inc. ("VISTA") and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

Effective date: April 1, 2009

The Certificate of Coverage is revised as follows:

Special Enrollment Period. *An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:*

- a. *The Eligible Employee or Eligible Dependent was covered under other health coverage (as defined by the Federal HIPAA Law) at the time coverage was previously offered to the employee or dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. Except as otherwise set forth herein, the Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage. Enrolling employee/dependent's whose Children's Health Insurance program (CHIP) or Medicaid coverage is terminated, please see below.*
 - (1) *For an Eligible Employee, the previous coverage:*
 - (a) *Must have been under COBRA or State Continuation and the coverage was exhausted; or*
 - (b) *Other group health plan or insurance coverage was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.*
 - (2) *For an Eligible Dependent, the coverage:*
 - (a) *Is newly made available to dependents;*
 - (b) *Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;*
 - (c) *Is for a person who becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption.*
 - (3) *New dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:*
 - (a) *The date coverage is made available; or*
 - (b) *The date of marriage, birth, adoption, or placement for adoption.*
 - (4) *In the case of a dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if VISTA receives enrollment applications in the time frame specified herein. Other dependent coverage is effective:*
 - (a) *In the case of marriage, as of the date of the marriage, or*

- (b) *In the case of a dependent's birth, as of the date of birth; or*
- (c) *In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.*

b. *Enrollment Pursuant to Termination of Medicaid or CHIP coverage.*

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the dependents of such Eligible Employee, if eligible but not enrolled, may enroll in VISTA if either of the following two conditions are satisfied.

- (1) **Termination of Medicaid or CHIP coverage.** *The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.*
- (2) **Eligibility for Employment Assistance under Medicaid or SCHIP.** *The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).*

Required Length of Special Enrollment Notification. *An Eligible Employee and/or his or her dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.*

Effective Date of Coverage. *Coverage shall become effective on the first (1st) day of the month following the month in which VISTA received the request for Special Enrollment.*

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

The Qualifying Events section is revised as follows:

Types of Qualifying Events

Documentation Required

<i>Marriage</i>	<i>Marriage Certificate</i>
<i>Adoption</i>	<i>Legal Adoption Papers</i>
<i>Birth</i>	<i>Birth Certificate</i>
<i>Change in Legal Guardianship</i>	<i>Court ordered legal papers for Legal Guardianship</i>
<i>Employment Status change of employee or spouse</i>	<i>HIPAA Certificate or employer letter</i>
<i>Medicaid Termination*</i>	<i>Medicaid Termination or Premium Assistance Notification letter</i>

**An eligible, but not enrolled employee or dependent is permitted to enroll for coverage if either of the following conditions are met:*

- 1. *the employee/dependent's Children's Health Insurance Program (CHIP) or Medicaid coverage is terminated due to loss of eligibility and the employee requests coverage with VISTA within sixty (60) days; or*
- 2. *the employee/dependent becomes eligible for premium assistance subsidies and requests coverage with VISTA within sixty (60) days, if applicable.*

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Self-Inflicted/Suicide Exclusion

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Coverage is revised as follows:

Exclusions and Limitations Section

This exclusion has been deleted:
Self-Inflicted/Suicide

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

BENEFITS SCHEDULE

Vista Healthplan, Inc.
Commercial Dental Plan

These co-payments are the maximum fees that will be charged by participating GENERAL DENTIST for the specified covered services.

		<i>Member Pays</i>			<i>Member Pays</i>
DIAGNOSTIC & PREVENTIVE					
0120▲	Periodic oral evaluation	5	2954	Prefabricated post and core in addition to crown	130
0140▲	Limited oral evaluation—problem focused	5	2955	Post removal not in conj. with endodontic therapy ..	116
0150▲	Comprehensive oral evaluation	5	2960	Labial veneer (laminate) (chairside)	219
0160▲	Detailed and extensive oral evaluation— problem focused	5	FIXED CROWN AND BRIDGE		
0210	Intraoral—complete series (1 per 24 months)	53	2510	Inlay—metallic, one surface	315
0220	Intraoral—periapical single film	10	2520	Inlay—metallic, two surfaces	376
0230	Intraoral—periapical each additional film	10	2530	Inlay—metallic, three or more surfaces	414
0240	Intraoral—occlusal film	15	2543	Onlay—metallic, three surfaces	445
0250	Extraoral—first film	20	2544	Onlay—metallic, four or more surfaces	453
0260	Extraoral—each additional film	18	2610	Inlay—porcelain/ceramic, one surface	356
0270▲	Bitewing single film (1 per 6 months)	5	2620	Inlay—porcelain/ceramic, two surfaces	397
0272▲	Bitewings 2 films (1 per 6 months)	5	2630	Inlay—porcelain/ceramic, three or more surfaces ..	440
0274▲	Bitewings 4 films (1 per 6 months)	5	2642	Onlay—porcelain/ceramic, two surfaces	430
0330	Panoramic film (1 per 24 months)	48	2643	Onlay—porcelain/ceramic, three surfaces	450
0340	Cephalometric film	56	2644	Onlay—porcelain/ceramic, four or more surfaces ...	470
0460	Pulp vitality tests	23	2650	Inlay—composite/resin, one surf. lab processed ...	310
0470	Diagnostic casts	40	2651	Inlay—composite/resin, two surf. lab processed	363
0471	Diagnostic photographs	24	2652	Inlay—composite/resin, three surf. lab processed ..	400
1110▲	Complete prophylaxis—adult (1 per 6 months)	5	2710	Crown—resin laboratory	285
1120▲	Complete prophylaxis—child (1 per 6 months)	5	2720	Crown—resin with high noble metal	480
1201▲	Fluoride treatment—child (prophylaxis included) (1 per 6 mos)	10	2721	Crown—resin with predominantly base metal	428
1203▲	Fluoride treatment—child (prophylaxis not included) (1 per 6 months)	5	2722	Crown—resin with noble metal	460
1204▲	Fluoride treatment—adult (prophylaxis not included) (1 per 6 months)	5	2740	Crown—porcelain/ceramic substrate	496
1205▲	Fluoride treatment—adult (prophylaxis included) (1 per 6 months)	10	2750	Crown—porcelain fused to high noble metal	478
1330	Oral hygiene instructions	No charge	2751	Crown—porcelain fused to base metal	445
1351	Sealants—per tooth	20	2752	Crown—porcelain fused to noble metal	466
1510	Space maintainer (fixed unilateral)	134	2790	Crown—full cast high noble metal	475
1515	Space maintainer (fixed bilateral)	175	2791	Crown—full cast base metal	420
1520	Space maintainer (removable unilateral)	163	2792	Crown—full cast noble metal	460
1525	Space maintainer (removable bilateral)	208	2810	Crown—¾ cast metallic	460
1550	Recementation of space maintainer	30	2910	Recement inlay (per unit)	37
▲ The combined charge for these dental procedures shall not exceed \$10 per visit.			2920	Recement crown (per unit)	39
RESTORATIVE (Fillings)					
2140	Amalgam—one surface (primary or permanent)	44	2930	Prefabricated stainless steel crown (primary—child) ..	108
2150	Amalgam—two surfaces (primary or permanent)	56	2931	Prefabricated stainless steel crown (permanent)	125
2160	Amalgam—three surfaces (primary or permanent)	70	2932	Prefabricated resin crown	132
2161	Amalgam—four+ surfaces (primary or permanent)	86	2933	Prefabricated stain. steel crown w/resin window	152
2330	Resin—one surface, anterior	55	6210†	Bridge pontic—cast high noble metal (per unit)	470
2331	Resin—two surfaces, anterior	68	6211†	Bridge pontic—cast base metal (per unit)	420
2332	Resin—three surfaces, anterior	85	6212†	Bridge pontic—cast noble metal (per unit)	430
2335	Resin—four or more surfaces or involving incisal angle (tooth reconstruction including incisal edge), anterior .	100	6240†	Bridge pontic—porc. to high noble metal (per unit) ..	470
2391	Resin—one surface, posterior	60	6241†	Bridge pontic—porcelain to base metal (per unit)	431
2392	Resin—two surfaces, posterior	82	6242†	Bridge pontic—porcelain to noble metal (per unit) ..	445
2393	Resin—three surfaces, posterior	102	6250†	Bridge pontic—resin with high noble metal	460
2394	Resin—four or more surface, posterior	102	6251†	Bridge pontic—resin with predom. base metal	431
2940	Sedative filling	40	6252†	Bridge pontic—resin with noble metal	454
2950	Core buildup including any pins	105	6545	Retainer—cast metal for resin bonded fixed pros. ..	265
2951	Pin retention (per tooth, in addition to restoration)	22	6720†	Crown—bridge retainer, resin w/high noble metal ..	475
2952	Cast post and core in addition to crown	165	6721†	Crown—bridge retainer, resin predom. base metal ..	437
			6722†	Crown (resin with noble metal)	454
			6750†	Bridge abutment—porcelain to high noble metal (per unit)	490
			6751†	Bridge abutment—porcelain to base metal (per unit) .	448
			6752†	Bridge abutment—porcelain to noble metal (per unit)	464
			6780†	Crown—retainer ¾ cast high noble metal	460
			6790†	Bridge abutment—full cast high noble metal (per unit) ...	467
			6791†	Bridge abutment—full cast base metal (per unit)	426
			6792†	Bridge abutment—full cast noble metal (per unit)	460
			6930	Recement fixed partial denture	57

BENEFITS SCHEDULE

Vista Healthplan, Inc.
Commercial Dental Plan

These co-payments are the maximum fees that will be charged by participating GENERAL DENTIST for the specified covered services.

	Member Pays
6970 Cast post and core (in add'n to fixed partial denture retainer) .	161
6971 Cast post as part of fixed partial denture retainer	160
6972 Prefabricated post and core in addition to fixed partial denture retainer	131
6973 Core buildup for retainer including any pins	109
6975 Coping—metal	280
† Per unit, up to six (6) units. Seven (7) or more units, add an additional \$40 per unit. Laboratory processed temporary splint, add an additional \$25 per unit for seven (7) or more units.	

***ENDODONTICS (Root Canal Therapy)**

3110 Pulp cap—direct (excluding final restoration)	28
3120 Pulp cap—indirect (excluding final restoration)	31
3220 Therapeutic pulpotomy (excluding final restoration)	70
3230 Pulpal therapy—resorbable fill, ant. primary tooth	90
3240 Pulpal therapy—resorbable fill, post. primary tooth ...	80
3310 Anterior root canal (excluding final restoration)	270
3320 Bicuspid root canal (excluding final restoration)	335
3330 Molar root canal (excluding final restoration)	428

***PERIODONTICS (Gum Treatment)**

4341 Scaling and root planing (per quadrant) (limit 4 per year) ...	104
4355 Full mouth debridement to enable comprehensive periodontal evaluation & diagnosis	67
4910 Periodontal maintenance (following active therapy)	59
4920 Unscheduled dressing change (not by treating dentist) ..	38
9941 Fabrication of athletic mouthguard	90
9950 Occlusion analysis—mounted case	120
9951 Occlusal adjustment (limited)	67
9952 Occlusal adjustment (complete)	270
9970 Enamel Microabrasion	76

PROSTHETICS (Full & Partial Dentures)

5110 Complete upper denture	600
5120 Complete lower denture	600
5130 Immediate upper denture	650
5140 Immediate lower denture	650
5211 Partial upper—resin base	460
5212 Partial lower—resin base	464
5213 Partial upper—cast metal frmwrk w/resin dent. base ...	680
5214 Partial lower—chrome cast frmwrk w/resin denture base ..	680
5281 Remove unilateral partial dent., 1pc. metal (w/teeth)	360
5410 Adjustments—complete upper	30
5411 Adjustments—complete lower	30
5421 Adjustments—partial upper	30
5422 Adjustments—partial lower	30
5710 Rebase complete upper denture (laboratory)	220
5711 Rebase complete lower denture (laboratory)	220
5720 Rebase partial upper denture (laboratory)	210
5721 Rebase partial lower denture (laboratory)	210
5730 Reline complete upper denture (office)	145
5731 Reline complete lower denture (office)	145
5740 Reline partial upper denture (office)	138
5741 Reline partial lower denture (office)	138
5750 Reline complete upper denture (laboratory)	190
5751 Reline complete lower denture (laboratory)	190
5760 Reline partial upper denture (laboratory)	190
5761 Reline partial lower denture (laboratory)	190
5810 Interim complete upper denture	320

	Member Pays
5820 Interim partial upper denture	280
5821 Interim partial lower denture	280
5850 Tissue conditioning, upper	50
5851 Tissue conditioning, lower	50

REPAIRS TO PROSTHETICS (Full & Partial Dentures)

5510 Repair broken complete denture base	69
5520 Replace missing or broken teeth, comp. dent/ (each tooth) .	50
5610 Repair resin denture base	65
5620 Repair cast framework	117
5630 Repair or replace broken clasp	87
5640 Replace broken teeth—per tooth	55
5650 Add tooth to existing partial denture	75
5660 Add clasp to existing partial denture	100

***ORAL SURGERY**

7111 Extraction, coronal remnants - deciduous tooth	56
7140 Extraction, erupted tooth or exposed root	52
7210 Surgical extraction of erupted tooth	111

***ORTHODONTICS (ADULTS OR CHILDREN)**

8070 Comprehensive orthodontic treatment of the Transitional Dentition	UCR less 20%
8080 Comprehensive orthodontic treatment of the Adolescent Dentition	UCR less 20%
8090 Comprehensive orthodontic treatment of the Adult Dentition	UCR less 20%
8210 Removable appliance therapy	UCR less 20%
8660 Pre-orthodontic treatment visit	UCR less 20%

MISCELLANEOUS

9110 Emergency treatment (palliative treatment for dental pain) -minor procedure ..	40
9210 Local anesthesia, not in conjunction with operative or surgical procedures	20
9211 Regional block anesthesia	22
9215 Local anesthesia	18
9230 Analgesia	22
9310 Consultation—second opinion (arranged by CompBenefits and provided by a Participating Dentist)	47
9430 Office visit for observation (during regularly scheduled hours)—No other services performed ..	29
9440 Office visit—after regularly scheduled hours	55
9910 Application of desensitizing medicament	25

***SPECIALIST CARE:** All dental procedures will be provided to the member in accordance with the Plan Benefits Schedule as long as that procedure is within the scope and competence of general dental practice. For those cases in which the procedure is beyond the scope and competence of the participating general dentist (i.e., certain oral surgery, endodontics, periodontics, pedodontics), the member will be referred to a participating specialist (where participating specialists are available), and receive a 20% discount from the usual, customary and reasonable (UCR) fees of the specialist.

NOTE: Procedures not listed on the Benefits Schedule will be provided at the participating dentist's usual, customary and reasonable (UCR) fees less 20%.

The plan does not cover all procedures which might be provided by general dentist.

*Not all participating dentists perform all listed procedures. Please
2 consult your dentist prior to treatment.*

CERTIFICATE OF COVERAGE

CHOICE OF DENTIST

CompBenefits contracts with established dentists in the community to provide quality care to our members. To receive benefits, you and your dependents must select a dental facility from the CompBenefits list of participating dental offices. Dentists undergo a thorough review process prior to acceptance to our network. Each privately owned office is operated by a licensed general dentist and a staff of professional auxiliaries.

MAKING AN APPOINTMENT WITH YOUR DENTIST

You may schedule an appointment by calling the dental office you selected on or after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the CompBenefits/Vista Healthplan, Inc. dental plan. You will receive a VISTA identification card, but this card is not necessary to receive dental services.

CHANGING YOUR SELECTION OF DENTIST

A situation may occur in which you need to change your dental office selection. Provider transfer requests may be made by calling our Member Support Department. Requests received prior to the 20th of the month will be effective the first of the following month. Transfers can only be processed if you have no balance due or pending appointments at your dental office.

SPECIALIST CARE REFERRALS

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, your general dentist will refer you to a participating specialist (where participating specialists are available). You will be provided a referral form to present to the participating specialist to ensure proper coverage.

WHAT ARE CO-PAYMENT FEES?

Co-payments are reduced fees charged by the participating dental offices for some covered dental procedures as specified in the Benefits Schedule. The reduced fees are 30-50% less than the usual, customary and reasonable fees charged in a dental office. Members are financially responsible for co-payment fees, payable to the dental office.

CANCELLING APPOINTMENTS

The time set aside for a patient is very valuable to the dentist. Therefore, if you cannot keep an appointment, notify the dental office a minimum of 24 hours in advance. If you do not notify the office, charges will be made for broken appointments.

EMERGENCY CARE WITHIN THE SERVICE AREA

In the event of an emergency, contact the participating CompBenefits dental office you selected. If you are unable to reach your dentist, call the CompBenefits 24-Hour Hotline and you will be instructed on how to receive necessary emergency dental care. CompBenefits 24-Hour Emergency Hotline Toll-Free: 800-848-3480

REIMBURSEMENT PROVISION FOR OUT-OF-AREA EMERGENCY CARE

Members and dependents are covered for emergency dental treatment while temporarily more than fifty (50) miles from their participating dental office. In the event of an emergency, obtain treatment to relieve your pain/discomfort only. Pay for the services rendered and submit the receipt to CompBenefits with your name, social security number, address, and phone number. CompBenefits will reimburse no less than 75% of the reasonable charges for covered services and supplies, subject to applicable co-payments, and shall not exceed \$100.00 per claim.

SECOND OPINIONS

CompBenefits can arrange for second opinions to the member. To coordinate second opinions, members should call the CompBenefits Member Support Department. Second opinions not arranged by CompBenefits or rendered by a non-participating dentist will not be covered.

MEMBER SUPPORT

CompBenefits is responsible for all administrative functions of the program. If you have an inquiry or grievance, CompBenefits encourages you to submit it in writing to:

CompBenefits
Grievance & Appeals Dept.
5775 Blue Lagoon Drive #400
Miami, Florida 33126

Or call the Member Support Department, Monday through Friday, 8:00 AM to 6:00 PM at:

Toll-Free: **800-848-3480**

EXCLUSIONS AND LIMITATIONS

The following dental benefits are not covered or offered under the plan:

- Oral surgery requiring the setting of fractures or dislocations.
- Treatment of congenital malformations.
- Treatment of malignancies.
- Dispensing of drugs.
- Any treatment requiring hospitalization.
- Any work which is not able to be performed because of the general health and physical limits of the eligible member, as indicated by said member's personal physician or the CompBenefits dentist.
- Precision attachments or stress breakers.
- Replacement of partial or full dentures within two (2) years after installation unless resulting from the acts or omissions of CompBenefits.
- Any treatment paid by Workers' Compensation or employer's liability laws, by a federal or state government agency, or provided without cost by any municipality, county or other political subdivision.
- Any procedure, implantation and/or any dental procedure considered to be experimental by the providing dentist.
- General anesthesia.
- Surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Replacement of lost or stolen prosthetic devices.
- Any dental care provided by a non-participating general dentist or specialist, except when authorized by CompBenefits.
- Services resulting from any act of war, declared or not, or resulting from military service.
- Charges for broken appointments are not covered.

The following limitations apply:

- The Participating Dentist shall have the right to refuse treatment to a member who fails to follow a prescribed course of treatment.
- Published member co-payments apply only when treatment is performed at a Participating Dental Office.
- If a member obtains dental services from other than a Participating Dentist/Specialist, the member shall be responsible for all costs.

Vista Healthplan™, Inc.
1340 Concord Terrace
Sunrise, Florida 33323

Health Maintenance Organization (HMO)

OPEN ACCESS

**Certificate of Coverage
for
North Florida & South Florida**

This Certificate of Coverage is delivered in the State of Florida.

The Certificate of Coverage is a part of the Group Agreement and is issued in consideration of the application of the Subscriber and payment of the premiums by the Subscriber as provided in the Group Agreement.

The Company agrees to provide the benefits shown in the Covered Services Section to the Subscriber and Eligible Dependents, if any, in accordance with the provisions and conditions of the Group Agreement.

This Certificate of Coverage is subject to all the conditions and provisions set forth on this and the subsequent pages, which are made a part of the Group Agreement.

**For inquiries or information about coverage or assistance in resolving problems call:
Telephone: 1-866-VISTA FL (1-866-847-8235) TDD #: 1-888-444-7352**

IN WITNESS WHEREOF, Vista Healthplan, Inc. has executed this Group Agreement at, Sunrise, Florida.

Primary Care Physician referrals for specialist care are not required.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

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Schedule of Benefits
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INTRODUCTION

This Certificate of Coverage provides Members with coverage for Medically Necessary Covered Services through a Health Maintenance Organization (“HMO”) provided by Vista Healthplan, Inc. (hereinafter referred to as “VISTA”). In an HMO, care must be provided or directed by the Primary Care Physician (“PCP”) and/or approved in advance, by VISTA, or its designee. Also, coverage will only be provided for care that is rendered by Participating Providers for the Open Access Plan, except in the case of Emergency Medical Conditions or when, in Our sole judgment, the care required is not available from a Participating Provider.

Coverage under this Agreement is made as a result of the Subscriber's relationship to a Group, such as an employer or union. Subscribers must meet VISTA's eligibility rules as well as eligibility rules established by the Group. The Group acts on behalf of the Subscriber by remitting premium for this coverage. VISTA will provide the benefits described in this Certificate of Coverage.

Each Member must select a Primary Care Physician (PCP) who will be responsible for providing the Member's primary health care. Should the Member fail to select a PCP, VISTA reserves the right to designate a PCP for the Member to ensure continuity and accessibility of care and the Member shall be so informed. The Member has the right to change his/her PCP by contacting VISTA. Changes will go into effect on the first of each month following such notification. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her Primary Care Physician.

Please note that VISTA is a Health Maintenance Organization that contracts with independently practicing physicians who render medical care and treatment to VISTA members. At all times, these physicians are acting and performing as independent practicing physicians with respect to VISTA, and VISTA does not exercise any control or discretion over the method by which the providers render services to Members. No work, act, commission or omission of any provider, his agents, servants or employees shall be construed to make or render any provider, agent, servant or employee, an agent, servant, representative, or an employee of, or joint venturer with VISTA. Furthermore, the providers render medical care to VISTA Members in accordance with the traditional physician/patient relationship, which in no way is affected or interfered with by VISTA. All judgments and decisions of a medical nature remain within the province of the treating physician and he/she remains solely responsible for all such medical judgments and related treatments.

VISTA shall not be liable for any negligent act or omission committed by any independent practicing physician or hospital, or any of their agents or employees, who may, from time to time, provide medical services to a Member of VISTA. Furthermore, VISTA shall not be vicariously liable for any negligent act or omission of any of these independent Healthcare Professionals who treat a Member of VISTA.

SECTION 1 ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Subject to any Eligibility Exceptions noted in the Binder & Agreement, which is available from the Employer, an employee becomes eligible for coverage on the date he/she completes any waiting period established by the Group, as shown in the Binder & Agreement. The waiting period is the length of time an employee must wait before becoming eligible for coverage.

If an Eligible Employee is covered under any other Large Group Agreement issued to the Group by VISTA, or any other health benefit plan established and maintained by the Group, he/she will not be considered eligible for coverage under this Group Agreement.

All Eligible Employees within a designated "employee class" must be allowed to participate. An Employer has the option to cover part-time employees provided that a minimum employer contribution, as required by VISTA, is made and all part-time employees have the opportunity to participate.

A. Eligibility

1. Subscriber. To be eligible to enroll, You must:
 - a. For a full-time employee: work twenty-five (25) hours or more during a normal work week and receive wages. Business owners must be noted on the Employers federal income tax Schedule C. Officers and/or Board Members of a company are not eligible for coverage unless they meet the same eligibility requirements specified herein for a full-time employee.
 - b. Satisfy any probationary or waiting period requirements established by the Group;
 - c. Be eligible under the eligibility criteria established by the Group and agreed to by VISTA.
2. Dependents. To be eligible to enroll as a Dependent, You must:
 - a. Meet all Dependent eligibility requirements established by the Group, reside with the Subscriber; and
 - b. Be the lawful Spouse of the Subscriber; or
 - c. Be a child, which means the Subscriber's unmarried own child; adopted child or child placed in the Subscriber's home for the purpose of adoption in accordance with chapter 63, Florida Statutes; a stepchild whom the Subscriber claims as an exemption on his or her federal income tax return; a child for whom legal guardianship has been established pursuant to chapter 744, Florida Statutes; or any other unmarried child for whom the Subscriber has been granted temporary or other court-ordered custody. Children are covered:
 - (1) From the date of birth to the end of the month in which the dependent child's 19th birthday occurs; and
 - (2) From the dependent child's 19th birthday to the end of the calendar year in which the dependent child's 25th birthday occurs, if the child is dependent on the Subscriber for support and can be claimed as an exemption on the Subscriber's federal income tax return, and the child is either living in the Subscriber's household or is a full-time or part-time student at a secondary, college, university or trade school which is certified or licensed by a state.
3. A child who has attained the limiting age for a Covered Dependent and continues to be both:
 - a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
 - b. Chiefly dependent on the Subscriber for support and maintenance.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this Group Agreement, the Subscriber has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

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 VISTA terminating such child's coverage for any other reason than the attainment of the limiting age. For newly enrolled handicapped children over the age of nineteen (19), the Subscriber must provide proof of prior coverage and proof of dependency.

4. A newborn child of You or Your Covered Dependent is covered from the moment of birth if VISTA has been notified of the child's birth in writing through the completion and submission of an Enrollment Application, as specified herein:
 - a. If You enroll the child within thirty-one (31) days of birth, a premium will not be charged for the first thirty-one (31) days.
 - b. If You fail to enroll the child within thirty-one (31) days of birth, but enroll the child within sixty (60) days of birth, You will be required to pay the applicable premium for the child from the date of birth.
 - c. If the child is enrolled within sixty (60) days of birth, VISTA will not deny coverage.
 - d. Enrollment of the child more than sixty (60) days after birth but prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and the child will be subject to the delayed coverage rules specified in the Late Enrollee provision.
 - e. A newborn child of a covered dependent child is covered for a period of eighteen (18) months from birth if the newborn child is enrolled within sixty (60) days of birth. Enrollment of the child more than sixty (60) days after birth but prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and the child will be subject to the delayed coverage rules specified in the Late Enrollee provision.
5. All health coverage applicable for children under this Group Agreement will be provided for the adopted child of the Subscriber if the Subscriber has dependent coverage. Coverage is provided to a child the Subscriber proposes to adopt who is placed in the Subscriber's residence in compliance with chapter 63, from the moment of placement. A newborn infant who is adopted by the Subscriber is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in Your residence in compliance with chapter 63. In the event the child(ren) is not placed, the Subscriber will be responsible for repayment of claims paid.

The Subscriber's adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if VISTA is notified of the event in writing through the completion and submission of an Enrollment Application as specified herein:

- a. If the Subscriber enrolls the child within thirty-one (31) days of the moment of birth or placement, a Premium will not be charged for the first thirty-one (31) days.
- b. If the Subscriber fails to enroll the child within thirty-one (31) days of the event, but enrolls the child within sixty (60) days of the event, the Subscriber will be required to pay an additional Premium from the date of birth or placement.
- c. If notice is given within sixty (60) days of the event, VISTA will not deny coverage.

- d. Enrollment of the child more than sixty (60) days after the event or prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and subject to the delayed coverage rules specified in the Late Enrollment provisions.
6. VISTA shall be responsible for requesting, verifying, and maintaining documentation for Eligible Dependents who reach the maximum age requirements to determine school enrollment or handicap status.
7. Military Personnel (per Florida Statute 250.341)

Any health insurance policy, certificate, or evidence of health coverage, which was in effect on April 30, 1991, or which is issued or renewed after such date that provides coverage to a member of the Florida National Guard, or a member of any branch of the United States military reserves who is a resident of this state, called to active military duty, must:

- a. Continue all coverage which were in effect for the person, or the person's dependents covered by the same policy, at the premium in effect for all insured under the same contract, unless the employee requests coverage changes which might alter the premium he or she was paying prior to such activation during the time he or she serves on active duty.
- b. Reinstatement the coverage for any such person who elects not to continue it while on active duty, at the person's request upon return from active duty, without a waiting period or disqualification for any condition, which existed at the time he or she was called to active duty. Such reinstatement must be requested within thirty (30) days after returning to work with the same employer or within sixty (60) days if the policy is an individual policy.
- c. Any coverage available to the insured employee's dependent under the CHAMPUS program will be considered in the payment of any benefits.
- d. The employee must notify his or her employer of his or her reserve or National Guard status and the employee's intent to invoke the provisions of subsections (1) and (2) prior to leaving his or her employer to report for active military duty.
- e. Nothing in this section is intended to require an employee group health insurance policy to provide coverage to a person serving on active military duty.

B. Enrollment

No person meeting eligibility requirements will be refused enrollment or re-enrollment by VISTA because of health conditions, age, need for health services or mental condition or pre-existing physical condition, including pregnancy.

1. **Initial Enrollment Period.** As an employee of the Group, You are entitled to apply for coverage for Yourself and Your Eligible Dependents during the initial Group Open Enrollment Period. Enrollment starts on the employee's initial date of eligibility and ends no less than thirty (30) days later. All persons included for coverage must be listed on the Enrollment Applications provided. No proof of insurability will be required.
2. **Annual Open Enrollment.** An Annual Open Enrollment Period shall be held at least once every twelve (12) months and no less than thirty (30) days prior to the Group's anniversary date during which an eligible Employee and any Eligible Dependents may enroll as a Member if:
 - a. You did not enroll during the Initial Enrollment Period, or
 - b. You maintained coverage under another employer sponsored plan and You change coverage to this Group Agreement.

No proof of insurability will be required.

3. **Newly Eligible Employees.** As a new employee of the Group who becomes eligible for coverage, You may enroll Yourself and Your Eligible Dependents within thirty-one (31) days of becoming eligible.
4. **Newly Eligible Dependents.** You may enroll a person who becomes newly eligible as a Dependent due to marriage, birth, adoption or legal guardianship by completing and submitting to VISTA signed Enrollment Applications along with supporting documentation within thirty-one (31) days of becoming eligible. If You have family coverage the addition of a Dependent will not change Your coverage type, although You must complete required forms within thirty-one (31) days of the event or be subject to the delayed coverage rules specified in the Late Enrollee provision. If You have single or two-person coverage, Your coverage type and associated premium will change. A newborn or adopted child as a Dependent added after the Employee's effective date, must be enrolled within the time frames specified in this Group Agreement. If a newly Eligible Dependent is not enrolled as specified herein, the Dependent will be considered a Late Enrollee and subject to the Late Enrollee provision.
5. **Changes in Eligibility.** It is Your responsibility to notify the Group Employer and VISTA in writing of any changes, which will affect Your eligibility or the eligibility of Your Dependents within thirty-one (31) days of the event.
6. **General Limitation Period.** If an Eligible Employee and his or her Eligible Dependents enroll for coverage under this Group Agreement during his or her Initial Enrollment Period, Annual Open Enrollment Period, or Special Enrollment Period, pre-existing conditions will be covered. If an Eligible Employee and his or her Dependents do not enroll for coverage during the Initial, Annual or Special Open Enrollment Period, they will be considered a Late Enrollee and subject to the delayed coverage rules and coverage for Pre-existing Conditions will be limited as specified in the Late Enrollee Provision.
7. **Special Enrollment Period.** An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:
 - a. The Eligible Employee or Eligible Dependent was covered under other health coverage at the time coverage was previously offered to the Employee or Dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. The Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage.
 - (1) For an Eligible Employee, the previous coverage:
 - (a) Must have been under COBRA or State Continuation and the coverage was exhausted; or
 - (b) Was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.
 - (2) For an Eligible Dependent, the coverage:
 - (a) Is newly made available to Dependents;
 - (b) Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;
 - (c) Is for a person who becomes an Eligible Dependent through marriage, birth,

adoption, or placement for adoption.

- (3) New Dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:
 - (a) The date coverage is made available; or
 - (b) The date of marriage, birth, adoption, or placement for adoption.
- (4) In the case of a Dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if VISTA receives enrollment applications in the time frame specified herein. Other Dependent coverage is effective:
 - (a) In the case of marriage, as of the date of the marriage, or
 - (b) In the case of a dependent's birth, as of the date of birth; or
 - (c) In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

8. **Late Enrollees.** Unless otherwise prohibited by law, an Eligible Employee or Eligible Dependent who tries to enroll outside the Initial Enrollment Period or Annual Open Enrollment Period will be considered a Late Enrollee, unless that person is considered a Special Enrollee as described above. A Late Enrollee who wants to enroll for coverage under this Group Agreement must complete an Enrollment Application. Coverage will be for all conditions except for Pre-existing Conditions. The Pre-existing Condition exclusion relates to a physical or mental condition regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period prior to the enrollment date. Pre-existing Conditions will not be covered by this Group Agreement until the Late Enrollee has been enrolled for eighteen (18) months from the date of enrollment. An Eligible Employee and his or her Eligible Dependents enrolling for coverage as a Late Enrollee may receive credit for the partial or full satisfaction of a Pre-existing Condition waiting period if the individual had Creditable Coverage as specified below.
 - a. **Creditable Coverage.** Creditable Coverage means benefits or coverage which is continuous to a date within sixty-three (63) days of enrollment under this Group Agreement, exclusively of any waiting period, and which was provided under any health plan, public or private. Accident or disability income policies, policies for supplements to liability insurance, Workers' Compensation, auto medical payments, credit-only insurance, coverage provided by pre-paid health clinics, and others as defined by Florida Department of Financial Services rules are not considered Creditable Coverage.

If offered separately, the following are not considered Creditable Coverage:

- (1) Limited scope dental or vision benefits.
- (2) Long term care, nursing home care, home health care, community-based care; or any combination.
- (3) Coverage for Medicare Supplement insurance and other limited benefits as specified by department rules.

If offered independently and as non-coordinated benefits, the following are also not considered Creditable Coverage:

- (1) Coverage for specified disease or illness-only insurance; and
 - (2) Hospital indemnity or other fixed indemnity insurance.
- b. **Late Enrollees with Creditable Coverage.** A Late Enrollee who has Creditable Coverage continuous to a date sixty-three (63) days before the individual's enrollment date under this Group Agreement, will be given credit for the partial or full satisfaction of a Pre-existing Condition limitation waiting period. An Eligible Employee or Dependent whose Creditable Coverage was in effect for twelve (12) months or longer, will not be subject to a Pre-existing Condition waiting period if he or she was covered under Creditable Coverage continuous to a date sixty-three (63) days before the enrollment date in this Group Agreement. If an Eligible Employee's or Dependent's Creditable Coverage was in effect less than twelve (12) months, it will be applied to the eighteen (18) month pre-existing period and reduced accordingly.
- c. **Late Enrollees without Creditable Coverage.** A Late Enrollee will be subject to the full Late Enrollee Pre-existing Condition waiting period if he or she does not have Creditable Coverage.

C. Effective Date of Coverage

After VISTA receives completed Enrollment Applications and the appropriate Premium arrangements are made, coverage under this Group Agreement shall begin on the earliest of the following dates:

1. Initial Enrollment and Annual Open Enrollment. Coverage shall begin on the date agreed upon by the Group and VISTA.
2. Newly Eligible Employees. Coverage will begin as of the first day of the calendar month following the date the employee becomes eligible, if written application is made on or before that date or within thirty-one (31) days after the date he or she becomes eligible.
3. Newly Eligible Dependents and Special Enrollees. Coverage will begin as of the first day of the calendar month following the date he or she becomes eligible (e.g. date of event such as guardianship, etc.), if written application is made on or before that date or within thirty-one (31) days after the date he or she becomes eligible. Newborn and adopted children are covered as specified in this Group Agreement.
4. Late Enrollee. Coverage will begin as of the first day of the calendar month following the date application is received.
5. The Effective Date of Coverage as noted in 1 through 4 above, may be changed by agreement of the Group and VISTA and only in accordance with applicable state and federal laws.

D. Enrollment Application

Newly Eligible Employees must complete a VISTA-approved Enrollment Application available from the Employer within thirty-one (31) days of the date of his/her eligibility to assure timely coverage. Eligible Employees who choose not to elect group coverage for themselves or any Eligible Dependents must complete and sign a Waiver of Coverage within thirty-one (31) days of initial eligibility. A newly eligible employee who does not complete an Enrollment Application (or waive coverage) within thirty-one (31) days of initial eligibility, and requests coverage at a later date, may be considered a Late Enrollee and subject to the delayed coverage rules specified in the Late Enrollee provision.

To assure timely issuance of initial coverage, VISTA should receive an Enrollment Application from all Eligible Employees by the 10th day of the month prior to the Group Effective Date.

Enrollment Applications and Premiums received by VISTA after the 10th day of the month, but before the Group's Effective Date may result in delayed coverage and/or an inaccurate invoice for the following month. Inaccurate invoices will be appropriately adjusted by VISTA during the next billing cycle.

For an Eligible Employee and his/her Eligible Dependent(s) enrolling during an Initial, Annual, or if applicable, Special Enrollment Period, VISTA should receive his/her Enrollment Applications by the 10th day of the month prior to the individual's Effective Date (or for Group renewal, the Anniversary Date), to assure timely coverage.

The following documentation will be required to be submitted with the Enrollment Application when enrolling a newly Eligible Dependent:

<u>Type of Qualifying Events</u>	<u>Documentation Required</u>
Marriage	Marriage Certificate
Birth	Birth Certificate
Adoption	Legal Adoption Papers
Employment Status Change of Employee or Spouse	HIPAA Certificate or Employer Letter
Change in Legal Guardianship	Court Ordered Legal Papers for Legal Guardianship

E. Member Status Change Form

For any change in coverage for existing Members, the Employer must submit a completed Member Status Change Form. The Member Status Change Form must be used when terminating a Member's coverage and the form must be signed by the Employer. The Member Status Change Form must be completed and sent by the Employer, under separate cover to VISTA Enrollment Department:

Vista Healthplan, Inc.
Attention: Enrollment Department
1340 Concord Terrace
Sunrise, Florida 33323
Phone: 1-866-VISTA FL (1-866-847-8235)

1. Additions

Notification of newly Eligible Dependent additions must be submitted to VISTA using a Member Status Change Form. Verification of such change (see required documents), must accompany the Member Status Change Form. A Member Status Change Form which is not completed in the time frames specified in this Group Agreement but submitted at a later date may be considered a Late Enrollment and the individual may be subject to the delayed coverage rules specified in the Late Enrollee provision.

2. Proof of Dependent Status

If a dependent has a different last name than that of the employee, You must attach copies of supporting documents showing evidence of his/her dependent status (e.g. Birth Certificate, Court Order for Guardianship, Marriage Certificate).

If adding a dependent, who is unmarried and age 19 or older, You must attach the following documents to show proof of dependent status:

- a. a copy of your last IRS 1040 form; and
- b. if a student, a letter from Registrar's Office certifying current hours enrolled; or
- c. if not a student but living in the household, provide proof that dependent maintains his/her primary residence with the Subscriber (e.g. driver's license, etc.); or
- d. if disabled, a Healthcare Professional's certification stating date and degree of disability.

After enrollment, VISTA may from time to time require proof of dependent eligibility.

F. Notification of Ineligibility

A condition of membership in VISTA is the Subscriber's agreement to notify VISTA of any changes in status that affects the Subscriber or his/her Eligible Dependent's ability to meet the eligibility criteria set forth in this Group Agreement within thirty-one (31) days of such change.

G. Restrictions upon Expulsion or Refusal to Issue or Renew Contract

VISTA shall not expel or refuse to renew the coverage nor refuse to enroll any eligible individual Member of a group on the basis of the race, color, creed, marital status, sex or national origin of the individual. VISTA shall not expel or refuse to renew the coverage of any eligible individual Member of a group on the basis of the age, health status, health care needs, or prospective costs of health care services of the individual. Nothing in this Section shall prohibit VISTA from requiring that, as a condition of continued eligibility for coverage, dependents of a Subscriber, upon reaching a specified age, convert to COBRA or a conversion contract. VISTA may also require that individuals entitled to have payments for health costs made under Title XVIII of the United States Social Security Act, as amended, be offered a VISTA contract for Medicare beneficiaries so long as VISTA is authorized to issue contracts for Medicare beneficiaries.

SECTION 2 MEDICARE ELIGIBLES

Medicare Part A: the Social Security Program that provides hospital health benefits.

Medicare Part B: the Social Security Program that provides Healthcare Professional services and outpatient health benefits.

A. The Effect of Medicare Coverage/Medicare Secondary Payer

When a Member becomes covered under Medicare and continues to be eligible and covered under the Group Agreement, the benefits of the Group Agreement shall be primary and the Medicare benefits shall be secondary as set forth below, but only to the extent required by law. In all other instances, the benefits under this Group Agreement shall be secondary to any Medicare benefits. To the extent VISTA is primary payer, claims for Covered Services should be filed with VISTA first.

In order to ensure compliance with the Medicare Federal regulations, the Employer shall advise VISTA, without delay, of any Member who is covered under Medicare prior to or immediately following the date such Member becomes so covered (e.g., prior to the Member's 65th birthday). Additionally, the Employer shall advise VISTA, without delay, of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date. The Employer shall indemnify and hold VISTA harmless to the extent of any liability, including attorney fees and costs that results directly or indirectly from the Employer's failure to so advise VISTA.

In any circumstances under which the Medicare secondary payer requires that the Benefits under the Group Agreement be primary for any Member, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individual. Also, the Employer may not induce such Member to decline or terminate his or her group health coverage and elect Medicare as primary payer.

B. Working Elderly

1. If the Employer employs:
 - a. 20 or more persons for 20 or more weeks of the current or preceding Calendar Year, or
 - b. is a member of a multi-employer group health plan that includes at least one (1) employer with 20 or more employees,

the Group Agreement provides primary coverage for employees and/or their spouses, age 65 or older. These names, along with any other identifying information requested by VISTA shall be provided to VISTA on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls under the Group Agreement pursuant to the following terms:

- (1) The Employer shall provide VISTA without delay, the names of employees, age 65 or older:
 - (a) Who are covered under this Group Agreement;
 - (b) Who are employed (not retired);
 - (c) Who are not eligible for Medicare due to end stage renal disease (ESRD).
- (2) The Employer shall provide VISTA, without delay, the names of spouses, age 65 or older, of current employees of any age:
 - (a) Who are covered under the Group Agreement;
 - (b) Who are not eligible for Medicare due to ESRD.

- (3) For an enrolled individual who meets one of the descriptions set out above, VISTA will provide group health coverage, as set forth in the Group Agreement, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is age 65 or over at the time of enrollment.
 - (4) Individual entitlement to primary coverage under this Section will terminate automatically.
2. Under the Medicare Federal Regulations, the Employer may not offer, subsidize, procure, or provide a Medicare supplement insurance policy to such individual. Also, the Employer may not induce such individual to decline or terminate his or her group health coverage and elect Medicare as primary payer.
 - a. Entitlement of the employee and/or spouse to primary coverage under this Section will terminate automatically when:
 - (1) The employee retires; or
 - (2) The employee no longer meets the employer eligibility requirements.
 - b. The primary coverage described in this Section will not be provided in the case of a member of a multi-employer group health plan where that Employer has fewer than 20 employees and the plan has elected treatment of that member's employees under the exception for Employers described in 42 U.S.C. 1395y(b)(1)(A)(iii).
 - c. A person becomes entitled to Medicare on the basis of disability after the individual has been entitled to Social Security disability for twenty-four (24) months. There is a five (5)-month waiting period. Once a disabled individual turns age 65, he or she may be entitled to benefits on the basis of age. This does not apply to an individual who is covered under Medicare due to ESRD.

NOTE: Changes in the number of employees to fewer than 20 employees or from fewer than 20 employees to 20 or more employees, including pertinent changes in multi-employer group health plans, must be immediately reported by the Employer to VISTA.

C. Individuals with End Stage Renal Disease (ESRD)

1. Primary coverage is provided for the Employer's current and former employees and/or their dependents who are covered under the Group Agreement and who are entitled to Medicare coverage because of ESRD, pursuant to the following terms:
 - a. The Employer shall provide VISTA, without delay, the names of any individuals covered under the Group Agreement who are or will be undergoing a regular course of renal dialysis, or who will receive or already have received a kidney transplant, including the beginning date of such dialysis or the date of such transplant, and any other identifying information requested.
 - b. For an enrolled individual who is entitled to Medicare coverage because of ESRD, VISTA will provide group health insurance coverage, as set forth in this Group Agreement, on a primary basis for thirty (30) months beginning with the earlier of:
 - (1) The month in which the individual becomes entitled to Medicare Part A ESRD benefits; or
 - (2) The first month in which the individual would have become entitled to Medicare Part A ESRD benefits if a timely application had been made.

2. If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD prior to March 1, 1996, VISTA will provide group health coverage, as set forth in the Group Agreement, on a primary basis for eighteen (18) months, on or after March 1, 1996, for thirty (30) months.
3. Under the Medicare Federal Regulations, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individuals. Also, the Employer may not induce such individuals to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

D. Miscellaneous

1. This Medicare Secondary Payer Section shall be subject to, modified 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 the Group Agreement.
2. VISTA shall not be liable to the Employer or to any individual covered under this Group Agreement on account of any non-payment of primary benefits resulting from any failure of performance of the Employer's obligations as set forth in this Section.
3. If VISTA should elect to make primary payments covering services rendered to an employee or dependent described in this Section in a period prior to receipt of the information required by the terms of this Section, VISTA may require the Employer to reimburse VISTA for such payments. Alternatively, VISTA may require the Employer to pay the rate differential that resulted from the Employer's failure to provide the required information in a timely manner.
4. The Employer shall indemnify and hold VISTA harmless to the extent of any liability that the Employer may be charged as a result of any failure of performance of the Employer's obligations as set forth in this Section.

NOTE: The federal laws described in this Section are directed at the Employer. Individuals with questions regarding their rights under those laws should direct their questions to the Employer.

SECTION 3 COVERAGE PROVISIONS

A. How the Plan Works - Benefits and Services

1. VISTA agrees to arrange for the Covered Services as listed in the Schedule of Benefits in accordance with these procedures and subject to the limitations and exclusions specified in this Agreement. Covered Services will be rendered by Participating Providers under reasonable standards of quality of care, as certified by the Agency for Health Care Administration.
2. Each Member must select a Primary Care Physician (PCP). If a Member fails to choose a Primary Care Physician when enrolling, VISTA will assign one to the Member and notify the Member of that assignment. The Primary Care Physician will be responsible for providing the Member's primary health care. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her Primary Care Physician.

A Member may select or change their Primary Care Physician by calling the VISTA Customer Service Department at 1-866-847-8235, TDD # 1-888-444-7352.

3. Except in the case of an Emergency Medical Condition, only benefits and services set forth in the Schedule of Benefits that are rendered by a Participating Provider will be covered.
4. Except in cases of an Emergency Medical Condition, Medically Necessary Covered Services as set forth in the Schedule of Benefits and subject to the limitations and exclusions specified in this Agreement shall be available and covered only when provided by a Participating Physician, a Participating Hospital or by another Participating Provider under contract with VISTA to provide health care services to Members, and subject to Prior Authorization requirements described herein.
5. In case of an Emergency Medical Condition, Members shall be entitled to the benefits and services set forth in the Covered Services Section and the Schedule of Benefits.
6. If a Participating Provider terminates his/her contract with VISTA or is terminated by VISTA for any reason other than for cause, a Member receiving active treatment may continue coverage and care with that provider when authorized by VISTA. Coverage will continue through completion of treatment of a condition for which the Member was receiving care at the time of the termination until:
 - a. the Member 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; or
 - b. the Member, 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 may refuse to continue to provide care to a Member who is abusive, non-compliant, or in arrears in payment for services provided.

7. A female Member is allowed to visit a participating obstetrician/gynecologist for one (1) annual visit as specified in this Group Agreement, as well as medical services provided by a general GYN & OB/GYN, excluding Sub-Specialty GYN & OB/GYN services without authorization from the Member's Primary Care Physician. Any care required at that visit does not require a referral but is subject to Prior Authorization by VISTA.

B. Payment for Covered Services

VISTA will pay for Covered Services per Calendar Year, after satisfaction of the applicable Copayments if any, provided:

1. The service is rendered while covered under this Group Agreement.
2. The service is rendered for Covered Services specified in this Section.
3. The service is not paid or payable under another benefit of this Group Agreement.
4. Such payment:
 - a. Will not exceed any Maximum Benefit set forth in the Schedule of Benefits of this Group Agreement.
 - b. Will be subject to the Covered Services Section, Exclusions and Limitations Section and Schedule of Benefits of this Group Agreement.

C. Benefits and Services Excluded from Coverage

1. Members shall not be entitled to the benefits and services set forth in the Exclusions and Limitations Section, nor are Members entitled to benefits and services set forth in this Group Agreement:
 - a. If rendered by a Participating Physician without a referral from the Member's Primary Care Physician, or
 - b. If rendered by a Non-Participating Provider without Prior Authorization in writing from VISTA with the exception of services rendered for Emergency Medical Conditions.
2. Copayment Responsibilities

Members may be required to pay Copayment amounts in connection with services and benefits covered under this Agreement. Such Copayments are set forth in the Schedule of Benefits. Copayments must be paid at the time of service unless alternate arrangements are made.

D. Role of the Primary Care Physician (PCP)

The PCP will be responsible for providing the Member's primary health care. Members may self-refer to Participating Providers for Covered Services.

E. Copayment

Some services may be subject to a nominal Copayment that must be paid to the Healthcare Professional at the time a service is rendered. Copayment amounts are specified in the Schedule of Benefits.

F. Copayment Maximum

1. Individual

In each Calendar Year, the individual maximum amount of Copayments to be paid by any Member for Covered Services rendered to such Member is the amount specified in the Schedule of Benefits. If during a Calendar Year the Individual Copayment Maximum is met for a Member, such Member shall have no further obligation to pay additional Copayments for Covered Services rendered to that Member for the remainder of that Calendar Year.

2. Family

In each Calendar Year, the total Copayment Maximum for Covered Services rendered to each Subscriber and all of his/her Dependents (collectively, a "Family") is the amount specified in the

Schedule of Benefits. If during a Calendar Year, the Family Maximum has been reached, no individual in the Family shall have any further obligation to pay additional Copayments for Covered Services rendered to that individual or any other individual in the Family for the remainder of that Calendar Year; provided, however, that unless and until the Family Maximum has been achieved, each individual in the Family shall be obligated for Copayments for Covered Services up to the amount of his/her Individual Maximum.

G. Prior Authorization

In order to be eligible to receive benefits available under this Group Agreement, VISTA requires Prior Authorization by the Medical Management Department for certain services. If You fail to obtain Prior Authorization when it is required, benefits that may have otherwise been covered will be denied. The following treatment or services are examples, but not an inclusive list of treatments and services that must be authorized by Us as explained below:

1. Hospital confinements and Skilled Nursing Facility confinements;
2. Non-emergent transportation; air ambulance;
3. All non-emergency outpatient hospital services, including but not limited to, surgical, laboratory and diagnostic;
4. Wound care procedures;
5. Inpatient rehabilitative services;
6. Outpatient rehabilitative services at a hospital;
7. DME (for North Florida only);
8. DME – customized/specialty items
9. Prosthetics, Braces, Hospice;
10. Pain Management;
11. C-PAP machine (see Sleep Studies benefit).

For a current list of all services requiring Prior Authorization, You may call Customer Service at 1-866-VISTA FL (1-866-847-8235), TDD #: 1-888-444-7352.

It is Your responsibility to verify with Your Healthcare Professional that Prior Authorization has been received before the service is rendered. However, Prior Authorization is not a guarantee of coverage. Members must be eligible for coverage at the time the services are rendered.

Prior Authorization Procedures:

For those services that require Prior Authorization, the Member or his/her attending Healthcare Professional must request Prior Authorization from Us as follows:

1. At least ten (10) days prior to the start of any treatment requiring Prior Authorization.
2. Within forty-eight (48) hours or as soon as reasonably possible after the start of and prior to discharge for emergency Hospital confinement.
3. Within ten (10) days for a planned inpatient Hospital admission.

4. In the case of pregnancy, within twenty-four (24) hours or as soon as reasonably possible after the date of a maternity delivery or maternity-related admission.

We will conduct Prior Authorization review for certain services. For requests for **urgent care services**, We will notify the Member and the requesting Healthcare Professional as soon as possible given the medical circumstances of the case, but not later than seventy-two (72) hours after We receive the request for such urgent care services, unless sufficient information to conduct the Prior Authorization review is not provided to Us. In such case, We will contact the Member or the requesting Healthcare Professional within the first twenty-four (24) hours after the Prior Authorization request is made. The necessary documentation being requested shall be submitted to Us within the following forty-eight (48) hours so that the Prior Authorization review can be completed within the earlier of forty-eight (48) hours of Our receipt of such information or forty-eight (48) hours after our request for such information in the event such information is not received.

For purposes of this section, a request for an urgent care service is one in which medical care or treatment is being requested and the application of non-urgent timeframes for conducting Prior Authorization could seriously jeopardize the life/health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is being requested. Requests for urgent care services are reviewed by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, except that when a physician with knowledge of the Member's medical condition specifically requests urgent Prior Authorization, the request will be deemed as such.

Prior Authorization for **non-urgent care services** will be completed within fifteen (15) business days of VISTA's receipt of the request. We may request for a one-time extension of this timeframe, for up to fifteen (15) days, if such extension is necessary due to matters beyond Our control. If We need to request an extension, We will let the Member know before the end of the initial 15 day period. If We need an extension because additional information is needed from the Member or requesting Healthcare Professional, we will notify the Member or provider and explain the process for submitting such information to Us for review.

When responding to the request for Prior Authorization We will:

1. Advise the requesting Healthcare Professional and Member that the treatment or service is authorized; or
2. Deny Prior Authorization and advise Member, PCP and Specialist, if applicable, as to the alternative treatment or service that will be authorized; or
3. Deny Prior Authorization entirely. If We deny an authorization, We will send the denial in writing to the Member, the attending Healthcare Professional, and if applicable, the Hospital.

If authorization is given only for outpatient care but you obtain inpatient care without notification prior to discharge, We will only pay for services at the outpatient benefit level, unless authorized by VISTA. If services are not authorized there is NO COVERAGE for the bills you incur.

If You need to be admitted to a hospital, VISTA will authorize Your admissions, and monitor Your stay. Each day will be reviewed and authorized when appropriate. We will send written confirmation of Your direct/scheduled authorized admission to the Healthcare Professional and/or hospital. Your Healthcare Professional's staff may sometimes assist with obtaining Prior Authorization, but it is Your responsibility to be sure it has been obtained to maximize Your benefits.

The Member or his/her attending Healthcare Professional may at any time ask Us to reevaluate Our decision on Prior Authorization or extend the number of days of Hospital confinement deemed to be appropriate for the treatment of the Member's Condition.

Prior Authorization is not a guarantee of payment and will not result in payment of benefits that would not otherwise be payable.

H. Semi-Private Room Rate

In the case of a Hospital which does not have semiprivate accommodations; the standard daily semiprivate room rate will, for purposes of this benefit, be 80% of the daily charges for regular Hospital services at its lowest rate for private accommodations. If the Hospital charges for a private room, We will not pay more than the rate for a semi-private room.

I. Second Medical or Surgical Opinion

A Member is entitled to request a second medical or surgical opinion by a Physician of his/her choice, subject to the following conditions:

1. The Member feels that he/she is not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the condition being treated.
2. The Member disagrees with Our opinion or a Physician's regarding the reasonableness or necessity of a surgical procedure; or, the treatment is for a serious injury or illness.
3. The Physician chosen by the Member for the second opinion is located in VISTA's Service Area.
4. The second surgical opinion coverage is limited to the consultation, physical examination and any laboratory work and diagnostic tests not already performed. VISTA retains the right to have any tests that may be required by a Non-Participating Physician administered by a Participating Physician.
5. The Member is responsible for the Physician's office visit Copayment when the second opinion is received from a Participating Physician.
6. The Member's Participating Physician or VISTA's Medical Director's judgment concerning the treatment shall be controlling, after review of the second opinion, as to the obligations of VISTA.
7. Any treatment, including follow-up treatment pursuant to the second opinion is authorized by the Member's Participating Physician or VISTA.
8. Reimbursement for a second opinion by Non-Participating Physician may be limited to a maximum of two (2) in a Calendar Year. VISTA will reimburse the Member for the second opinion in an amount equal to sixty percent (60%) of all charges which are usual, reasonable, and customary, in the community for the second opinion services performed by a Non-Participating Physician, as determined by VISTA. The Member shall be responsible for the balance of charges for services performed by a Non-Participating Physician.

VISTA will cover the second surgical opinion for a Member who has received a recommendation to have elective surgery which is covered under this Contract if in addition to the conditions listed above the following conditions are also met:

1. The consulting Physician must personally examine the Member and VISTA and the Member's PCP must receive a copy of the written opinion.
2. The consulting Physician must not be affiliated in practice with the surgeon who first recommended surgery.
3. The consulting Physician must not perform the surgery to correct the condition for which the second opinion was sought.

SECTION 4 COVERED SERVICES

Members are entitled to receive the services and benefits set out in this section. Except for preventive health care, services and benefits must be Medically Necessary and are subject to the Exclusions and Limitations, and specified Copayments, Deductibles and Coinsurance if applicable. Some services, as specified herein, or in the Schedule of Benefits, are subject to a maximum benefit amount per Calendar Year.

You may be eligible to receive the following medical care and services from Participating Healthcare Professionals in the Service Area including medical, surgical, diagnostic, therapeutic and preventive services (subject to the provisions of the Exclusions and Limitations Section). Some services require You to pay a Copayment to the Participating Healthcare Professional. Copayments must be made at the time services are received. Copayment amounts are included in Your Schedule of Benefits and on Your ID card.

VISTA shall make all determinations that are required for the administration of this Agreement, including determinations, regarding medical necessity and Covered Services, at its discretion. In accordance with the Grievance Procedure Section, the Member has the right to file a Grievance regarding decisions made by VISTA. In all cases, medical necessity is to be determined in accordance with generally accepted standards of medical care as determined by VISTA.

A. Covered Services

A Member is entitled to receive Covered Services when provided, prescribed or directed by a Healthcare Professional.

1. Hospital Inpatient Services

VISTA covers the Inpatient Hospital Services when the Healthcare Professional receives authorization from VISTA in advance of the inpatient hospitalization. We encourage you in the case of an Emergency Medical Condition, to notify Us within forty-eight (48) hours or as soon as reasonably possible after the start of Emergency Services and Care treatment or an Emergency Hospital confinement. Covered Hospital Services include, but are not limited to:

- a. Semi-private room and board including special diets, use of operating room, anesthesia, intensive care or other special care units, oxygen, and general or private duty nursing when prescribed. If a Member signs a waiver assuming private room charges, the Member will be responsible for the cost.
- b. Healthcare Professional services including surgery, delivery and administration of anesthesia.
- c. Laboratory, X-Ray, and diagnostic services.
- d. Acute dialysis.
- e. Blood, blood plasma, blood derivatives and blood factors.
- f. Drugs, medications and biologicals, dressings and casts.
- g. Reconstructive Surgery:

Benefits are available for reconstructive surgery if it is incidental to or follows surgery from trauma, infection or other diseases of the part of the body involved. With respect to a child covered under this Contract, benefits are available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.

h. Rehabilitative Services (speech, occupational, physical, respiratory):

Rehabilitative services provided while the Member is Hospital confined will be covered for the duration of the Hospital confinement, subject to the conditions listed herein.

Speech, occupational, physical and respiratory therapy services received during an admission to a Hospital do not reduce the number of outpatient rehabilitative therapy visits as indicated on the attached Schedule of Benefits.

i. Inpatient Neonatal Intensive Care Unit (NICU) admission and subsequent inpatient care.

2. Outpatient Services

Office visits to include:

- a. Routine adult check-up and physical examination. See Schedule of Benefits for Member Responsibility and limitations.
- b. Pediatric examinations and well-child care. Visits include hearing and vision screening and preventive care services when ordered and performed by a Healthcare Professional for health maintenance and preventive care. Services include Healthcare Professional delivered or Healthcare Professional -supervised visits from birth to sixteen (16) years which include a history, a physical examination, developmental assessment and anticipatory guidance, and laboratory tests. Services and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Benefits are limited to one visit payable to one provider for all of the services provided at each visit.
- c. Annual OB/GYN visit (breast exam, pelvic exam and Pap smear) with a Healthcare Professional, Gynecologist or Obstetrician/Gynecologist. See Schedule of Benefits for Member Responsibility and limitations.
- d. Immunizations required because of an injury or immediate risk of infection.
- e. Immunizations for routine preventive care as recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (CDCACIP) and subsequently published in the CDC Morbidity and Mortality Report and approved by VISTA.
- f. Allergy serum.
- g. Newborn hearing screening at birth and any follow-up re-evaluations leading to diagnosis is covered through age twelve (12) months. Treatment and services covered under this Group Agreement and delivered or authorized by the child's Healthcare Professional will be provided to any Covered dependent child diagnosed as having a permanent hearing impairment.
- h. Non-surgical Spine and Back Disorder Treatment: Manual manipulation of the spine to correct subluxation. See Schedule of Benefits for Member Responsibility and limitations.
- i. Rehabilitative Services: ordered by a treating physician and approved by VISTA are limited to the therapy categories listed below. VISTA must specifically pre-approve a written plan of treatment submitted by the Member's Physician and agree that the Member's Condition will improve significantly within sixty (60) days of the date therapy begins.

Covered Rehabilitative Therapy Services are limited to four (4) modalities per day not to exceed the benefit maximum set forth in the Schedule of Benefits. They include:

- (1) Services of a licensed speech-language pathologist to aid in the restoration of speech loss or swallowing disorders or an impairment resulting from injury, stroke or a surgical procedure while this coverage was in force.
- (2) Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to injury, stroke or a surgical procedure while this coverage was in force.

Outpatient therapies listed below may be Covered Services when ordered by a Healthcare Professional licensed to perform such services. The outpatient therapies listed below are in addition to the Cardiac Rehabilitation, Occupational Therapy, Physical Therapy and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

- (1) Cardiac Rehabilitation – Services provided under the supervision of a Healthcare Professional, or a Healthcare Professional trained for Cardiac Rehabilitation, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.
- (2) Occupational Therapy – Services provided by a Healthcare Professional or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Covered Condition are covered.
- (3) Speech Therapy – Services of a Healthcare Professional, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Covered Condition are covered.
- (4) Physical Therapy – Services provided by a Healthcare Professional or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.
- (5) Respiratory or Inhalation Therapy – Services provided for the purpose of aiding in the restoration of normal physical function of the lungs, due to injury, stroke or a surgical procedure while this coverage was in force.

3. Additional Services

Alcohol and Substance Abuse Care

Detoxification: Coverage is available for the medical services relating to short duration medical detoxification and alcohol or drug abuse treatment on an inpatient basis, subject to Prior Authorization by Us. See Schedule of Benefits for Member Responsibility and limitations.

Ambulance Services

Ambulance services for an Emergency Medical condition are covered. Non-emergency transportation between healthcare facilities for receipt of Covered Services is subject to Prior Authorization by VISTA. Air ambulance requires a Prior Authorization.

Breast Cancer Treatment

Coverage for breast cancer treatment includes inpatient Hospital care and outpatient post-surgical follow-up care for mastectomies in accordance with prevailing medical standards and authorized by VISTA.

Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include the Hospital, treating Healthcare Professional's office, outpatient center, or the Member's home.

Inpatient Hospital treatment for mastectomies will not be limited to any period that is less than that determined by the attending Physician.

The Federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- a. reconstruction of a surgically removed breast;
- b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including Copayments, Deductible and Coinsurance provisions.

Chemotherapy

Any drug prescribed for the treatment of cancer will not be excluded from coverage if the drug is not approved by the FDA for a particular indication but the drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature. Coverage includes medically appropriate services associated with the administration of the chemotherapy agent.

Cleft Palate and Cleft Lip

Treatment is provided for a dependent under age eighteen (18). Benefits are available for medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the Healthcare Professional. Coverage is subject to benefit and benefit limitations listed in the Covered Services and Exclusions and Limitations Sections of this Group Agreement.

Dental Services

Benefits are available for the treatment of an Accidental Dental Injury to sound natural teeth if the services are rendered, and the treatment is received within six (6) months of the accident. This benefit does not include coverage for expenses for services related to an injury occurring while, and as a result of biting or chewing. Bite splints are covered.

Dental Treatment in a Hospital or Ambulatory Surgical Center

Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or surgery, subject to Prior Authorization by VISTA.

- a. A dependent child under age eight (8) whose treating Healthcare Professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

- b. A Member who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any 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. Use of general anesthesia in a hospital or Ambulatory Surgical Center is subject to Prior Authorization by VISTA.

Dermatologic Services

A Member is limited to five (5) visits every twelve (12) months. Visits exceeding the maximum of five (5) visits in a twelve (12) month period and services or testing not considered minor or routine in nature, require an authorization from VISTA.

Diabetes Treatment

Benefits are available for services including all medical equipment, supplies and diabetes outpatient self-management training and educational services used to treat diabetes when the Member's Healthcare Professional or a Healthcare Professional that specializes in the treatment of diabetes certifies that such services are necessary and Prior Authorization is received from VISTA. We may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes instructor or a board-certified endocrinologist. We may require that a licensed dietitian provide nutrition counseling. Supplies will be obtained from a vendor designated by VISTA.

Durable Medical Equipment (DME) for Outpatient Use

Benefits are available for DME as prescribed by a Healthcare Professional and subject to Prior Authorization by Us, as per the Prior Authorization section, up to the maximum benefit allowed. DME must meet Medicare Guidelines as defined in the Medicare DME manual. See Schedule of Benefits for Member Responsibility and limitations. Benefits include:

- a. Repair, replacement and maintenance of authorized durable medical equipment. Coverage is limited to normal wear and use and body growth or change.
- b. Equipment for the treatment of diabetes.
- c. Drug infusion pumps and release devices.

Enteral (Elemental) Nutrition

Benefits are available for home Enteral (Elemental) Nutrition made up of single amino acids and simple sugars and if the following requirements are met:

- a. It is the primary source of nutrition (at least 50% of his/her daily nutritional requirements);
- b. Adequate nutrition must not be possible with dietary adjustment and/or oral supplements; and
- c. A Participating Physician must see the Member within thirty (30) days prior to initial Prior Authorization and any subsequent re-authorization.

Coverage for inherited diseases of amino acid and organic acids includes food products modified to be low protein.

Eye Care

Benefits are available for initial prescription lenses (eye glasses or contact lenses) following an operation for cataracts. See Schedule of Benefits for Member Responsibility and limitations.

Family Planning:

Benefits are available for diagnostics, counseling and planning for problems of fertility and infertility subject to Prior Authorization by Us.

- a. Services and supplies for the purpose of diagnosing the cause of infertility, including examinations, diagnostic surgical services and related hospital or facility costs in connection with such surgery.
- b. Voluntary sterilizations, tubal ligations and vasectomies.
- c. Testing for problems of infertility will be provided, subject to Prior Authorization by Us and any applicable Member Responsibility.
- d. Diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography (HSG) and diagnostic laparoscopy (limited to one (1) sequence per Member per lifetime).
- e. Prescribed Contraceptives filled by a Pharmacist.
- f. Intrauterine Devices (IUD), insertion and removal. See Schedule of Benefits for Member Responsibility).
- g. Measurement and fitting for contraceptive diaphragms.

Foot Care

Benefits are available for the treatment of a disease or injury of the foot, including infection, bony malformation, tendonitis, hammertoes and treatment of bunions.

Foot Care (routine) for Diabetics only

Benefits are available for removal of warts, corns or calluses or trimming of toenails.

Gene Testing

Subject to Prior Authorization, coverage is limited to chromosome analysis when there is a risk of a genetic defect.

Genetic Counseling

Subject to Prior Authorization, services are provided for counseling with trained Healthcare Professionals before testing begins and when Members receive the test results, as well as appropriate post testing follow-up, if the medical indication of significant potential for occurrence of genetic defects exists.

Government Hospital

Benefits are available for Covered Services in a Government Hospital if, because of serious injury or sudden illness, the Member is taken to one of these Hospitals for an Emergency Medical Condition. In this instance, We will continue to cover services only for as long as

Emergency Services and Care, is appropriate and it is not possible for the Member to be transferred to a Participating Hospital.

Hearing

1. Benefits are available for hearing screening in a licensed Healthcare Professional's office. Services of a licensed audiologist to determine and measure the hearing function loss and aid in the restoration of hearing function loss, if such loss has occurred while this coverage was in force.
2. Cochlear implants are covered subject to Prior Authorization by VISTA.

Home Health Care Services

Benefits are available if the Member is confined at home and requires Home Health Care Services in lieu of hospitalization.

Services must be provided:

- a. by a licensed home health agency or
- b. through a licensed nurse registry or
- c. by an independent nurse licensed under Section 464 of the Florida Statutes.

Covered Home Health Care Services include:

- a. Part-time or intermittent nursing care by a registered nurse or licensed practical nurse which shall consist of a visit not to exceed four (4) hours in duration.
- b. Physical therapy by a licensed physical therapist; occupational therapy by a licensed occupational therapist; and speech therapy by a licensed speech-language pathologist.
- c. Medical appliances, equipment, laboratory services, supplies, drugs and medicines prescribed by the Member's Healthcare Professional and other services provided by the home Healthcare Professional.

Home peritoneal dialysis

Benefits are available for home peritoneal dialysis.

Hospice Care

Benefits are available for terminally ill Members. Hospice services must be pre-authorized and provided by a licensed Hospice organization:

- a. A Member is considered terminally ill if the Healthcare Professional has certified the Member as having a life expectancy of one (1) year or less, should the illness run its normal course.
- b. Care relating to the terminal condition may be provided on an inpatient basis (in either a Hospice or a Hospital as directed by Hospice) or an outpatient basis.

- c. Coverage includes drugs and medical supplies, bereavement counseling and respite care provided by Hospice. Bereavement counseling must be received within three (3) months after the Member's death.

Laboratory Testing

Mammography Screening

Benefits are available for:

- a. one (1) or more mammograms a year at any age for any woman who is at risk for having breast cancer, because of having a personal or family history of breast cancer, having a history of biopsy-proven benign breast disease, having a mother, sister or daughter who has or has had breast cancer, and because a woman has not given birth before the age of thirty (30) based upon the recommendation of the treating Healthcare Professional; and
- b. a single baseline mammogram for women age thirty-five (35) through thirty-nine (39), inclusive; and
- c. mammograms shall be covered every two (2) years, or more frequently upon the recommendation of a Healthcare Professional, for women age forty (40) through forty-nine (49), inclusive; and
- d. an annual mammogram for women age fifty (50) and older. Except with respect to mammograms performed more frequently than one every two years from ages forty (40) through forty-nine (49).

Mammograms performed pursuant to the above are covered in full and not subject to a deductible, copayment or coinsurance.

Maternity Services (See Schedule of Benefits for Member Responsibility)

Benefits are available for:

- a. maternity care received on an inpatient or outpatient basis including pre-natal and post-natal care of the mother and child authorized by VISTA;
- b. the performance of any clinical tests and immunizations in keeping with prevailing medical standards;
- c. the use of Hospital delivery rooms and related facilities or affiliated birthing centers;
- d. the use of newborn nursery and related facilities;
- e. special procedures as may be authorized by VISTA and performed by a Healthcare Professional;
- f. complications of pregnancy; and
- g. Specialist and Sub-Specialty Obstetrics and Gynecology (See Schedule of Benefits for Member Responsibility.)

Post-delivery care may be provided:

- a. at the Hospital,

- b. at the attending Healthcare Professional's office,
- c. at an outpatient maternity center, or
- d. in the home by a qualified licensed Healthcare Professional trained in mother and baby care.

Services provided by affiliated licensed birthing centers, certified nurse-midwives and licensed midwives working within the scope of his or her license are covered.

The Newborns' & Mothers' Health Protection Act of 1996 (the Newborns' Act) provides that health plans that offer maternity coverage, may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than forty-eight (48) hours of inpatient care following a vaginal delivery or ninety-six (96) hours of inpatient care following a cesarean delivery.

Members have the option, with the Healthcare Professional's authorization, to leave the Hospital earlier than stated above and receive a home health visit within seventy-two (72) hours of leaving the Hospital. If you choose to leave the Hospital early and receive a home health visit, the postpartum home health visit shall not be subject to Copayments or Coinsurance, if any.

Neuropsychological Testing

Benefits are available subject to Prior Authorization by VISTA.

Newborns

The coverage, benefits, or services for newborns shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or pre-maturity, and up to \$1,000 transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the treating Healthcare Professional as necessary to protect the health and safety of the newborn child.

If a newborn is admitted to a Neonatal Intensive Care Unit (NICU) there is a separate hospital admission with applicable Copayments or Coinsurance and authorization.

Benefits are available for a circumcision performed within the first month in either a hospital setting or in a physician's office. See the Schedule of Benefits for Member Responsibility.

Oral Surgery

Benefits are available for diagnostic and surgical procedures involving bones or joints of the jaw and facial region, to treat conditions caused by congenital or developmental deformity, , or injury. This coverage does not include coverage for care or treatment of the teeth or gums, temporomandibular joint (TMJ) or craniomandibular (CMJ) disorders, intra-oral prosthetic devices, removal of wisdom teeth or for surgical procedures for cosmetic purposes.

Orthognathic Surgery

Benefits are available for the surgical procedures involving bones or joints of the jaw and facial region, to treat conditions caused by congenital or developmental deformity. This coverage does not include coverage for care or treatment of the teeth or gums,

temporomandibular disorders, intra-oral prosthetic devices, or for surgical procedures for cosmetic purposes.

Orthotic Devices (as authorized by VISTA)

Benefits are available for:

- a. customized devices such as braces and trusses.
- b. other supports for the feet are not a Covered Benefit unless they are an integral part of the leg brace or a Healthcare Professional prescribes therapeutic shoes for a Member with diabetes.

The appliance must be an Orthotic Device as defined by the Medicare DME Manual and subject to Prior Authorization by VISTA.

Osteoporosis Screening

Benefits are available for the diagnosis and treatment of osteoporosis, subject to Prior Authorization by Us for estrogen-deficient Members who:

- a. are at clinical risk for osteoporosis,
- b. have vertebral abnormalities,
- c. are receiving long-term glucocorticoid (steroid) therapy,
- d. have primary hyperparathyroidism, or
- e. have a family history of osteoporosis.

Outpatient Facility Services

The place of service determines the applicable Member Responsibility as set forth in the Schedule of Benefits and subject to Prior Authorization by VISTA, where applicable.

1. Ambulatory Surgical Care Services

Benefits are available for diagnostic services received on an outpatient basis at a Hospital, an Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. Benefits include, but are not limited to:

- a. Use of operating room and recovery room
- b. Respiratory or inhalation therapy
- c. Drugs and medicines administered (except for take home drugs)
- d. Intravenous solutions
- e. Dressings, including casts
- f. Anesthetics and their administration

2. Outpatient Diagnostic Services

Benefits are available for diagnostic services received on an outpatient basis at a Hospital, an Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. Benefits include, but are not limited to:

- a. Laboratory and pathology

- b. Radiology
- c. Ultrasound
- d. Nuclear medicine
- e. Chest x-rays
- f. Blood tests
- g. Urinalysis
- h. EKG and EEG
- i. MRI and CT scans

3. Endoscopic Procedures

Benefits are available for the following procedures when received on an outpatient basis at a Hospital, an Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. Benefits include, but are not limited to:

- a. Colonoscopy
- b. Endoscopy
- c. Sigmoidoscopy

4. Outpatient Surgery

Benefits are available in a Hospital, licensed Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. The place of service determines the applicable Member Responsibility as set forth in the Schedule of Benefits and subject to Prior Authorization by VISTA.

Prosthetic Devices

Benefits are available for:

- a. Special features prescribed by the Healthcare Professional are subject to Prior Authorization by Us. See the Schedule of Benefits for Member Responsibility and limitations.
- b. Devices are limited to standard/evaluated internal and external devices such as artificial limbs, organic lenses, pacemakers, heart-valve replacements, artificial joints, and external breast prostheses.
- c. Repair, replacement and maintenance of authorized prosthetic devices. Coverage is limited to normal wear, and use and body growth or change.
- d. Special appliances and surgical implants required by a Member for an illness or injury when they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue of the human body.

The appliance must be a Prosthetic Device as defined by the Medicare DME Manual and subject to Prior Authorization by VISTA.

Radiology and Diagnostic Testing

For a current list of radiology and diagnostic tests that require Prior Authorization, contact Customer Service at 1-866-VISTA FL (1-866-847-8235).

Skilled Nursing Facility Care

Benefits are available for Skilled Nursing Facility Services subject to Prior Authorization by Us (excluding nervous and mental conditions and alcohol/substance abuse) when a Member requires skilled nursing care twenty-four (24) hours per day and when rendered in a licensed Hospital or Skilled Nursing Facility:

- a. Services must be provided in lieu of hospitalization or continued hospitalization.
- b. Covered Services 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), and chemotherapy treatment for proven malignant disease.
- c. A Member is entitled to a limited number of days, as indicated on the attached Schedule of Benefits, for short-term speech therapy, occupational therapy, physical therapy and respiratory therapy upon admission to a Skilled Nursing Facility. Such coverage is available only for rehabilitation following injuries, surgery or other Medical Conditions and is intended to improve or restore bodily functions within a reasonable and generally predictable period of time. Coverage is not provided to maintain the Member at his/her present level or to prevent further deterioration.
- d. Services must be skilled level services and must be ordered by and provided under the direction of a Healthcare Professional.
- e. Services are limited as specified in the Schedule of Benefits.

If a Member is a resident of a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the Member's PCP (if applicable) must refer the Member to that facility's skilled nursing unit or assisted living facility if requested by the Member, agreed to by the facility and subject to final authorization by VISTA. The facility must meet all guidelines established by VISTA related to quality of care, utilization, referral authorization, risk assumption, use of VISTA's HMO provider network, and other criteria applicable to Participating Providers for the same services and supplies. If the request for referral or authorization is denied, the Member may use the grievance process described in the Grievance Procedure section of this Certificate of Coverage.

Sleep Studies

Benefits are available for:

- a. sleep study for diagnostic purposes;
- b. treatment for obstructive sleep apnea (OSA) which includes continuous positive airway pressure (CPAP) machine if confirmed by a sleep study.

Surgical Procedures in a Healthcare Professional's Office

Temporomandibular Joint (TMJ)

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. Coverage does not include coverage for care or treatment of the teeth or gums, for intraoral prosthetic devices or for surgical procedures for cosmetic purposes.

Transplantation

Organ transplants are covered when Prior Authorized by VISTA and performed at a transplant facility when such facility is participating in VISTA's designated transplant network to perform such type of transplant.

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications related to transplantation. The Member or the Member's Healthcare Professional must notify Us in advance of the Member's initial evaluation for the transplant procedure. VISTA will cover services received in connection with the transplantation of the following human tissue or organs:

- a. Cornea
- b. Heart
- c. Lung
- d. Liver
- e. Kidney
- f. Pancreas
- g. Bone Marrow Transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental in accordance with applicable Florida law. As used in this Certificate of Coverage, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the Member in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.
- h. Other transplants as approved by Vista in its sole discretion consistent with nationally established guidelines.

Vista will cover organ acquisition and donor costs. Testing to find a suitable donor is limited to the reasonable costs of searching for the donor and is limited to the immediate family members and the national donor programs.

The Member or the Member's Healthcare Professional must notify Us in advance of the Member's initial evaluation for the transplant procedure. Prior Authorization is required for a transplant procedure.

Hospital services and medical services will be paid under provisions set forth in this Agreement, in accordance with the same terms and conditions as VISTA will cover benefits for care and treatment of any other covered condition.

Transportation costs for the Member to and from the approved facility where the transplant is to be performed if the facility is more than one-hundred (100) miles from the Member's home.

Direct, non-medical costs for one (1) member of the Member's immediate family, two (2) Members if the patient is under age eighteen (18), for:

- a. transportation to and from the approved facility where the transplant is performed, but no more than one (1) round trip per person per transplant and
- b. temporary lodging at a prearranged location during the Member's confinement in the approved transplant facility, not to exceed \$75 per day. Costs listed above are only

payable if the Member lives more than one-hundred (100) miles from the approved transplant facility. The maximum benefit for these services is \$5,000 per transplant.

Wigs and Cranial Prosthesis

Benefits are available when related to restoration after cancer or brain tumor treatment with a \$250 limit per calendar year.

B. Emergency Services and Care

Emergency Services and Care for Emergency Medical Conditions are covered in accordance with applicable law. When time and circumstances permit, a Member is encouraged to contact his/her PCP within forty-eight (48) hours, or as soon as reasonably possible, of receiving Emergency Services and Care. A Member's PCP provides access to coverage twenty-four (24) hours-a-day, 365 days a year.

VISTA will pay for the screening, evaluation and examination that are reasonably calculated to assist the provider in arriving at the determination as to whether the Member's condition is an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination may be denied.

1. In the Service Area

In the case of an Emergency Medical Condition inside VISTA's Service Area, the Member should contact his/her PCP if possible. If the Member cannot contact his/her PCP prior to Emergency Services and Care being rendered, the Member should notify the PCP as soon as reasonably possible, from the onset of the Emergency Medical Condition. VISTA will pay for or reimburse Members for costs incurred for Covered Services subject to the payment and reimbursement provisions set forth in this Certificate of Coverage.

2. Out of the Service Area

- a. Emergency Medical Conditions which require Emergency Services and Care before the Member can reasonably return to VISTA's Service Area are covered on the same basis as in-area Emergency Medical Conditions. The Member should notify VISTA or his/her PCP as soon as reasonably possible.
- b. Coverage or treatment out of VISTA's Service Area is limited to Emergency Services and Care for an Emergency Medical Condition. The Member shall obtain all continuing or follow-up treatment from their PCP.
- c. Benefits are payable for Emergency Medical Conditions for which Emergency Services and Care is provided. Elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from VISTA's Service Area may not be covered.

3. Emergency Room follow-up Care

A Member is covered for any follow-up care necessary after receiving Emergency Services and Care in accordance with this Certificate of Coverage. All follow-up care must be provided or arranged by a Member's PCP in accordance with this Certificate of Coverage. If the Member receives follow-up care in the Emergency Department, the Member may be responsible for payment for such services.

SECTION 5 EXCLUSIONS and LIMITATIONS

Any and all services not specifically listed as a Covered Service in this Certificate of Coverage or in any rider, unless such services are required by applicable state or federal law, are excluded. In addition to certain exclusions and limitations already described in this Certificate of Coverage, benefits will not be provided under this Certificate of Coverage if they fall within any of the below-listed categories, unless provided for by a separate rider or amendment. Except as otherwise provided herein, any service or supply that is not provided or arranged through Participating Providers in accordance with our utilization management policies and procedures will be excluded. In addition, VISTA does not cover any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service.

The fact that a Healthcare Professional may prescribe, recommend, approve or furnish a service or supply does not, of itself, make it Medically Necessary or a Covered Service, under this Group Agreement, even though the service or supply is not specifically listed as an exclusion.

Abdominoplasty and/or Panniculectomy.

Acupuncture Services.

Alcoholism or Substance Abuse: Benefits are not available for treatment services and supplies except as specifically stated in the Covered Services Section or provided for by Rider, if elected by the Group.

Alternative Medicine: Benefits are not available for services, testing, equipment, and supplies associated with alternative modalities of care including, but not limited to acupuncture, hypnosis, hypnotic anesthesia, naturopathy, homeopathy, massage therapy, and aromatherapy.

Ambulance Services: Benefits are not available for Ambulance services obtained for a non-emergency, or if the service is determined by VISTA to be for the convenience of the Member, except those services specifically provided for in the Covered Services Section.

Arch Supports: Benefits are not available for orthopedic shoes, sneakers, support hose, or similar type therapeutic devices/appliances regardless of intended use.

Athletic Event-Related: Benefits are not available for care and treatment for injuries sustained by a Member in the course of any athletic event, or while training for such athletic event, for which the Member is to receive remuneration in cash or in kind.

Autopsy or Post Mortem Examination Services.

Biofeedback: Benefits are not available for services and other forms of self-care or self-help training or educational programs and any related diagnostic testing, meditation, pain control, pain management therapies, (except for medically-related conditions that receive Prior Authorization).

Breast Reduction Mammoplasty: Benefits are not available for breast reduction mammoplasty regardless of medical necessity.

Childbirth and Surrogate Parenting Classes.

Complications: Benefits are not available for medical or surgical complications, such as wound infections, during or as a result of a non-covered surgical procedure or service including, but not limited to services rendered for cosmetic purposes including any body piercing and tattooing, gastric bypasses, gastric stapling, breast reductions, breast implants, hypertrophic scars, breast asymmetry.

Contraceptives: Benefits are not available for over-the-counter contraceptives.

Cosmetic Surgery: Benefits are not available for:

1. Any service and supply to improve the Member's appearance or self-perception, including but not limited to, electrolysis, procedures or supplies to correct baldness or the appearance of skin, face lifts, scar reduction (except as related to surgery that has received Prior Authorization), or ear lobe repair.
2. Any professional services and/or hospitalization in connection with elective Cosmetic Surgery, including but not limited to, body piercing and tattooing, tattoo removal, rhinoplasty, liposuction, blepharoplasty, varicose vein injections, removal or injection of skin tags, of cherry angiomas, telangiectasias, spider angiomas.
3. Diagnosis and treatment of any medical complications as a result of previous elective Cosmetic Surgery, regardless of how long ago such services were performed.
4. Removal of breast implants related to Cosmetic Surgery.
5. Excess skin surgery and treatment of complications arising from this procedure.

Costs Rendered for Sickness and Injury: Benefits are not available for:

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.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Counseling: Benefits are not available for marriage or relationship counseling, services or adoption agencies, pastoral counseling, family counseling, social, occupational, religious, or other social maladjustments; chronic behavior disorders; codependency; impulse control disorders; organic disorders; learning disabilities; hyperkinetic syndromes. This exclusion includes any prescription medications prescribed for treatment associated with any of the above conditions.

Court-Ordered Services: Benefits are not available for Court ordered care or treatment, unless otherwise listed as Covered Services.

Criminal Activities: Benefits are not available for:

1. Care and treatment rendered in connection with injuries which occurred during a crime committed by a Member or which the Member tries to commit including, without limitation, treatment and care for any injuries sustained when the Member's blood alcohol content is in excess of the legal limit whether or not the Member is charged with or convicted of any criminal offenses.
2. Care and treatment for injuries sustained while the Member is under the influence of any illegal or illicit drug, or any controlled or legend drug or substance if the drug or substance is not then subject to a valid prescription issued in the name of the Member by a Healthcare Professional and being administered to treat a current episode of illness.

Custodial Care (Residential Care): Benefits are not available for any service or supply of a custodial nature primarily intended to assist the Member in the activities of daily living. This includes rest homes, home health aides (sitters), home mothers, domestic maid services, and health resorts and spas and respite care. This includes services provided by a non-eligible institution and which is primarily a place of rest or for the aged or similar institution.

Dental Care: (unless covered by a Dental Endorsement, if applicable), Benefits are not available for routine dental procedures including, but not limited to:

1. extraction of teeth,
2. restoration of teeth with fillings,
3. crowns or other materials,
4. bridges,
5. cleaning of teeth,
6. dental implants,
7. dentures,
8. periodontal or endodontic procedures,
9. orthodontic treatment including palatal expansion devices,
10. bruxism appliances,
11. dental x-rays,
12. routine intra-oral surgical procedures,
13. orthodontics and fixed and removable prosthetics, and
14. services related to an injury occurring while, and as a result of biting or chewing

except as otherwise specifically referenced in this Certificate of Coverage as covered.

Benefits are not available for:

1. all procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaw as a result of temporomandibular joint (TMJ) or craniomandibular (CMJ). disorders.
2. diagnosis or treatment of dental disease, or the services of the dentist or oral surgeon, nor are the services set forth in this provision covered if provided in a dental office.

Diagnostic Admissions: Benefits are not available for diagnostic services that could have been provided in a Healthcare Professional's office, an outpatient department of a Hospital, or some other setting without adversely affecting the Member's condition.

Dietary Regimens: Benefits are not available for dietary regimens, treatments, food, food substitutes or vitamins.

Disposable Medical Supplies and Personal Convenience: Benefits are not available for supplies, equipment, or personal convenience items such as, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags or the use of telephones or television while an inpatient.

Durable Medical Equipment: Benefits are not available for the following:

1. Devices and equipment used for environmental control, convenience functions or physical fitness.
2. Lost, abused or improperly cared for equipment.
3. Customized equipment.
4. Deluxe or motorized equipment.
5. Wheelchair lifts or ramps.
6. Support hose and compression hose.

Educational Materials and Supplies: Benefits are not available for educational materials and supplies commonly available for purchase, except in the treatment of diabetes.

Enteral (Elemental) Nutrition: Benefits are not available for home Enteral (Elemental) Nutrition for the treatment of eating disorders, such as anorexia or bulimia. The following are not considered Enteral (Elemental) Nutrition:

1. food thickeners, dietary supplements;
2. nutritional support puddings, protein shakes and powders;
3. gluten or lactose free food products;
4. baby food;
5. weight loss foods and products.

Experimental and/or Investigational Treatments and Procedures.

Eye Care: (unless covered by Vision Rider, if applicable) Benefits are not available for:

1. Eyeglasses and/or contact lenses unless indicated on the attached Schedule of Benefits.
2. Training or orthoptics, including eye exercises.
3. Prescription inserts for diving masks or other protective eyewear.
4. Nonstandard items for lenses including tinting and blending.
5. Refractive eye surgery to correct visual acuity problems.

Family Planning Services: Benefits are not available for any service other than those specified in the Covered Services Section of this Group Agreement.

Foot Care (routine): Benefits are not available for any service or supply in connection with foot care in the absence of disease, injury, or accident. This exclusion includes, but is not limited to, clipping of nails, soaking the feet, removing calluses, treatment of flat feet, fallen arches, chronic foot strain and weak feet.

Gastric Bypass, Gastric Stapling, Gastric Balloon and Cylastic Bands: Benefits are not available regardless of medical or psychological condition.

Gene Therapy.

Government Hospital: Benefits are not available for care in any Hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless for an Emergency Medical Condition.

Government Programs: Benefits are not available for any service that is received and payment made on behalf of the Member, under any federal, state or local government program.

Health Care Services: Benefits are not available for consultations, treatment or services or supplies received at a penal facility or outside a penal facility while a Member is incarcerated.

Hearing Aids: Benefits are not available for hearing aids (external and implantable), and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Home Hemodialysis: Benefits are not available for any furniture, plumbing, electrical or other fixtures needed to perform dialysis treatments at home.

Home Oxygen Equipment: Benefits are not available for certain home oxygen equipment items including, but not limited to, emergency oxygen inhalators, portable preset oxygen units, and oxygen administration equipment.

Hypnotism or Hypnotic Anesthesia.

Illegal Actions: Benefits are not available for treatment of a condition resulting from participating in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony; includes care and treatment rendered in connection with injuries suffered in a fight in which the Member is the aggressor.

Immediate Relatives and Self Imposed Treatment: Benefits are not available for charges for physicians' services provided by an immediate relative, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation. This exclusion also precludes a Member that is also a physician from treating himself or herself and submitting claims to VISTA for such coverage. For the purpose of this exclusion, "Immediate Relative" means any of the following:

1. Husband or wife;
2. Natural or adoptive parent, child or sibling;
3. Stepparent, stepchild, stepbrother or stepsister;
4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;
5. Grandparent or grandchild;
6. Spouse of grandparent or grandchild.

Immunizations: Benefits are not available for immunizations and autogenous vaccines related to foreign travel.

Impotence Treatment: Benefits are not available for penile prosthesis, medications such as Viagra, and other devices except as specifically provided for in the Prescription Drug Benefit Rider to this Group Agreement, if elected by the Group.

Infertility Treatment.

Learning Disorders: Benefits are not available for non-medical conditions related to hyperkinetic syndromes and learning disabilities (including ADD and ADHD disorders), autism, mental retardation, developmental delay, and adult onset of attention deficit disorder and treatment for Tourette's syndrome.

Medical Care or Surgery not Prescribed.

Mental Health Treatment: Benefits are not available for treatment, services and supplies, except as specifically provided for by Rider, if elected by the Group.

Military-Related: Benefits are not available for Military service-related medical care, for which the Member is legally entitled to service from military or government facilities and for which facilities are reasonably accessible.

Non-Prescription Drugs: Benefits are not available for any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin or mineral supplements, appetite suppressants, fluoride products, or health foods.

Oral Surgery: Benefits are not available for coverage for care or treatment of the teeth or gums, temporomandibular joint (TMJ) or craniomandibular (CMJ) disorders, intra-oral prosthetic devices, or for surgical procedures for cosmetic purposes.

Orthognathic Surgery: Benefits are not available for:

1. care or treatment of the teeth or gums;
2. temporomandibular disorders;
3. for intra-oral prosthetic devices; or
4. for surgical procedures for cosmetic purposes.

Orthomolecular Therapy: Benefits are not available for therapy including nutrients, vitamins, and food supplements.

Orthotic Devices: Benefits are not available for Dynamic Orthotic Cranioplasty (DOC) – bands or similar devices and helmets or any other type of devices to treat plagiocephaly except when Medically Necessary.

Personal Comfort, Hygiene or Convenience Items: Benefits are not available for services and supplies not directly related to the care of the Member including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, allergenic pillows or mattresses or waterbeds, physical fitness equipment, travel expenses other than authorized ambulance services that are specifically provided for under the Covered Services section.

Physical Examinations: Benefits are not available specifically for obtaining or continuing employment or required for, travel, immigration, insurance, government licensing or premarital purposes.

Prescription Drugs: Benefits are not available for prescription drugs, except medications administered in the course of covered treatment by the Member's Healthcare Professional during an office visit and drugs administered in the course of covered treatment. A Member is entitled to prescription drugs as delineated by a Prescription Drug Rider.

Prosthetic Devices: Benefits are not available for:

1. Deluxe equipment.
2. Devices related to erectile dysfunction except if due to an organic cause. This includes, but is not limited to penile implants.

Rehabilitation: Benefits are not available for:

1. Inpatient rehabilitation services if outpatient services are appropriate.
2. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Member's Condition within a sixty (60) day period.
3. Long-term therapy.

Self-Inflicted/Suicide: Benefits are not available for treatment for a condition resulting from intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Member.

Services Outside the Service Area: Benefits are not available for services rendered outside the Service Area except for treatment of an Emergency Medical Condition.

Services or Supplies: Benefits are not available for services or supplies received prior to a Member's effective date or received on or after the date a Member's coverage terminates under this Group Agreement, unless coverage is extended in accordance with the Extension of Benefits provision.

Sexual Dysfunction: Benefits are not available for sex therapy and drug therapies except certain injectable drugs approved by Us and only to treat erectile dysfunction due to an organic cause.

Sexual Reassignment (gender transformation) or modification services: Benefits are not available for any services or supplies related to such treatment including psychiatric services.

Sleep Disorders: Benefits are not available for insomnia, and/or narcolepsy, treatment, services and supplies for the purpose of treating or diagnosing sleep disorders or any related condition thereof, medical or surgical treatment for snoring, except when provided as part of treatment for documented sleep apnea.

Smoking Cessation: Benefits are not available for smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco; including, but not limited to, nicotine withdrawal programs and treatments such as Nicorette gum or patch.

Specific Therapies and Treatments as follows: Benefits are not available for hypnotherapy, biofeedback, acupuncture, sleep therapy, behavioral training, and hair analysis, unless used as a diagnostic tool for heavy metal poisoning.

Sterilization Reversals: Benefits are not available for reversal of voluntary, surgically induced sterility, including the reversal of tubal ligations and vasectomies and complications thereof.

Temporomandibular Joint (TMJ) Syndrome: Benefits are not available for:

1. Treatment for symptoms (e.g. headaches, clicking, etc.) characterized as TMJ Syndrome, in which the joint is anatomically intact.
2. All procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as craniomandibular joint disorders (CMJ).
3. Physical therapy as a primary treatment for TMJ syndrome.
4. Occlusal orthopedic appliances-orthotics, occlusal splints, bite appliances/planes/splints, mandibular occlusal repositioning appliances (MORAs).

Transplantation: Benefits are not available for:

1. The services related to the transplantation of any nonhuman organ or tissue;
2. The services related to the donation or acquisition of an organ for a recipient who is not covered by VISTA;
3. Services, follow-up care and immunosuppressive drugs, for non-covered transplants and complications from such transplants;
4. Artificial heart devices.

Transportation Services: Benefits are not available for non-emergency transportation between institutional care facilities, and/or to and from the Member's residence unless Prior Authorized by Us.

Treatment of Obesity: Benefits are not available for weight control and weight loss programs; including, but not limited to dietary supplements, appetite suppressants, dietary regimens or treatments, exercise programs or equipment, laboratory testing, examinations and prescription drugs. Gastric stapling, gastric balloon, gastric bypass, liposuction and related procedures, or reversal there of, including treatment of the complications resulting from surgical treatment; regardless of associated medical or psychological conditions.

Vocational Rehabilitation: Benefits are not available for training and educational programs.

War-Related Treatment: Benefits are not available for treatment of a condition resulting, from war or an act of war, whether declared or not.

Wigs or Cranial Prosthesis: Benefits are not available except when related to restoration after cancer or brain tumor treatment with a \$250 limit per Calendar Year.

Workers' Compensation: Benefits are not available for care and treatment of any injury, illness, or condition which arises out of, or in the course of, any occupation for wage or for-profit, any injury, illness, or condition for which the Member is paid or receives benefits under any Workers' Compensation policy law, employer's liability policy, or any similar policy.

SECTION 6 CLAIMS

A. Assignment

The Member may authorize Us to pay benefits under this Group Agreement directly to the provider on whose charges a claim is based.

B. Discharge

Any payment by Us in accordance with these provisions will discharge Us from all further liability to the extent of the payment made.

C. Facility of Payment

If Member dies while benefits under this Group Agreement remain unpaid, We may, at Our option, make payments directly to the provider on whose charges the claim is based; or to the surviving spouse of the Member; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Member's estate.

D. Reimbursement for Participating and Non-Participating Provider Services

VISTA will provide or arrange for services to be received from Participating Providers on a direct service basis. If a Member receives services from a Participating Provider, VISTA will pay the Healthcare Provider directly for all care received. The Member will not have to submit a claim for payment, and will be responsible only for any applicable Copayments, Deductibles and Coinsurance.

In the event the Member has an Emergency Medical Condition that requires services from a Non-Participating Provider while inside or outside the Service Area: if a Member receives Covered Services in a foreign country as a result of an Emergency Medical Condition, the bill and supporting medical records must be in English and the amounts charged and paid must be in U.S. currency with the exchange rate attached for validation. It is the Member's responsibility for obtaining the necessary documents and translations.

When a Non-Participating Provider renders services as a result of an Emergency Medical Condition, notice of a claim for benefits must be given to VISTA. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by VISTA within twenty (20) days after the date of the injury or the first treatment date for the sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the twenty (20) day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

E. Time Payment of Claims

After receiving written proof of claims, VISTA will reimburse all claims or any portion of any claim from a Member or a Member's assignees, for payment under this Group Agreement within forty (40) days after receipt of the claim by VISTA. If a claim or portion of a claim is contested by VISTA, the Member or the Member's assignees will be notified, in writing, that the claim is contested, within forty (40) days after the receipt of the claim by VISTA. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim.

VISTA, upon receipt of the additional information requested from a Member or the Member's assignees, will pay or deny the contested claim or portion of the contested claim within sixty (60) days.

VISTA will pay or deny any claim no later than one hundred twenty (120) days after receiving the claim.

Payment will be treated as being made on the date a draft or valid instrument, which is equivalent to payment, was placed in the United States mail in a properly addressed post-paid envelope or, if not so posted, on the date of delivery.

All overdue payments will bear simple interest at the rate of twelve percent (12%) per year.

F. Notice

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

Vista Healthplan, Inc.
1340 Concord Terrace
Sunrise, Florida 33323

G. Legal Actions

No legal action may be brought to recover under this Group Agreement until at least sixty (60) days after written proof of claim has been filed with VISTA. If such action is taken after the sixty (60) day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

H. Clerical Error

Clerical error, whether of the Group or VISTA in keeping any record pertaining to the coverage under this Agreement, will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

I. Examination

VISTA, at its own expense, shall have the right to examine the person whose Sickness or Injury is the basis of a claim when and as often as it may be reasonably required during the pended status of the claim.

J. Subrogation

Immediately upon paying or providing any benefit hereunder, VISTA shall be subrogated to all rights of recovery a Member has against any third party, to the full extent of benefits provided by VISTA. In addition, if a Member receives any payment from any third party as a result of an injury, VISTA has the right to recover from, and be reimbursed by the Member for all amounts paid hereunder and will pay as a result of that injury, less the pro rata share of attorney's fees and cost, up to the amount the Member has received from all third parties.

As used throughout this provision, the term "third party" means any party possibly responsible for making any payment to the Member for any injuries or any insurance coverage, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, Workers' Compensation coverage or no-fault automobile insurance coverage. As used throughout this provision, the term "Member" means the injured person or persons or any of their agent, representatives, assignees, guardians, heirs, or beneficiaries.

The Member shall do nothing to prejudice VISTA's subrogation and reimbursement rights and shall, when requested, cooperate with Our efforts to recover its benefits paid. It is the duty of the Member to notify VISTA within forty-five (45) days of the date when any notice is given to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the Member.

The Member acknowledges that VISTA's subrogation and reimbursement rights are a first priority claim against all potential third parties and are to be paid to VISTA before any other claim for the Member's damages. VISTA shall be entitled to reimbursement first from any third party payments,

even if the remainder is insufficient to make the Member whole or compensate the Member in part or in whole for the damages sustained. VISTA is limited to the actual amount of damages recovered by the claimant minus its pro rata share of costs and attorney's fees incurred by the claimant in recovering such damages. In determining VISTA's pro rata share of the costs and attorney's fees VISTA shall have deducted from its recovery a percentage amount equal to the percentage of the judgment or settlement which is for costs and attorney's fees.

This entire subrogation and reimbursement provision will apply regardless of whether liability for payment is admitted by the third party and regardless of whether the settlement or judgment received by the Member identifies the medical benefits the plan provided. In the event any claim is made that any part of this subrogation and reimbursement clause is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Member and this plan agree that VISTA shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. The right of subrogation provided to VISTA under this paragraph will be determined in accordance with Florida Statutes or the Courts of Florida.

SECTION 7 GRIEVANCE PROCEDURE

A. Introduction

At VISTA, We are committed to Member satisfaction. We will try to resolve any problems You may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, We have a Grievance Procedure available that provides channels for You, or an Authorized Representative acting on Your behalf (including Your treating provider) to voice Your concerns and have them reviewed and addressed by VISTA.

VISTA's Grievance Procedure is designed to provide prompt, meaningful and confidential resolution of Member concerns regarding quality of care, physician behavior, office waiting times, claims payment, coverage of services, and other similar matters.

The Grievance Procedure includes informal and formal steps. You have one (1) year from the date of the occurrence of the action that initiated the Grievance (which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date you receive initial notice of the Adverse Benefit Determination) to submit a Grievance to Us, verbally or in writing.

B. Definitions

The following definitions will be used for purposes of this Grievance Process described in this Section.

Adverse Benefit Determination: means a denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay, or other health care service does not meet VISTA's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. As Adverse Benefit Determination based in whole or in part on medical judgment, includes the failure to cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate. The denial of payment for services or charges (in whole or in part) pursuant to VISTA's contracts with network providers, where the Member is not liable for such services or charges, are not Adverse Benefit Determinations.

AHCA: means the Florida Agency for Health Care Administration.

Authorized Representative: means an individual authorized in writing or verbally by the Member or state law to act on the Member's behalf in requesting a health care service, obtaining claim payment, or during the Grievance process. A provider may act on behalf of a Member without the Member's express consent when it involves an Urgent Grievance.

Clinical Peer: means a health care professional in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, who was neither involved in the initial Adverse Benefit Determination nor a subordinate of such individual. A Clinical Peer may include a VISTA medical director not involved in the initial Adverse Benefit Determination with the appropriate expertise.

Complaint: means any oral expression or dissatisfaction including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a provider pursuant to VISTA's contract and which is submitted to VISTA or to a State agency. A Complaint is part of the informal steps of a Grievance procedure and is not part of the formal steps of a Grievance procedure, unless it is a Grievance as defined below.

Concurrent Review: means utilization review conducted during a Member's hospital stay or course of treatment.

DOL: means the United States Department of Labor.

Grievance: means an oral or written Complaint submitted by or on behalf of a Member to VISTA or a State agency regarding the:

- (a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an Adverse Benefit Determination made pursuant to utilization review;
- (b) Claims payment, handling, or reimbursement for health care services; or
- (c) Matters pertaining to the contractual relationship between a Member and VISTA.

A Grievance includes both Pre-Service Grievances and Post-Service Grievances (as defined below). A Grievance does not include a written complaint submitted by or on behalf of a Member eligible for a grievance and appeals procedure provided by VISTA pursuant to contract with the Federal Government under Title XVIII of the Social Security Act or other government programs.

Grievance and Appeals Committee (Committee): means a panel comprised of a majority of Clinical Peers, established to review second level Grievances related to Adverse Benefit Determinations made by VISTA. In cases in which there was a denial of coverage, persons previously involved with the Adverse Benefit Determination will not be a Member of the Committee but may appear before the Committee to present information or answer questions. The Committee has the authority to bind VISTA to its decisions. Committee Members, Clinical Peer or otherwise, shall not be subordinate to those person(s) who made the initial Adverse Benefit Determination, or those person(s) who made the first level Grievance review decision. The Committee may consist of:

- Grievance and Appeals Manager
- Grievance and Appeals Administrator(s) (**Important note:** The role of the Grievance and Appeal Administrator(s) is solely to impartially present the facts of the case at hand. The Grievance and Appeal Administrator does not vote or otherwise influence the proceeding.);
- Quality Management Director (or designee);
- Provider Operations Director (or designee);
- Customer Service Director (or designee);
- Claims Director (or designee);
- Sales and Marketing Director (or designee);
- Utilization Management Director (or designee);
- Benefits Director (or designee); and
- VISTA's Medical Director that was not involved in the initial Adverse Benefit Determination or first level review.

The Committee shall conduct regular meetings on at least a biweekly or monthly basis (unless there is no business to be transacted at such meeting).

Member: means an individual who has contracted, or on whose behalf a contract has been entered into, with VISTA for health care services.

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

Post-Service Grievance: means a Grievance for which an Adverse Benefit Determination was rendered for a service that was already provided, and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.

Pre-Service Grievance: means any Grievance for which a requested service requires prior authorization, an Adverse Benefit Determination was rendered and the requested service was not

provided and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.

Relevant: means a document, record or other information that:

- a. was relied upon in making a benefit determination;
- b. was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- c. demonstrates compliance with the federal requirements for safeguards designed to ensure and to verify that benefit claim determinations were made in accordance with governing plan documents and that, where appropriate, the plan provisions were applied consistently with respect to similarly situated Members; or
- d. constitutes a statement of policy or guidance with respect to VISTA concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Retrospective Review: means a review, for coverage purposes, of medical necessity conducted after services were provided to the Member.

SAP: means the Subscriber Assistance Program.

Urgent Grievance: means a Grievance for which a requested service requires prior authorization, or an extension of concurrent care is being requested; an Adverse Benefit Determination was rendered; the requested service has not been provided; and the application of non-urgent care Grievance time frames could seriously jeopardize: (a) the life or health of the Member or the Member's unborn child; or (b) the Member's ability to regain maximum function. An Urgent Grievance is also a Grievance where application of the non-Urgent timeframes would, in the opinion of a physician with knowledge of the Member's medical condition, subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

C. Complaints

To advise VISTA of a Complaint, the Member should first contact Customer Service, either by telephone or in person. The Customer Service telephone is listed on the Member identification card. The Member must provide to the Customer Service Representative all of the facts relevant to the Complaint. The Member's failure to provide any requested or relevant information may delay VISTA's review of the Complaint. Consequently, the Member is obliged to cooperate with VISTA in its review of the matter.

The Customer Service Representative, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction.

If the Complaint cannot be resolved to the Member's satisfaction, and the Member remains dissatisfied, the Member may submit a Grievance for formal review.

D. Grievances

The Member, or an Authorized Representative of the Member, may submit a Grievance. VISTA will provide the Member the forms necessary to initiate a Grievance. The Member may request these forms by contacting the Customer Service telephone number listed on their Member ID card. While the Member is not required to use VISTA's pre-printed form, VISTA strongly encourages that Grievances be submitted on such a form to facilitate logging, identification, processing, and tracking of the Grievance through the review process.

If the Member needs assistance in preparing the Grievance, or in submitting a Grievance verbally, the Member may contact VISTA for such assistance. Hearing impaired Members may also contact VISTA via TDD at 1-888-444-7352.

Members (or their Authorized Representatives) must file a first level Grievance within **1 year** from occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination. If the decision of the first level Grievance is still unfavorable to the Member, the Member may:

- In the case of an Urgent Grievance, directly request review by the state Subscriber Assistance Program;
- In the case of a Grievance not involving an Adverse Benefit Determination, directly request review by the state Subscriber Assistance Program; or
- In the case of a Grievance involving an Adverse Benefit Determination, request a second level Grievance within 31 days of the date on VISTA's first level Grievance decision letter.

Within 5 business days of receiving a first or second level Grievance, VISTA will send the Member (or Authorized Representative) a letter acknowledging receipt of the Grievance. Except as stated below regarding Grievances related to non-Adverse Benefit Determinations, VISTA will respond to all first and second level Pre-Service Grievances within fifteen (15) calendar days, and all first and second level Post-Service Grievances within thirty (30) calendar days.

The timeframes in which VISTA must review Grievances may be extended if VISTA needs to collect information from outside the service area in order to properly review the Grievance. If this extension is necessary, VISTA will notify the Member in writing. The extension will not be longer than 30 days. Once the information is collected, VISTA will resume review of the Grievance according to the applicable timeframes.

If the first or second level Grievance is resolved in the Member's favor, the notice to the Member ("Grievance Decision Letter") will advise of the favorable determination and further instructions on authorization of services and/or claims payment.

If the first or second level Grievance is not resolved in the Member's favor, the Grievance Decision Letter will be drafted clearly and include the following information:

- The specific reason(s) for the Grievance decision;
- Reference to the specific plan provision on which the Grievance decision is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the Member's Grievance;
- A statement describing any further procedures for review rights offered by VISTA, if any, and the Member's right to obtain information about the procedures and a statement of the Member's right to bring action under the Employee Retirement Income Security Act of 1974, if applicable;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Grievance decision, a statement that such rule, guideline, protocol or other criterion was relied upon in making the Grievance decision and that a copy of such rule, guideline, protocol or other criterion will be provided upon request and free of charge;
- If the Grievance decision is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the specific clinical judgment for the decision, applying the terms of the benefit plan to the Member's medical circumstances, or notice that a written explanation of the clinical rationale is available upon request and free of charge;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. DOL office and your State insurance regulatory agency; and
- In any case when VISTA issues a first level Grievance Decision Letter related to (a) an Urgent Grievance; or (b) a non-Adverse Benefit Determination; or a second level Grievance

Decision Letter, VISTA will notify the Member of (1) the Member's right to request a review of VISTA's decision concerning the Grievance to the SAP, as provided in Section 408.7056 of the Florida Statutes, within **365 days** after receipt of the final decision letter; (2) how to initiate such review; (3) the addresses and toll-free number of AHCA and SAP; and (4) the name of the appropriate employees or a list of grievance departments responsible for implementing the Grievance procedure and their address and toll-free number. This right of SAP review extends to both standard and expedited Grievances. The Member can initiate a review by communicating to: AHCA, Bureau of Managed Health Care, Building 1 Room 339, 2727 Mahan Drive, Tallahassee, FL 32308, (850) 921-5458 in accordance with Section 408.7056, F.S

➤ **Grievances Regarding Non-Adverse Benefit Determinations**

Grievances regarding such issues as: (1) quality of service; (2) allegations of VISTA agent misrepresentation or provider discrimination; or (3) non-clinical potential provider issues will be researched by VISTA and VISTA will send the Member written notice of investigation results and actions taken by VISTA within an appropriate amount of time, not to exceed **30 calendar days** from the date the Grievance was received by VISTA.

➤ **Grievances Regarding Adverse Benefit Determinations**

Grievances involving Adverse Benefits Determinations based, in whole or in part, on medical judgment will be reviewed by a Clinical Peer, or by a Committee that is comprised of a majority of persons who are Clinical Peers.

Upon request, the Member may present their case, in person or via telephone, to the Committee hearing the second level Grievance. The Member's presentation will be limited to a maximum of **15 minutes** (mirroring the State of Florida's guidelines for SAP review) and such time limit shall include presentations offered by others on behalf of the Member, such as the treating provider, an attorney, or other representative.

➤ **Expedited Review of Urgent Grievances**

1. Members may request expedited review of an Urgent Grievance if the application of the standard Grievance review timeframes would seriously jeopardize the Member's life or health (or in the case of a pregnant woman, the life/health of the unborn child), or the Member's ability to regain maximum function. Expedited review may also be applied where application of the standard Grievance review timeframes would, in the opinion of a physician with knowledge of the Member's medical condition, subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.
2. The Member, or an Authorized Representative acting on the Member's behalf, must specifically request the expedited review. For example, the request may be made by stating, "I want an expedited review" or "Please review this request in an expedited manner." Only services subject to pre-authorization, or requests for extension of concurrent care services made within twenty-four (24) hours prior to the termination of authorization for such on-going services, may be subject to expedited review.
3. A Member may request an Urgent Grievance for the first time (similar to a first level Grievance). If VISTA's decision on review of the Urgent Grievance is unfavorable to the Member, the Member must then request a review by the Subscriber Assistance Program. Second level reviews are not offered by VISTA for Urgent Grievances. However, if a Member initially requested a first level Grievance (non-Urgent) related to an Adverse Benefit Determination and VISTA upheld its initial Adverse Benefit Determination, the Subscriber will not be precluded from requesting second level Grievance as an Urgent Grievance, if relevant.
4. Generally, in determining whether a Grievance will be subject to the expedited timeframes applicable to Urgent Grievances, VISTA must apply the judgment of a

prudent layperson that possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Member's medical condition requests an Urgent Grievance, the Grievance shall be deemed as such.

5. Within **24 hours** after receiving an Urgent Grievance, VISTA's Grievance and Appeal Administrator will collect and forward all relevant information to an appropriate Clinical Peer(s) who shall perform the expedited review. The Clinical Peer will not have been involved in making the initial Adverse Benefit Determination, or if applicable, the first level Grievance decision, nor be a subordinate to someone who was.
6. VISTA will notify the Member (or their Authorized Representative) of VISTA's benefit determination on review as expeditiously as the Member's medical condition requires, but no more than **72 hours** after VISTA's receipt of the request for review of the Urgent Grievance. If the expedited review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member is notified of the determination. Written notice of the final decision concerning expedited review of an Urgent Grievance will be provided to the Member or their Authorized Representative within **2 working days**, if the initial notification was not already provided in writing.
7. If the Member's request for expedited review arises out of an Adverse Benefit Determination that a continued hospitalization or continuation of a course of treatment is not Medically Necessary, coverage for the course of treatment or hospitalization shall continue until the Member is notified of the Grievance decision.
8. VISTA will not honor a request for expedited review that relates to services that have already been performed, rendered, or provided to the Member, or a request that is not eligible for expedited review (Urgent Grievance). VISTA will process any such Grievances in accordance with its standard Grievance time frame.
9. **If it is VISTA's decision to uphold the initial Adverse Benefit Determination, the Member will be notified of their right to request review by the Subscriber Assistance Program, as discussed below. No second level review of Urgent Grievances is available through VISTA's internal Grievance process.**

E. Subscriber Assistance Program

The Member may, at any time, send a copy of his/her Grievance to the OIR, or AHCA, or the SAP. However, the Member must exhaust, and receive a final disposition from, VISTA'S internal Grievance Program, as described in this Section, before requesting review by the SAP. The Member must submit Grievances for review by the SAP within three-hundred and sixty-five (365) days of VISTA's second level Grievance Decision Letter.

F. General Rules and Information

General rules regarding VISTA's Complaint and Grievance Process include the following:

1. The Member must cooperate fully with VISTA in Our effort to promptly review and resolve a Complaint or Grievance. In the event the Member does not fully cooperate with VISTA, the Member will be deemed to have waived the Member's right to have the Complaint or Grievance processed within the time frames set forth above.
2. VISTA will offer to meet with the Member if the Member believes that such a meeting will help VISTA resolve the Complaint or Grievance to the Member's satisfaction. For the Member's convenience, and at the Member's option, the Member may elect to meet with Our representatives in person or by telephone conference call. VISTA will not reimburse the Member for travel or lodging in connection with any such meeting. Appropriate arrangement will be made to allow telephone conferencing to be held at Our administrative offices. VISTA will make these telephone arrangements with no additional charge to the Member. The Member must notify

VISTA that the Member wishes to meet with its representatives concerning the Complaint or Grievance.

3. VISTA will not honor a request for expedited review that relates to Services that have already been performed, rendered, or provided to the Member or a request that is not eligible for expedited review of an Urgent Grievance. VISTA will process any such Grievance, however, in accordance with the standard Grievance procedure.
4. VISTA must receive all Grievances within one (1) year after the date of the occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.
5. If the Grievance involves a determination that the Services did not meet VISTA's guidelines for coverage of a Service or that the Service is excluded because it meets the definition of an Experimental or Investigational Service or a similar exclusion or limitation, then the Member may request an explanation of the scientific or clinical judgment relied upon, if any, for determination, that applies the terms of the Contract to the Member's medical circumstances.
6. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
7. The member may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

G. Telephone Numbers and Addresses

The member may contact a VISTA Grievance Coordinator at the number listed on the acknowledgement letter or Grievance Decision Letter. If a Grievance is unresolved, or at any time, the Member may contact an agency at the telephone numbers and addresses listed below.

Department of Financial Services

Division of Consumer Services
200 E. Gaines St.
Tallahassee, FL 32399-0322
1-800-342-2762

Subscriber Assistance Program

2727 Mahan Drive, Building 1, Room 339 Mail Stop-27A
Tallahassee, FL 32308
1-850-921-5458
1-888-419-3456

VISTA

In person or in writing:

Attention: Grievance Department
1340 Concord Terrace
Sunrise, FL 33323
Customer Service: 1-866-VISTA-FL (1-866-847-8235)
Hours: Monday through Friday, 8 a.m. – 6 p.m.
TDD: 1-888-444-7352

SECTION 8 COORDINATION OF BENEFITS

A. Avoidance of Duplicate Payment

The Coordination of Benefits provision is intended to assure that a Member covered under any other Health Plan receives as much of his/her medical services as possible, while avoiding duplicate payment of Covered Services. Health Plans include:

1. Coverage under government programs (excluding Workers' Compensation and Medicaid) required or provided by a statute unless law forbids coordination of benefits with any such program.
2. Group coverage (other than group automobile insurance) or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including any prepayment coverage, group practice or individual practice coverage and any coverage for students which is sponsored by, or provided through, a school or other educational institution above the high school level and individual and family (or non-group) plans.

B. Definition of Health Plan

The term "Health Plan" shall be construed separately with respect to:

1. Each policy, contract or other arrangement for benefit or services.
2. The portion of any such policy, contract or other arrangement which reserves the right to take the benefits of other Health Plans into consideration in determining its benefits and that portion which does not.

C. Rules

Should a Member be covered by or under any other Health Plan, in addition to coverage under this Group Agreement, the following provisions and rules shall determine whether VISTA or the other Health Plan is primarily responsible for paying the costs of benefits and services.

1. Benefits Subject to this Provision

All of the benefits and services, which VISTA is obligated to provide under this Group Agreement, are subject to the provisions of this Section. Copayments, Deductibles and/or Coinsurance are required, even if a Member is covered under other health insurance.

2. Determination of Benefits

a. Wherever the sum of all benefits available under this Group Agreement determined without regard to this provision and all benefits available under all other Health Plans determined without regard to provisions similar to this exceed the amount payable by VISTA under this Agreement, and in accordance with applicable law, during the Claim Determination Period, the benefits that would otherwise be payable by VISTA in the absence of this provision shall be reduced by such excess. Benefits payable under other health insurance include the benefits that would have been payable had claim been duly made therefore.

b. The following rules apply to determination of benefits:

- (1) The benefits of a policy or plan which covers the person as an employee, Member, or Member and not as a dependent are determined before those of the policy or plan which covers the person as a dependent.

- (2) Except as stated below, when two (2) or more policies or plans cover the same child as a dependent of different parents:
 - (a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time. However, if a policy or plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan shall determine the order of benefits.
- (3) If two (2) or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) First, the policy or plan of the parent with custody of the child;
 - (b) Second, the policy or plan of the spouse of the parent with custody of the child; and
 - (c) Third, the policy or plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if such parent has actual knowledge of those terms, the benefits of that parent's policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.
- (4) The benefits of a policy or plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph shall not apply.
- (5) If none of the rules set forth in this Group Agreement determine the order of benefits, the benefits of the policy or plan which covered a Member for a longer period of time are determined before those of the policy or plan which covered that person for the shorter period of time.
 - (a) None of the above coordination of benefits rules shall serve as a barrier to the Member first receiving direct health care services under VISTA where such services are covered under this Group Agreement.
 - (b) Whenever an VISTA Member is also a Medicaid recipient, VISTA's coverage shall be primary to the recipient's Medicaid benefits and VISTA shall be a third party subject to the provisions of Florida Statute 409.266(3)(c).

D. The Effect of COBRA

The Plan which covers the person as an employee (or as that employee's dependent) is the primary Plan; the Plan which covers the person pursuant to COBRA is the secondary Plan.

E. The Effect of Medicare

This Plan will be primary to Medicare as required by the Tax Equity and Fiscal Responsibility Act (TEFRA/DEFRA), the Omnibus Budget Reconciliation Act (OBRA), and other laws and regulations applicable to GROUP.

F. The Effect of Automobile Coverage

This Group Agreement is not in lieu of and does not affect any requirement for, or coverage by, or benefits paid by Automobile Insurance. VISTA will not pay for benefits that are covered under the Automobile Insurance. The rules of this Group Agreement should be followed in the event Automobile Insurance is exhausted or does not pay for the injury.

G. Right to Receive and Release Necessary Information

VISTA may release any information considered to be necessary for VISTA Coordination of Benefits with respect to any person claiming benefits under this Group Agreement without consent of, or notice to, the Member or any other person or organization. However, VISTA shall not be required to determine the existence of any other Group Agreement or insurer or the benefits payable under such plan or insurer when computing services or benefits due a Member covered under this Group Agreement.

H. Facility of Payment

Whenever payments which should have been made under VISTA coverage in accordance with this provision have been made under any other health plan or insurer, VISTA will have the right to pay over to such health plan or insurer any amount VISTA will determine to be warranted in order to satisfy the intent of this provision. Any amounts so paid shall be deemed to be benefits under this Group Agreement, and to the extent of such payments, VISTA will be fully discharged from liability under this Group Agreement.

I. Right of Recovery

Whenever VISTA payment for Covered Services exceeds the maximum amount of payment necessary to satisfy the intent of this provision, VISTA shall have the right to recover such payment to the extent of such excess, from any insurer, any organization, or any person(s) to whom such payments were made.

J. Disclosure

Each Member agrees to disclose to VISTA at the time of enrollment, at the time of receipt of services and benefits, and from time to time as requested by VISTA the existence of other health insurance coverage, the identity of the carrier, and the group through whom provided.

SECTION 9 TERMINATION OF COVERAGE

A. Upon Notification

This Group Agreement may be terminated by either VISTA in accordance with the terms of this Group Agreement or by the Group upon written notice to VISTA at least sixty (60) days prior to the termination date. Such termination by VISTA or the Group shall occur at midnight of the day preceding the termination date. In the event either party gives no such notice, this Group Agreement shall continue in effect for another Contract Year unless terminated pursuant to other provisions of this Group Agreement.

B. Termination of Subscriber's Coverage

Unless otherwise prohibited by law, if in VISTA's opinion any of the following events occur, VISTA may terminate a Covered Person's coverage as specified below:

1. The date specified by VISTA due to the Covered Person's disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Covered Person's continued Membership in the Group Plan, impairs Our ability to provide coverage and/or benefits or to arrange for the delivery of health care services to such Covered Person or to other Covered Persons. Prior to disenrolling a Covered Person for any of the above reasons, VISTA will:
 - a. make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of VISTA'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 VISTA that all coverage will terminate due to: (a) fraud or material misrepresentation in applying for or presenting any claim for benefits under this Group Plan; or (b) permitting the use of his or her Membership Card by any other person or (c) furnishing of false or incomplete information on the enrollment forms, or other forms completed for VISTA, by or on behalf of the Member for the purpose of fraudulently obtaining coverage. False, material information includes, but is not limited to information relating to residence and/or employment, information relating to another person's eligibility for coverage or status as a Dependent. VISTA has the right to rescind coverage back to the effective date, in accordance with s. 641.31(23), Florida Statutes, *Time Limit on Certain Defenses*.
3. The date specified by VISTA if the Member is no longer eligible for coverage, based upon the Group's eligibility requirements, or due to the Member leaving VISTA's Service Area with the intention to relocate or establish a new residence.
4. The date specified by VISTA if a Covered Dependent reaches the limiting age as specified in the Eligibility Section of this Group Plan or if a court order, including a qualified medical child support order, covering a dependent child is no longer in effect.
5. If the Member or the Group does not pay premiums, such termination, and notice thereof, to be in accordance with the terms and conditions of the Group Agreement.
6. The date that the Group Agreement between the Group and VISTA terminates for any reason whatsoever.

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

NOTE: "Time Limit on Certain Defenses", Relative to a misstatement in the application, after two (2) years from the issue date, only fraudulent misstatements in the application may be

used to void the policy or deny any claim for loss incurred or disability starting after the two (2) year period.

C. Termination of a Dependent's Coverage

Unless otherwise prohibited by law, a Covered Dependent's coverage may be terminated by VISTA for any of the following reasons:

1. The Group Agreement between the Subscriber and VISTA ends for any reason;
2. The Subscriber's coverage ends for any reason;
3. The Dependent fails to continue to meet each of the Dependent eligibility requirements under this Group Agreement;
4. The Dependent becomes covered under another health benefit plan that is offered through or in connection with the Subscriber as an alternative to this Group Agreement; or
5. A court order, including a qualified medical child support order covering a Dependent is no longer in effect.

D. Ineligibility for Coverage

1. Death of Subscriber

Upon the death of the Subscriber, coverage under this Group Agreement shall automatically terminate as of the date of his death and as to his Covered Dependents, as of the date to which Premiums have then been paid. In the event that the Group and VISTA determine that a surviving family member shall remain as a Covered Dependent in accordance with the Group's eligibility rules, then such Member's coverage shall continue in effect as if the Subscriber were not deceased, except that no Premiums shall be due with respect to the deceased Subscriber and any action with reference to VISTA required to be taken by the Subscriber shall be taken by the Covered Dependent who is the deceased Subscriber's spouse or, if none, then by the eldest Covered Dependent (or his legal guardian if such Covered Dependent is a minor or legally incapacitated).

2. Severance of family relationship or retirement if the Group's health benefits do not extend to retirees.

3. Subscriber No Longer Eligible

If the Subscriber ceases to be eligible (other than by reason of death), his/her coverage and that of the Covered Dependent's coverage under this Group Agreement shall automatically terminate as of the date to which Premium charges have then been paid.

4. Covered Dependent no Longer Eligible

If a Covered Dependent ceases to be eligible, his/her coverage under this Group Agreement shall automatically terminate in accordance set forth in this Group Agreement.

Upon termination of the Individual's coverage for any reason, VISTA shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Group Agreement.

NOTE: VISTA has the right to terminate coverage back to the effective date, in accordance with s. 627.607, Florida Statutes, "Time Limit on Certain Defenses" states, "Relative to a misstatement in the applications, after two (2) years from the issue date, only fraudulent misstatements in the applications may be used to void the coverage or deny any claim for loss incurred or disability starting after the two (2) year period."

SECTION 10 CONTINUATION OF COVERAGE

If coverage for a Member ends, the Member may, depending on his/her situation, have the right to have coverage extended under the extension of benefits provision. Also, the Member may be eligible for coverage under the federal coverage provisions or a health benefit plan under the conversion privilege provision.

A. Extension of Benefits (Post Termination Disability Coverage)

If VISTA's Group Agreement with the Group terminates for any reason and the Member is Totally Disabled on the effective date of termination, he or she may be entitled to continue to receive the benefits under this contract for the treatment of the condition or illness or injury resulting in the total disability until the earlier of:

1. Twelve (12) months from the effective date of the termination of coverage;
2. The Member receives the maximum benefit payable under this Agreement; or
3. A succeeding carrier elects to provide replacement coverage without limitation as to the disabling condition; or
4. The Member is no longer totally disabled as a result of the condition or illness that existed and manifested itself as of the effective date of the termination of coverage.

In the case of maternity coverage, an extension of benefits is provided. The extension is for the period of the pregnancy and is not based on total disability.

For the purposes of this section, an individual is totally disabled if the individual has a condition resulting from an illness or injury which prevents an individual from engaging in any employment or occupation for which the individual is or may become qualified by reason of education, training, or experience, and the individual is under the regular care of a physician.

Except as provided in above, no subscriber is entitled to an extension of benefits if the termination of the contract by VISTA is based upon:

1. Fraud or intentional misrepresentation, subject to the limitations of "Time limit on certain defenses";
2. Disenrollment for cause as outlined in Florida Statute; or
3. The subscriber has left VISTA's geographic area with the intent to relocate or establish a new residence outside VISTA's geographic area.

B. COBRA

Federal law (the Consolidated Omnibus Budget Reconciliation or "COBRA"), as amended, permits Members to continue coverage under an employer-established health benefit plan under certain circumstances. This provision does not apply to employers with fewer than twenty (20) employees. Covered Employees should consult with the Employer regarding the availability of this option. It is the Employer's responsibility to make employees aware of any COBRA rights they may have.

A qualified beneficiary must make timely election of COBRA coverage. An election is considered timely if it is made during the election period. The COBRA election period begins on or before the date that the qualified beneficiary would lose coverage due to a qualifying event. The election period ends sixty (60) days from the later of:

1. The date coverage is lost due to the qualifying event; or

2. The date the qualifying beneficiary is given notice of the right to elect COBRA coverage.

Member responsibilities include:

1. A Member must contact the Group to determine if he/she is entitled to COBRA continuation coverage.
2. If a Member is eligible for COBRA, he/she may elect to continue group health benefits if he/she qualifies under one (1) of the circumstances specified in COBRA and satisfies all of the requirement for such coverage, including payment of required Premiums.
3. The Member must provide the Group with all required notices, in the form and within the time period required by COBRA and the Group, including but not limited to, notice of:
 - a. Medicare entitlement, divorce or legal separation, or the failure of a Covered Dependent child to meet eligibility requirements of the Group Agreement.
 - b. Coverage under another group Health Plan.
 - c. With respect to the Member's ability to receive additional periods of coverage under COBRA in the event that the Member is disabled, a determination by the Social Security Administration that the Member is disabled, or a determination by the Social Security Administration that the Member has ceased to be disabled.

A Member must apply for continuation coverage under COBRA. Upon exhaustion of coverage, or if the Member is not eligible for COBRA, he or she may be eligible to apply for coverage under the Conversion privilege. A request for conversion coverage must be made no later than sixty-three (63) days from termination of coverage under this health benefit plan.

C. Conversion Plans

In the event a Member's Group coverage terminates for any reason other than those set forth in this Group Agreement, the Member may elect to apply immediately for conversion. Neither VISTA nor the Group has any obligation to notify any such individual of the conversion privilege. Such individual has the sole responsibility to exercise this conversion privilege.

The Member should contact VISTA Enrollment Department at 954-962-3008 x1804 immediately following termination and give Us notification of interest in conversion. VISTA will mail to the eligible individual within fourteen (14) days, an Election and Premium Notice Form including Outlines of Coverage for the conversion plans available. The individual must return the completed application and the first monthly premium to VISTA no later than sixty-three (63) days after termination of Group coverage.

Members' eligibility for conversion coverage shall be strictly subject to the following requirements and conditions set forth below:

1. Member must have been a Member (or have been covered under any group contract providing similar benefits hereto) for at least three (3) months immediately prior to termination of Member's coverage hereunder;
2. Member must not be covered or be eligible for coverage under Medicare;
3. Member must not be 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 any other plan;

4. Member must not be eligible for similar benefits, whether or not covered thereby, under any arrangement of coverage for individuals in a group, whether on an insured basis or uninsured basis;
5. Member must not be entitled to receive similar benefits pursuant to or in accordance with the requirements of any state or federal law.
6. To be eligible for conversion, the Member must not have lost his or her eligibility for coverage hereunder for any of the following reasons:
 - a. failure to pay any require premium or contribution unless such nonpayment of premium was due to acts of an employer or person other than the individual;
 - b. replacement of any discontinued group coverage by similar group coverage within thirty-one (31) days;
 - c. fraud or intentional misrepresentation in applying for any benefits under this Group Agreement.

D. Scope of Conversion Coverage

At the time of application, the individual will be offered a choice of at least two (2) conversion plans; the Standard conversion plan and at least one other plan in which benefits are substantially similar to the level of benefits of this Group Agreement. The conversion plan shall cover only the Subscriber and those dependents covered by this Group Agreement on the date of termination of Member's coverage hereunder. Such conversion coverage may continue in effect, provided that each individual who has converted to the conversion contract continues to meet all applicable eligibility requirements, pay all premiums, and otherwise complies with all requirements set forth in the conversion contract.

VISTA's conversion plans are monthly policies whereby a Member is required to pay monthly for coverage. Pro-rated refunds are not available under these policies. Conversion plan Members contract directly with VISTA and have no further interaction with their former employer. The premium for conversion coverage shall be determined in accordance with premium rates applicable to the age and class and risk of each person to be covered and shall be paid in advance on a quarterly basis to VISTA.

Upon receipt of an application not later than sixty-three (63) days after termination of Group coverage and payment of the first monthly premium, the effective date of the conversion contract shall be the day following termination of coverage hereunder.

Issuance of conversion coverage shall not be subject to evidence of health qualification of the Member. Furthermore, conversion coverage shall not exclude a Pre-existing Condition not excluded by the Group Agreement. The conversion contract will provide that any benefits thereunder shall be reduced by the amount of any coverage or benefits afforded under this Group Agreement after the Member's termination of coverage. During the first coverage year, the coverage or benefits under the converted contract shall not exceed those that would have been provided had the individual's coverage or benefits under the Group Agreement remained in force.

Please note that if the employee qualifies for COBRA or State of Florida Continuation Coverage, conversion benefits take place at the end of the federal or state continuation period, if written application is made and the first monthly payment is made within sixty-three (63) days of the date coverage under the continuation plan ends.

SECTION 11 MISCELLANEOUS

A. Records and Information

1. It is the Member's responsibility to insure that any Healthcare Professional, Hospital, insurance company, employee benefit association, governmental body or program, or any other person or entity with knowledge of or records relating to:
 - a. any illness or injury for which benefits are claimed under this Group Agreement,
 - b. any medical history which might be pertinent to such illness or injury or claim or
 - c. any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such claim,to furnish VISTA, at any time upon its request, any and all information and records (or copies of records) relating to such illness, injury or claim.
2. VISTA may furnish similar information and records (or copies of records) to any insurance company, governmental body or program or other entity providing insurance type benefits requesting the same.

B. Notices

1. Any notice under this Group Agreement, required of the Subscriber or the Group may be mailed to the following address:

Vista Healthplan, Inc.
1340 Concord Terrace
Sunrise, Florida 33323
2. Any notice required of VISTA shall be sufficient if mailed to the holder of this Group Agreement, at the address appearing on the records of VISTA.

C. Civil Remedy

In any civil action brought to enforce the terms and conditions of a VISTA contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. This Section shall not be construed to authorize a civil action against the Department of Financial Services.

D. Entire Group Agreement

This Group Agreement and any attached riders and the Binder and Agreement constitute the entire contract between the Group and VISTA. To be valid, any change in the form must be approved by an officer of VISTA and attached to the affected form and no agent has the authority to change the form or waive any of the provisions.

E. Member's Copy

A copy of this Group Agreement, all Attachments, Applications, and forms hereto will be provided to the Member.

F. Workers' Compensation

This Group Agreement is not in lieu of and does not affect any requirement for, or coverage by, or benefits paid by Workers' Compensation Insurance. VISTA will not pay for benefits that are covered under Workers' Compensation. The rules of this Group Agreement should be followed in the event Workers' Compensation and/or Automobile Insurance does not pay for the injury.

G. Refusal to Accept Treatment from Participating Healthcare Professionals

For personal reasons, You may refuse to accept procedures or treatment from a Participating Healthcare Professional. The Healthcare Professional may regard such refusal to accept his or her recommendation as incompatible with continuance of the physician-patient relationship and if no acceptable alternative exists for what the physician believes to be proper medical care, You will be so advised in writing. If You still refuse to accept the recommended treatment, neither VISTA nor the Participating Healthcare Professional will be responsible for treatment of the condition.

H. Relationship of Parties

Healthcare Providers, including Participating Providers under an independent contract, are not agents or employees of VISTA, nor is VISTA or any of its employees, an employee or agent of Healthcare Providers. VISTA shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You in connection with the furnishing of, or failure to furnish services by any Healthcare Providers.

I. General Limitation

In the event that, due to circumstances not within the control of VISTA, including but not limited to: a major disaster; epidemic; the complete or partial destruction of facilities; riot; civil insurrection; disability of a significant part of VISTA's Participating Provider's personnel or similar causes, the rendering of Professional Services or Hospital Services provided under this Contract is delayed or rendered impractical, VISTA shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, VISTA and Participating Providers shall render the Hospital and Professional Services provided under this Contract insofar as practical, and according to their best judgment. VISTA and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

J. Termination

This Group Agreement shall remain in effect for the first Contract Year and thereafter for successive Contract Years unless terminated earlier as provided herein. The effective time for any dates used is 12:01 A.M. at the address of the Subscriber.

K. Amendment

This Group Agreement may be amended at any time, without the consent of the Members, or any other person having a beneficial interest in it, upon written request made by the Group and agreed to by VISTA. Any such amendment shall be without prejudice to any claim arising prior to the date of such amendment.

L. Force Majeure

No party to this Agreement shall be liable for any default or delay in the performance of its obligations hereunder if and to the extent the default or delay is caused, directly or indirectly, by strikes, picketing, insurrection, acts of God, military actions, terrorist attacks, war, emergencies, shortages or unavailability of materials or other causes beyond a party's reasonable control (a "Force Majeure Event"), and such party shall be excused from performance and shall not be considered to be in default hereunder in respect to the affected obligation. The suspension of performance due to a Force Majeure Event shall be of no greater scope and no longer duration than that which is reasonably necessary. The excused party shall use its reasonable best efforts to remedy its inability to perform as soon as possible.

M. Performance Outcomes and Financial Data

You may obtain information regarding performance outcomes and financial data for VISTA published by the State of Florida Agency for Health Care Administration by accessing the VISTA website www.vistahealthplan.com. This website includes the link to FloridaHealthStat where this information is published, or You can go directly to www.floridahealthstat.com.

N. Third Party Beneficiary

This Group Agreement is entered into exclusively between VISTA and the Subscriber. This Group Agreement is intended only to benefit the individual Subscribers and their dependents covered under this Group Agreement and does not confer any rights to any third parties. There are no intentional or incidental third-party beneficiaries to this agreement.

O. Construction

VISTA shall interpret this Agreement including any terms or provisions which may otherwise be or appear to be ambiguous, whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions, and interpretations made by VISTA, and in accordance with applicable law, shall be binding upon the Member.

SECTION 12 DEFINITIONS

As used in this Certificate of Coverage, the following words and phrases shall apply:

Accredited Institution: a secondary, college, university or trade school which is certified or licensed by a state.

Acute: sudden onset, acting keenly on the senses; sharp, brief and severe.

Administrator: VISTA and/or its designated agents who perform a number of administrative duties, including processing all claims occurring under this Agreement.

Allowed Amount: the amount that a Participating Provider has agreed to accept as payment in full for Covered Services.

Ambulatory Surgical Center: a facility duly licensed and billing as a freestanding ambulatory surgical center pursuant to applicable state and federal law, the primary purpose of which is to provide surgical care to a patient, admitted to and discharged from such facility within the same working day, as listed on VISTA's internet website www.vistahealthplan.com.

Anniversary Date: the yearly return of the Effective Date.

Annual Open Enrollment Period: an annual thirty (30) day period, beginning no less than thirty (30) days prior to the Anniversary Date of the Group's health benefits program, during which:

1. If the Group has established and maintained more than one health coverage plan for their Eligible Employees, an Eligible Employee who had elected another plan, and maintained coverage under that plan up to the beginning of the Annual Open Enrollment Period, can change to this Group Agreement.
2. Employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under this Group Agreement during the Initial or Special Enrollment Periods can enroll.

Birthing Center: an outpatient facility, as listed on VISTA's internet website www.vistahealthplan.com which:

1. complies with licensing and other legal requirements in the jurisdiction where it is located;
2. is engaged mainly in providing a comprehensive birth services program to pregnant individuals who are considered normal low risk patients;
3. has organized facilities for birth services on its premises;
4. has birth services performed by a Healthcare Professional specializing in obstetrics and gynecology, or at his or her direction, by a midwife or nurse midwife; and
5. has a twenty-four (24)-hour-a-day Registered Nurse service.

Calendar Year: a period of one (1) year that starts January 1 and ends December 31.

Chronic: lasting a long time, lingering, long duration involving very slow changes.

Coinsurance: the sharing of expenses for Covered Services between VISTA and the Member. Coinsurance is expressed in a percentage rather than a dollar amount.

Complications of Pregnancy: is a Condition diagnosed as separate from a pregnancy. Complications means a condition, requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, therapeutic abortion, non-elective Caesarean section, tubal pregnancy which is terminated; miscarriages; or medical and surgical conditions of similar severity. Complications of pregnancy do not include false labor, occasional spotting, Healthcare Professional prescribed bed rest during the period of pregnancy, morning sickness, uncontrolled vomiting; convulsions and high blood pressure; or similar conditions associated with a difficult pregnancy.

Condition: the state in which a person has any sickness, illness, injury, bodily dysfunction or pregnancy.

Copayment: a specific dollar amount, except as otherwise provided for by statute that the Member must pay upon receipt of Covered Services. Healthcare Professionals have the obligation to collect these Copayments.

Cosmetic Services and Surgery: plastic or reconstructive surgery: (1) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

Covered Dependent: an Eligible Dependent who receives health care benefits through VISTA and meets the dependent criteria specified in the Eligibility Section of this Group Agreement.

Covered Services: those Medically Necessary professional services of Healthcare Professionals or other Providers, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services and supplies specified in the Covered Services Section of this Group Agreement, listed on the Schedule of Benefits or any rider, amendment or endorsement attached.

Custodial Care: care primarily provided to assist a patient in meeting the activities of daily living such as help in walking; getting out of bed; bathing; dressing; feeding and preparation of special diets; and supervision of medications which are ordinarily self-administered.

Deductible: the amount a Member must pay before VISTA will make any payment toward Covered Services.

Disease: a condition of an organism that impairs normal physiological functioning.

Disposable Medical Supplies: those supplies that are not meant to be re-used by another individual and include, but are not limited to, gauze, tape, syringes, needles, I.V., plastic tubing, canvas/Velcro splints, and blood pressure cuffs.

Durable Medical Equipment (DME): medical equipment furnished by a supplier or a Home Health Agency that:

1. can stand repeated use;
2. is primarily and usually used to serve a medical purpose;
3. is not for comfort or convenience;
4. is appropriate for use in the home; and
5. is generally not useful to You in the absence of a Condition.

Effective Date: the date on which coverage begins for this Group Agreement.

Eligible Dependent: the Subscriber's spouse, natural child, adopted child, stepchild, or child for whom legal guardianship has been established where such child is primarily dependent on the Subscriber for support and lives with the Subscriber in a permanent parent-child relationship.

Eligible Employee: an employee of the Group who works for the Group on a full-time basis, with a normal work week of twenty-five (25) hours or more and is eligible based on the criteria established by the Group.

Eligible Retiree: a retiree of the Group who is eligible for retiree health coverage from the Group based on criteria established by the Group.

Emergency Medical Condition: 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:

1. Serious jeopardy to the health of the patient, including a pregnant woman or fetus;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care: medical screening, examination, and evaluation by a Healthcare Professional to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Healthcare Professional, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Healthcare Professional necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

Enrollment Applications: the forms prescribed by VISTA which the Subscriber shall be required to complete and submit to the Employer for the purpose of enrolling him or herself and any Eligible Dependents for coverage hereunder.

Expenses: the cost incurred for healthcare services and supplies.

Experimental and Investigational Treatment: a drug, device, health service or health product or service is deemed experimental and investigational if one or more of the following criteria are met:

1. any drug, device, health service or product not approved for use by the FDA; any FDA approved drug, device, health service or product prescribed for an off-label use whose effectiveness is unproven based on clinical evidence as reported in peer-reviewed medical literature; or, any drug, device, health service or product that is classified as IND (Investigational New Drug) by the FDA;
2. any drug, device, health product or service that is subject to Investigational Review Board (IRB) review or approval;
3. any drug, device, health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;
4. any drug, device, health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.

Extended Care or Skilled Nursing Facility: an institution or a distinct part thereof, including an intermediate nursing facility, as listed on VISTA's internet website www.vistahealthplan.com which:

1. is licensed pursuant to state and local laws;
2. is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness;
3. is approved by and is a participating facility with Medicare;
4. has organized facilities for medical treatment;
5. provides twenty-four (24)-hours-a-day nursing service under the full-time supervision of a Healthcare Professional or Registered Nurse;
6. maintains daily clinical records on each patient;
7. has available the services of a Healthcare Professional under an established Policy;
8. provides appropriate methods for dispensing and administering drugs and medicines;
9. has transfer arrangements with one (1) or more Hospitals; a utilization review plan in effect; and operational policies developed with advice of and reviewed by a professional group including at least one (1) Healthcare Professional; and
10. is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

Full Time Student: a Member who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Full Time Student status. A student is considered full time during normally scheduled school vacations if he/she is registered to return to that or a similar institution at the end of the vacation. A Member is considered enrolled during summer or holiday vacations when school is not in session.

Gene Testing: examining a sample of blood or other body fluid or tissue for biochemical, chromosomal, or genetic markers that indicate the presence or absence of a genetic abnormality.

Gene Therapy: treatment of disease, condition or genetic abnormality by replacing, altering, or supplementing a gene that is absent or abnormal and is responsible for the disease, condition or pre-disposition to disease.

General Obstetricians and Gynecologists: physicians as listed on VISTA's internet website www.vistahealthplan.com that manage women's care during normal pregnancies. Their obstetric patients are women who are in good health or who have common medical conditions. These physicians also provide preventive and routine gynecologic care including, but not limited to, the treatment of endometriosis, pelvic pain, sexually-transmitted diseases, the symptoms of menopause, and uterine fibroids. They counsel their patients on family planning/contraception and perform gynecologic surgeries including, but not limited to, laparoscopy and endoscopy.

Genetic Counseling: meeting with trained Healthcare Professionals before testing begins, when Members receive the test results, and for appropriate post-testing follow-up.

Group: an employer or other party that has entered into an agreement with VISTA, and through which an employee, retiree and/or his or her Eligible Dependents, if any, may enroll in this Group Agreement.

Group Agreement: the Certificate of Coverage, Binder and Agreement, and all applicable attachments and riders thereto, as duly executed by and between VISTA and the Group.

Health Intervention: an activity taken for the primary purpose of preventing, improving, or stabilizing a Medical Condition. Activities that are primarily Custodial Care, part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered Health Interventions.

Health Outcomes: outcomes of Medical Conditions that directly affect the length or quality of a person's life.

Healthcare Professionals: Physicians, dentists, nurses, midwives, nurse midwives, certified registered nurse anesthetists, advanced registered nurse practitioners, audiologists, podiatrists, osteopaths, chiropractors, ophthalmologists, Physician assistants, clinical psychologists, social workers, mental health counselors, pharmacists, nutritionists, physical therapists, speech therapists and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, are certified, or practice under the authority of a Physician or legally constituted professional association, or other authority consistent with the laws of the State of Florida.

Home Health Agency: an organization licensed by the State and certified by Medicare to render home health services at an outpatient facility, as listed on VISTA's internet website www.vistahealthplan.com.

Hospice: an organization that meets the standards outlined by the National Hospice Association and is licensed, certified and registered as required by Florida law, as listed on VISTA's internet website www.vistahealthplan.com. A Hospice primarily provides services for pain relief, symptom management, and supportive services to terminally ill persons and their families. A Member is considered terminally ill if the Healthcare Professional has certified the Member as having a life expectancy of twelve (12) months or less.

Hospice Care Program: a coordinated, interdisciplinary program:

1. to meet the physical, psychological, spiritual and social needs of terminally ill persons and their families;
2. that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
3. for persons who have a terminal illness and for the families of those persons.

Hospital: an institution, as listed on VISTA's internet website www.vistahealthplan.com which is operated pursuant to law, is accredited by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, and is primarily engaged in providing, on an inpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which services must be provided on its premises under the supervision of a staff of Healthcare Professionals and with twenty-four (24)-hour-a-day nursing service.

Hospital Services: (except as limited or excluded herein) those services furnished and billed by a Hospital or skilled nursing facility.

Identification Card: the card that VISTA issues to a Member upon enrollment. When a Member arrives at a Participating Healthcare Professional to receive Covered Services, the Member must show the Healthcare Professional his/her Identification Card to verify coverage by VISTA.

Infertility: the inability of a woman to conceive a pregnancy after six (6) months of unprotected intercourse or the inability of a woman to carry a pregnancy to live birth.

Infertility Treatment: all services, supplies and drugs related to the diagnosis and treatment of infertility, including but not limited to counseling, testing, semen analysis, ferning, spinbarkeit and Huhner's test, sperm agglutination or penetration studies, hysterosalpingography, endometrial biopsy, laparoscopy,

laparotomy, myomectomy, dilation and curettage, tuboplasty, microsurgical procedures of the female pelvis or male genital tract, ovulation induction and artificial intercervical or intrauterine insemination.

Initial Enrollment Period: the period of time during which an employee or dependent is first eligible to enroll. It starts on the employee's and/or dependent's initial date of eligibility and ends no less than thirty (30) days later.

Injury: an accidental bodily condition that:

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

Large Group Employer: an organization that is actively engaged in business and employs more than fifty (50) Eligible Employees as of the Effective Date and subsequent Agreement Anniversary Dates.

Late Enrollee: any Member who applies for coverage under this Group Agreement other than during the first period in which the Member is eligible to enroll or during a Special or Annual Open Enrollment Period.

Late Enrollment: that enrollment period that is provided for employees and/or their dependents who do not enroll in a timely manner as specified in this Group Agreement and does not meet the requirements of special enrollment.

Medical Condition: a disease, an illness, or an injury. A biological or psychological condition which lies in the range of normal human variation is not considered a disease, illness, or injury.

Medical Services: (except as limited or excluded under this Group Agreement) those professional services of Healthcare Professionals or other Participating Providers, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services.

Medically Necessary: those services and supplies that are not expressly excluded under this Agreement and that are determined by VISTA to be:

1. Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;
2. Necessary to meet the basic health needs of the Member as a minimum requirement;
3. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
4. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan;
5. Consistent with the diagnosis of the condition;
6. Required for reasons other than the comfort or convenience of the Member or his or her physician; and
7. Of demonstrated value based on clinical evidence reported by peer reviewed medical literature and by generally recognized academic medical experts; that is, it is not experimental (investigational; unproven).

Medicare: Title XVIII of the Social Security Act and regulations there under.

Member: the Subscriber or an Eligible Dependent who is covered under this Group Plan and for whom payment has been received.

Member Responsibility: Deductibles, Coinsurance and Copayments, in connection with Covered Services, in accordance with the Member's benefit plan.

Mental Health and Nervous Disorders: disorder that impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin.

Modalities: a form, method, or apparatus of therapy, especially physiotherapy or electrotherapy.

Non-Participating Provider: Healthcare Professional, organization, supplier of healthcare items, or a healthcare facility who does not have a written contract at the time services are provided with VISTA to provide Covered Services to VISTA Members.

Orthognathic Surgery: the surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw) or the maxilla (upper jaw). These malformations may be present at birth, or they may become evident as the patient grows and develops.

Orthotic Devices: devices must (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity, protect against injury or assist with function; and (ii) be rigid or semi-rigid and correct a diagnosed musculoskeletal mal-alignment of a weakened or diseased body part: or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part.

Outpatient: a person who receives care at a Hospital or other facility that does not last longer than twenty-three (23) hours.

Outpatient Diagnostic Center: a facility duly licensed and billing as a freestanding outpatient diagnostic center pursuant to applicable state and federal law, the primary purpose of which is to provide diagnostic services to a patient as listed on VISTA's internet website www.vistahealthplan.com.

Part Time Student: a Member who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Part Time Student status. A student is considered part time during normally scheduled school vacations if he/she is registered to return to that or a similar institution at the end of the vacation. A Member is considered enrolled during summer or holiday vacations when school is not in session.

Participating Provider: any physician or Healthcare Professional, organization, supplier of healthcare items, or a healthcare facility having a written contract at the time services were provided with VISTA to provide medical services to a VISTA Member.

Physician: an individual who is (a) licensed to practice medicine and/or surgery; or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose services are required to be covered under this Contract by the laws of the jurisdiction where treatment is given; or is a partnership or professional association or corporation of such individuals in (a) or (b) above.

Pre-Admission Tests: laboratory tests or x-ray examinations done on an outpatient basis in a Hospital or other facility no more than seven (7) days before a Member is scheduled to be admitted to the Hospital or receives outpatient surgery.

Pre-existing Condition: any condition related to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be treated as a condition in the absence of a diagnosis of the condition related to such information.

Primary Care Physician (PCP): the physician (licensed under Chapter 458, 459, 460 and 461 of the Florida Statutes) who has a written contract with VISTA to be primarily responsible for the overall medical care of a Member.

Prior Authorization: an advance approval that a Member must receive from VISTA, before the Member receives certain Covered Services under this Group Agreement. Prior Authorization does not guarantee payment or coverage if the member is not eligible for services under the Agreement at the time the service is provided.

Prosthetic Appliances: appliances must: (i) replace all or part of a missing body organ and its adjoining tissue or all or part of the function of a permanently useless or malfunctioning body organ; and (ii) be an implantable prosthetic appliance or equivalent external device.

Psychiatric Treatment Program: services offered by programs licensed for the treatment of Mental and Nervous Disorders, or Substance Abuse Rehabilitation.

Rehabilitative Outpatient Therapy long-term (except as limited or excluded under this Contract): treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy, respiratory therapy and occupational therapy that would take longer than sixty (60) days.

Rehabilitative Outpatient Therapy short-term (except as limited or excluded under this Contract): treatment modalities that are part of a rehabilitation program which will not exceed sixty (60) days from date therapy begins and includes physical therapy, speech therapy, respiratory therapy and occupational therapy.

Room and Board: services provided by a Hospital that include room, meals and all general services and activities needed for the care of regular bed patients.

Service Area: the geographic area within the State of Florida where VISTA has Participating Providers under contract. The counties in North Florida are: Alachua, Bradford, Calhoun, Columbia, Dixie, Escambia, Franklin, Gadsden, Gilchrist, Hamilton, Jefferson, Lafayette, Leon, Levy, Liberty, Madison, Marion, Santa Rosa, Suwannee, Union and Wakulla. The counties in South Florida are: Miami-Dade, Broward, and Palm Beach.

Sickness: a physical illness or disease, including a pregnancy and any resulting complications of such pregnancy. The term "sickness" does not include mental illness or substance abuse.

Special Enrollment Period: an enrollment period that is provided for employees and/or their dependents due to special circumstances as described in the Special Enrollment provision.

Specialist: any Healthcare Professional duly licensed to practice medicine or osteopathy in the State of Florida.

Subscriber: the Eligible Employee of the Employer whose Enrollment Applications have been accepted by VISTA in accordance with the enrollment requirements of this Group Agreement, and for whom the Premium charges required under this Group Agreement have been received by VISTA.

Sub-Specialty Obstetrics and Gynecology: Obstetrician-Gynecologists who are board certified in this specialty and who have completed fellowship training in Reproductive Endocrinology & Infertility, Gynecologic Oncology, Maternal Fetal Medicine, or Uro-Gynecology.

Sufficient Evidence: evidence is considered to be sufficient to draw conclusions if it is peer reviewed, is well controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Total Disability (Totally Disabled):

1. for the Subscriber and covered spouse, the person's inability to perform any work or occupation for which the person is reasonably qualified or trained; and

2. for a covered Dependent child, the inability to engage in the normal activities of a person of like age or sex in good health.

Urgent Care Facility: a licensed, non-hospital facility, as listed on VISTA's internet website www.vistahealthplan.com, that has a written contract with Us as an independent contractor to provide services for treatment of conditions which, although not life threatening, could result in serious injury or disability if left untreated.

VISTA: Vista Healthplan™, Inc. a Florida corporation licensed by the State of Florida Department of Financial Services.

Waiting Period: the period, if any that must pass with respect to an individual before the individual is eligible to be covered for benefits under this Group Agreement.

We, Us, Our, Company: Vista Healthplan™, Inc.

Website: www.vistahealthplan.com

Well-Child Care: office visits for Covered Dependent children that include, but are not limited to, routine physical exams, pediatric immunizations, developmental assessments and anticipatory guidance, vision screening, lab procedures, health education and counseling, and hearing testing.

You, Yours: refers to You (Subscriber) and Your eligible enrolled Dependents.

Vista Healthplan™, Inc.
Rider to Certificate of Coverage
Broward County Board of County Commissioners
Domestic Partner

In consideration of the payment of all applicable Premiums, the Vista Healthplan™, Inc. Group Master Contract and Certificate of Coverage are hereby amended, as follows:

A Subscriber may add a Domestic Partner and his/her dependent children, if any, if the Subscriber enrolls in the applicable tier of coverage. A Domestic Partner of the Subscriber is an eligible Dependent if:

1. each party is at least 18 years of age and competent to contract;
2. neither person is married, nor a partner to another domestic partnership relationship;
3. consent of either person to the domestic partner relationship has not been obtained by force, duress or fraud;
4. each person agrees to be jointly responsible for each other's basic food and shelter; and
5. both parties must be domiciled in Broward County OR one of the parties must be employed by the Broward County Board of County Commissioners.

The domestic partner may be the same or opposite sex as the Subscriber.

To add a domestic partner, the Subscriber and domestic partner must register their domestic partnership with the Broward County Records Division and the Subscriber must enroll the domestic partner as his/her dependent within 31 days of such registration. The effective date of coverage is the 1st of the month following the date of submission of the Domestic Partner Registration. A Subscriber may not elect coverage for more than 2 registered domestic partners in each calendar year.

A dependent of the registered domestic partner is also eligible for coverage if:

1. the dependent meets eligibility criteria for dependent children as defined in the Certificate of Coverage;
2. a copy of the child's birth certificate showing the partner is the parent of the child is provided;
3. if the domestic partner is the legal guardian of the child, a copy of the court order is provided;

Coverage for the domestic partner and dependents, if any, terminates 30 days following the date a certificate of termination of domestic partnership is issued by the Broward County Records Office. Upon such termination, the domestic partner and dependents may continue the coverage they were receiving immediately prior to the termination of the domestic partnership for up to 18 months upon timely election and payment of the premium.

All of the other terms, conditions, limitations and exclusions of the Group Master Contract and Certificate of Coverage applies.

This Rider is effective as of the Effective Date of the Certificate to which it is attached.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
Rider to Open Access Contract/Certificate of Coverage
Broward County Board of County Commissioners
CDH - High and Low Options
Mental Health Services

Mental Health Services	Member Responsibility
Inpatient Treatment	Refer to Schedule of Benefits
Outpatient Treatment	Refer to Schedule of Benefits

In consideration of the payment of all applicable Premiums, the Vista Healthplan™, Inc. Open Access Certificate of Coverage is hereby amended and supplemented by the terms and conditions of this Rider.

A. Definitions

All terms used in this Rider shall have the respective meanings specified in the Group Agreement, unless the context otherwise requires.

Further, as used in this Rider:

1. "Mental Health Conditions" shall mean mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.
2. "Partial Hospitalization" shall mean outpatient treatment offered by a program accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or in compliance with equivalent standards.

B. Conditions

1. The benefits and services covered by this Rider are set forth herein which are for the treatment of Mental Health Conditions deemed by the VISTA Participating Providers to be subject to significant clinical improvement through short-term therapy. All services must be provided, prescribed, directed, authorized, or approved by VISTA and/or its Participating Providers, in accordance with the terms and conditions of the Group Agreement.
2. The Premium for this Rider is set forth in the Binder and Agreement comprising part of the Group Agreement. The terms and conditions regarding payment of the Premium for this Rider are as set forth in the Group Agreement.
3. Nothing contained in this Rider shall be held to vary, alter, waive, supplement, or extend any of the terms, conditions, provisions, agreements or limitations of the Group Agreement, other than as specifically set forth below, and the provision of the Covered Services contemplated in this Rider shall be governed by the terms and conditions of the Group Agreement.
4. Coverage under this Rider shall commence and terminate in accordance with the terms of the Group Agreement.

C. Benefits and Limitations

1. Inpatient Benefits: Inpatient benefits will be provided for those Mental Health Conditions which are deemed by the VISTA Participating mental health provider to be responsive to short-term treatment and not to be chronic or organic in nature. All admissions must be approved in advance.
2. Partial Hospitalization Benefits: Partial Hospitalization benefits shall be available in lieu of Hospital confinement on the basis of 2 partial hospital days for each inpatient day, if the Member's Participating mental health provider deems partial hospitalization to be appropriate for the member. In any benefit year, if Partial Hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid shall not exceed the cost of the number of days of inpatient benefits for psychiatric services, including fees.
3. Outpatient Benefit: Outpatient services shall be provided for consultations, treatment, evaluation and/or crisis intervention. Coverage is for mental health conditions as listed in the Diagnostic and Statistical Manual, (DSM), unless specifically excluded. These diagnoses shall be inclusive of all DSM V-code diagnoses. Benefit will provide initial authorization of 10 visits with subsequent visits subject to treatment plan review by a health plan mental health designee. Services must be provided by a VISTA Participating physician, psychologist licensed pursuant to Chapter 490, Florida Statutes, or mental health counselor, clinical social worker or other clinician licensed pursuant to Chapter 491, Florida Statutes.
4. The benefits available to members hereunder shall not include coverage for treatment pursuant to voluntary or involuntary confinement under Florida's Baker Act, Florida Statutes 394.451-394.4789, whether such confinement is considered to be routine or an Emergency, except within the limits of paragraphs C(1) and C(2) above.

D. Exclusions

1. Psychotherapy for organic conditions including mental retardation.
2. Psychoanalysis.
3. Evaluation or treatment for forensic purposes.
4. Short-term evaluation, diagnosis, treatment or crisis intervention.
5. Treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
6. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice.
7. Services utilizing methadone treatment as maintenance, L.A.A.M.(1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
8. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized.
9. Residential treatment services.

This Rider will be effective as of the Effective Date of the Certificate to which it is attached.

Vista Healthplan™, Inc.

[signature
Name
Title]

Vista HealthplanTM, Inc.

Rider to Open Access Contract/Certificate of Coverage Broward County Board of County Commissioners CDH - High Option

In consideration of the payment of all applicable Premiums, the Vista Healthplan, Inc. (hereinafter referred to as "VISTA") Group Master Contract and Certificate of Coverage is hereby amended and supplemented by the terms and conditions of this Rider.

A. New Definitions

The following definitions are added:

1. **"Annual Deductible"**: the amount you must pay each Calendar Year before VISTA will make payment toward specified Covered Services.
2. **"Coinsurance"**: the sharing of health care expenses for specified Covered Services between you and VISTA. The Coinsurance is expressed as a percentage rather than as a dollar amount.
3. **"Coinsurance Maximum"**: the amount of Coinsurance you will pay each Calendar Year before VISTA pays the Allowed Amount at 100% for Covered Services. Expenses used to satisfy the coinsurance percentage apply toward satisfying the Coinsurance Maximum.
4. **"Enteral Formulas"**: low protein food products for home use which are physician prescribed as appropriate for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.
5. **"Lifetime Maximum Benefit"**: the lifetime maximum amount payable by VISTA per Member for Covered Services during the entire time a Member is enrollee in VISTA, including benefits provided under additional coverage Riders.

B. New Benefit Provisions

The following provisions are added to the Benefit Section:

1. **Annual Deductible**: before VISTA will begin paying health care expenses for specified Covered Services, you must satisfy the Annual Deductible of \$1,100 per Individual and \$2,200 per Family. The following Covered Services are not subject to the Annual Deductible:
 - a. Outpatient Physician Services;
 - b. Outpatient Speech, Physical, Occupational, Respiratory and Cardiac Therapy Services;
 - c. Outpatient Diagnostic Services excluding Therapeutic services: CAT Scans, PET Scans, MRI and Nuclear Medicine when rendered in a Freestanding Facility
 - d. Human Organ Transplants;
 - e. Emergency, Urgent Care and Ambulance Services;
 - f. Inpatient/Outpatient Mental Health and Substance Abuse Services;
 - g. Family Planning Services: Voluntary Counseling, Abortions and Elective Sterilizations at a physician's office or freestanding facility;
 - h. Durable Medical Equipment; and
 - i. Insulin/diabetic supplies.

Deductible amounts satisfied under previous plans, will not count towards the satisfaction of your annual deductible.

2. **Coinsurance:** once the Annual Deductible is met for specified Covered Services, you are responsible for paying 20% Coinsurance.
3. **Coinsurance Maximum:** the maximum amount of Coinsurance you will pay each Calendar Year before VISTA pays the Allowed Amount at 100% for Covered Services is \$1,500 per Individual and \$3,000 per Family.

Expenses that will not apply towards the Coinsurance Maximum:

- a. Copayments;
 - b. Services that are not considered covered under this Group Policy or are specifically excluded;
 - c. Expenses used to satisfy the Annual Deductible;
 - d. Charges that are not considered a covered expense;
 - e. Charges in excess of the Allowed Amount;
 - f. Expenses for services that exceed treatment limitations explained in the Certificate of Coverage; and
 - g. Amounts due to failure to obtain Prior Authorization for a specified service or supply.
4. **Enteral Formulas:** Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein for members through the age of 24. Coverage of low protein food products is limited to \$2,500 per calendar year.
 5. **Lifetime Maximum Benefit:** the lifetime maximum benefit is \$2 million.

All the terms, conditions, limitations and exclusions of the Contract/Certificate of Coverage apply to the benefits provided by this Rider.

This Rider will be effective as of the Effective Date of the Contract/Certificate of Coverage to which it is attached.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.

**Rider to Open Access Contract/Certificate of Coverage
Broward County Board of County Commissioners
CDH - High and Low Options
Alcohol and Substance Abuse Services**

Alcohol and Substance Abuse Services	Member Pays
Inpatient Detoxification and Rehabilitation Treatment	Refer to Schedule of Benefits
Outpatient Rehabilitation Treatment	Refer to Schedule of Benefits

In consideration of the payment of all applicable Premiums, the Vista Healthplan™, Inc. Open Access Certificate of Coverage is hereby amended and supplemented by the terms and conditions of this Rider.

A. Definitions

All terms used in this Rider shall have the respective meanings specified in the Group Agreement, unless the context otherwise requires.

Further, as used in this Rider, the term "Substance Abuse Impaired" shall have the meaning specified in Florida Statutes 397.311.

B. Conditions

1. The benefits and services covered by this Rider are limited to those set forth herein which are for substance abuse treatment. All services must be provided, prescribed, directed, authorized, or approved by VISTA or its Participating Providers, in accordance with the terms and conditions of the Group Agreement.
2. The Premium for this Rider is set forth in the Binder and Agreement comprising a part of the Group Agreement. The terms and conditions regarding payment of the Premium for this Rider are as set forth in the Group Agreement.
3. Nothing herein contained shall be held to vary, alter, waive, supplement or extend any of the terms, conditions, provisions, agreements or limitations of the Group Agreement to which this Rider is attached, other than as specifically stated below, and the provisions of the Covered Services contemplated by this Rider shall be governed by the terms and conditions of the Group Agreement.
4. Coverage under this Rider shall commence and terminate in accordance with the terms of the Group Agreement.

C. Benefits

1. Inpatient Benefits: Covered Services provided under this Rider consist solely of the diagnosis, medical treatment and services to appropriate alcohol and drug abuse treatment and rehabilitation programs for the abuse or addiction to alcohol and/or drugs for the care and treatment of substance abuse impaired persons. The hospital treatment facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a similar organization and all admissions must be authorized by the VISTA participating provider.
2. Outpatient Benefits: Treatment must be provided by, or under the supervision of, a VISTA Participating provider who is a licensed physician, licensed psychologist or other provider duly licensed to provide substance abuse treatment. The treatment program must be approved by the State of Florida, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a similar organization.

D. Limitations

1. The benefits described in Subsection C(1) of this Rider will only be deemed Covered Services to the extent that treatment is approved by the VISTA Participating Physician, and provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if such services are provided in a program accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or in compliance with equivalent standards.
2. Members shall be financially responsible for charges not paid by VISTA hereunder. Such obligations incurred on the part of the Member shall be paid directly to the Participating Provider.

E. Exclusions

1. Outpatient Detoxification under the program.
2. Evaluation or treatment for forensic purposes.
3. Short-term evaluation, diagnosis, treatment or crisis intervention.
4. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized.
6. Residential treatment services.

This Rider will be effective as of the Effective Date of the Certificate to which it is attached.

Vista Healthplan™, Inc.

[signature
Name
Title]

Vista Healthplan™, Inc.
Rider to Certificate of Coverage
HMO Large Group
Vision

➤ Eye Examinations	Copayment
Basic examination once per calendar year by a participating optometrist for:	
Eyeglasses .....	..... \$0
Contact Lenses (includes fitting for regular daily wear, extended wear and disposable lenses, 3 months of follow-up care and starter kit)	..... \$69
➤ Prescription Eyeglasses	Copayment
One pair each calendar year from the VISTA Standard Collection at a participating provider:	
Frame and Plastic Single Vision Lenses .....	..... \$29
Frame and Plastic Bifocal Lenses (FT 25 - 35 or Executive Lenses) .....	..... \$49
Frame and Plastic Trifocal Lenses (FT 25 - 35 or Executive Lenses) .....	..... \$59
The following lens options are available:	
Progressive No Line Bifocals and Trifocals .....	..... \$95
Lenticular .....	..... \$95
High Index Plastic .....	..... \$50
Polycarbonate .....	..... \$30
Glass .....	..... \$10
Photo Chromatic .....	..... \$20
Tints .....	..... \$10
UV Coating .....	..... \$12
Scratch Coating .....	..... \$15
Transitions .....	..... \$70
Polarized .....	..... \$45
Anti-Reflective Coating .....	..... \$36
➤ Contact Lenses	Copayment
Daily Wear .....	..... \$35 per pair
Daily Wear Replacement Lenses .....	..... \$20 per lens
Extended Wear .....	..... \$39 per pair
Extended Wear Replacement Lenses .....	..... \$25 per lens
Disposable Lenses (6 packages – 1- week or 2-week wear) .....	...\$19 per package
Frequent Replacement Lenses (6 packages – 1- week or 2-week wear) .....	...\$29 per package
Daily Disposable Lenses (30 packages – 1-day wear)	\$23.50 per package

Items not listed above may be available from the participating provider at other copayments or discounts. Copayments above may not apply to non-standard or special orders.

All the terms, conditions, limitations and exclusions of your Certificate of Coverage apply to the benefits provided by this Rider.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
SCHEDULE OF BENEFITS – 2010
BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
Open Access CDH High Option - \$1,100 Deductible

Referrals are not required for Covered Services*

This Schedule of Benefits is not a complete summary or explanation of the Covered Services. Please review the Certificate of Coverage for an exact description of the Covered Services, limitations and exclusions and other terms and conditions of coverage.

Annual Deductible (per calendar year)

Individual	\$1,100
Family	\$2,200

Coinsurance Maximum (per calendar year)

Individual	\$1,500
Family	\$3,000

Lifetime Maximum Benefit	\$2 million
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BENEFITS

MEMBER RESPONSIBILITY

Outpatient Physician Services

Primary Care Physician (PCP) Office Visits	\$20 copay
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Specialist Physician Office Visits	\$35 copay
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Office visit includes routine lab tests, diagnostic procedures and radiology, hearing and vision screening and outpatient surgery in the physician's office.

Wellness Care (Wellness/Preventive care includes physical exams, eye exams, health education and counseling, immunizations; well-woman care, including Pap smears.)	No copay
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Well-child care to age 16 including immunizations	No copay
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Annual well-woman care, including Pap smears	No copay
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Allergy injections at a PCP or Specialist's office Limitation: copay applies for injections received in physician's office when no other health service is received.	\$20 copay
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Routine Mammography (based on established guidelines)	No copay
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Maternity Prenatal/ Postnatal Care	
• in a Physician's office	One-time \$25 copay
• in a Sub-Specialty office	\$25 copay

Non-Surgical Spine and Back Services Limitation: 1 visit & treatment per day; 24 visits per calendar year	\$25 copay
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Second Medical & Surgical Opinion	
• by Participating Physician	\$25 copay
• by Non-Participating Physician	40% of Allowed Amount

Inpatient Hospital/Physician Services

Inpatient Hospital Facility Services (Facility Services include semi-private room & board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms and prescription medications dispensed while confined.)	20% after annual deductible
Inpatient Rehabilitative Services	20% after annual deductible
In-Hospital Maternity Care	20% after annual deductible
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	20% after annual deductible
Inpatient Physician Services (Physician Services include surgeon and assistant surgeon, anesthesiologist, specialists' consultations and other physician visits while confined.)	20% after annual deductible
Human Organ Transplants	\$5,000 copay per Inpatient stay, NO deductible

Outpatient Services

Outpatient Surgery	
• at a Hospital	20% after annual deductible
• at an Ambulatory Surgical Center	\$25 copay
• in a Physician's office	No copay, included in office visit copay
Outpatient Physical, Speech, Occupational Therapy Limitation: 60 visits per calendar year, combined for all therapies	\$15 copay
Outpatient Respiratory Therapy Limitation: 20 visits per calendar year	\$25 copay
Outpatient Cardiac Therapy Limitation: 36 visits per calendar year	\$25 copay
Outpatient Radiation and Chemotherapy	
• at a Hospital	20% after annual deductible
• at a Freestanding Facility	No copay
Outpatient Diagnostic Services including tests, chest X-rays, EKG's, blood tests, urinalysis, radiology and X-rays	
• at a Hospital	\$25 copay
• at a Freestanding Facility	No copay
• in a Physician's office	No copay, included in office visit copay
• at a separate lab	No copay
Outpatient Diagnostic/Therapeutic Services including CAT Scan, PET Scan, MRI and Nuclear Medicine	
• at a Hospital	20% after annual deductible
• at a Freestanding Facility	No copay
Outpatient Endoscopic Procedures (Colonoscopy, Endoscopy, Sigmoidoscopy)	
• at a Hospital	20% after annual deductible
• at an Ambulatory Surgical Center	\$25 copay
• at an Outpatient Diagnostic Center	\$25 copay
• in a Physician's office	No copay, included in office visit copay
Outpatient Dialysis	20% after annual deductible

Skilled Nursing, Home Health and Hospice Care Services

Skilled Nursing Facility Care / Rehabilitation Center Limitation: 60 days per calendar year	20% after annual deductible
Home Health Care Limitation: 60 visits per calendar year	\$25 copay
Hospice Care Limitation: 180 days per lifetime	20% after annual deductible

Emergency and Urgent Care Services

Emergency Care at Hospital Emergency Room	\$150 copay (waived if admitted)
Emergency Care at Urgent Care Facility	\$35 copay
Emergency Care at Physician's Office	See office visit copay
Ambulance service to hospital (emergency only)	\$150 copay per transport

Mental Health, Alcohol & Substance Abuse Services

Mental Health Care

Inpatient Treatment	No copay
Outpatient Treatment	No copay

Alcohol and Substance Abuse Care

Inpatient Detoxification & Rehabilitation	No copay
Outpatient Rehabilitation Treatment	No copay

Family Planning Services

Voluntary Counseling	\$35 copay
Infertility Services	Not covered
Abortion - Medically Necessary <ul style="list-style-type: none"> • in a Physician's office or Freestanding Facility • at a Hospital 	\$25 copay 20% after annual deductible
Abortion - Elective <ul style="list-style-type: none"> • in a Physician's office or Freestanding Facility • at a Hospital 	\$35 copay 20% after annual deductible
Elective Sterilization <ul style="list-style-type: none"> • in a Physician's office or Freestanding Facility • at a Hospital 	\$35 copay 20% after annual deductible
Intrauterine Devices (IUD) (device, insertion, removal)	\$35 copay



Vista Healthplan™, Inc.
Summary of Benefits - 2010
Broward County Board of County Commissioners
Open Access CDH High Option
\$1,100 Deductible

Referrals are not required for Covered Services

Annual Deductibles (Individual / Family)	\$1,100 / \$2,200
Coinsurance Maximums	\$1,500 / \$3,000
Lifetime Maximum Benefit	\$2,000,000
Major Provisions	Member Responsibility
Primary Care Physician (PCP) office visits	\$20 copay
Preventive care, including physical exams, eye exams, health education and counseling and immunizations	No copay
Well-child care to age 16 including immunizations	No copay
Annual well-woman care, including pap smears	No copay
Routine mammography (based on established guidelines)	No copay
Specialist office visits	\$35 copay
Hospital admission	20% after annual deductible
Emergency room (waived if admitted)	\$150 copay
Inpatient Hospital/Physician Services	Member Responsibility
Inpatient hospital facility services (includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, rehabilitation service, surgeon services, anesthesiologist services, specialist consultation, physician visits, maternity care, neonatal intensive care unit)	20% after annual deductible
Human Organ Transplants	\$5,000 copay per inpatient stay NO deductible
Outpatient Medical Services	Member Responsibility
Allergy injections (Benefits are available for injections received in a Physician's office when no other health service is received)	\$20 copay
Diagnostic procedures, tests, chest x-rays, blood tests, urinalysis, EKG's in physician's office	No copay; included in OV copay
Outpatient diagnostic services, lab, radiology and x-ray	
<ul style="list-style-type: none"> • at a Hospital • at a Freestanding Facility 	<p>\$25 copay</p> <p>No copay</p>
Outpatient diagnostic/Therapeutic Services, CT Scans, PET Scans, MRI and Nuclear Medicine	
<ul style="list-style-type: none"> • at a Hospital • at a Freestanding Facility 	<p>20% after annual deductible</p> <p>No copay</p>
Outpatient surgery (including physician and facility services)	
<ul style="list-style-type: none"> • at a Hospital • at an Ambulatory Surgical Center 	<p>20% after annual deductible</p> <p>\$25 copay</p>
Maternity Prenatal/Postnatal Care	
<ul style="list-style-type: none"> • in a Physician's office • in a Sub-Specialty office 	<p>One time \$25 copay</p> <p>\$25 copay</p>
Radiation and chemotherapy	
<ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	<p>20% after annual deductible</p> <p>No copay</p>
Non-Surgical Spine and Back Services Limitation: 1 visit and treatment per day; 24 visits per calendar year	\$25 copay
Second medical and surgical opinion	
<ul style="list-style-type: none"> • Participating Provider • Non-Participating Provider 	<p>\$25 copay</p> <p>40% of Allowed Amount</p>

Mental Health, Alcohol & Substance Abuse Services	Member Responsibility
Mental health care	
• Inpatient	No copay
• Outpatient	No copay
Alcohol and substance abuse care	
• Inpatient detoxification and rehabilitation	No copay
• Outpatient rehabilitation treatment	No copay
Special Kinds of Care	Member Responsibility
Emergency and urgent care	
• in hospital emergency room (waived if admitted)	\$150 copay
• in urgent care facility	\$35 copay
• in physician's office	See office visit copay
• Ambulance service to hospital Emergency Only	\$150 per transport
Home health care Limitation: 60 visits per calendar year	\$25 copay
Hospice care Limitation: 180 days maximum lifetime benefit	20% after annual deductible
Skilled nursing facility care/Rehabilitation Center Limitation: 60 days per calendar year	20% after annual deductible
Dialysis treatment	20% after annual deductible
Insulin/Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	\$50 copay per month, Combined copay
Outpatient physical, speech, and occupational therapy Limitation: 60 visits per calendar year, combined for all therapies	\$15 copay
Outpatient cardiac therapy	\$25 copay
Outpatient respiratory therapy	\$25 copay
Durable medical equipment: other external orthotics and prosthetics Limitation: \$2,500 per calendar year	No copay
Enteral Formulas up to age 24 Limitation: \$2,500 per calendar year	20% after annual deductible
Hearing Aids	Not covered
Family Planning	
• Voluntary Counseling	\$35 copay
• Intrauterine Device (IUD) (device, insertion, removal)	\$35 copay
• Infertility Services	Not covered
Elective Sterilization	
• Office visit or Freestanding Facility	\$35 copay
• Outpatient hospital	20% after annual deductible
Abortions, Medically Necessary	
• Office visit or Freestanding Facility	\$25 copay
• Outpatient hospital	20% after annual deductible
Abortions, Elective	
• Office visit or Freestanding Facility	\$35 copay
• Outpatient hospital	20% after annual deductible
Dental care	
• Preventive dental care	Cleaning, fluoride treatment & bitewing x-rays every 6 months, \$5 per service, maximum \$10 copay per visit
• General dental care	Discounted fee schedule of 25%
Vision care - at a participating Optometrist	
• Basic eye exam	No copay
• Eyeglasses (1 pair/year, single vision, bifocal, VISTA Standard Collection)	\$29/\$49
• Basic examination for Contact Lenses	\$69
• Daily Wear Contact Lenses	\$35 per pair
• Replacement Lenses	\$20 per lens
• Extended wear Contact Lenses	\$39 per pair
• Replacement lenses	\$25 per lens
• All other services available from participating provider	25% discount

Deductible and copayments do not apply toward the Coinsurance Maximum. Coinsurance amounts only apply toward the Coinsurance Maximum. PCP referrals are not required to obtain Covered Services; however **certain Covered Services require Prior Authorization**. Please refer to the Certificate of Coverage for further detail on Prior Authorization requirements. Services must be rendered within the VISTA network. VISTA participating physicians and providers have contracted with VISTA to provide care to our members. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.

This plan has exclusions, limitations and terms which may be continued in force or discontinued.

Vista Healthplan™, Inc. **Amendment to Certificate of Coverage** **Autism Spectrum Disorder**

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

Effective date: April 1, 2009

The Certificate of Coverage is revised as follows:

The Certificate of Coverage has been revised to include Autism Spectrum Disorder and other Developmental Disability Therapies.

Eligibility

In order to be eligible to receive benefits, a Member is under eighteen (18) years of age or a Member is eighteen (18) years of age or older and in high school who has been diagnosed as having a developmental disability at eight (8) years of age or younger.

Definitions

Applied Behavior Analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

1. Autistic disorder.
2. Asperger's syndrome.
3. Pervasive developmental disorder not otherwise specified.

Covered Services

Autism Spectrum Disorder

Benefits are provided for the recognized services listed below when prescribed by the Member's treating physician in accordance with a treatment plan:

1. Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.
2. Speech therapy: treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly or Autism Spectrum Disorder.
3. Occupational therapy.
4. Physical therapy.
5. Applied Behavior Analysis shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

A treatment plan shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

Coverage may not be denied on the basis that provided services are habilitative in nature.

Exclusions and Limitations

Coverage is subject to a maximum benefit of \$36,000 per calendar year not to exceed \$200,000 in total individual lifetime benefits.

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Bone Marrow Transplant

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Coverage is revised as follows:

The Transplantation benefit in the Covered Services section has been revised with the following language.

Covered Services Section

Transplantation

Bone Marrow Transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental in accordance with applicable Florida law. As used in this section, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, 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 chemotherapy.

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Dependent to Age 30

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Coverage is revised as follows:

Dependent Eligibility

To be eligible to enroll a Dependent, the Subscriber's Dependent must meet all the requirements as the Eligible Dependent as set forth below and be the Subscriber's s:

1. lawful spouse; or
2. a dependent child until the end of the Calendar Year in which the child turns twenty-five (25) years of age, if the child meets all of the following requirements:
 - a. the child is dependent on the Subscriber for support; and
 - b. the child is living in the Subscriber's household, or a Full Time or Part Time Student.
3. a dependent child until the end of the Calendar Year in which the child turns thirty (30) years of age, if the child meets all of the following requirements:
 - a. is unmarried and does not have a dependent of his or her own; and
 - b. is a resident of Florida or a Full Time or Part Time Student; and
 - c. is not provided coverage as a named subscriber, insured, enrollee, or a covered person under any other group or individual health benefit plan or is not entitled to benefits under Title XVIII of the Social Security Act.

If a Dependent child is provided coverage under the Subscriber's Certificate of Coverage after the child reaches age twenty-five (25) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Subscriber's Certificate of Coverage unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

The term child includes the Subscriber's natural born child, stepchild, or a foster or legally adopted child of the Subscriber upon placement in the residence, or at the birth of a newborn adopted child, where a written agreement to adopt such child had been entered into prior to the birth of the child, whether or not that agreement is enforceable. If the foster or adopted child is ultimately not placed in the residence of the Subscriber, no benefit will apply.

The term also includes any child for whom the Subscriber is the legal guardian or a child who is dependent on the Subscriber for health care coverage pursuant to a valid court order. VISTA has the right to request proof of any child's dependency status at any time.

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
Amendment to
HMO Open Access Certificate of Coverage
Broward County Board of County Commissioners

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

EFFECTIVE DATE: January 1, 2010

The HMO Open Access Certificate of Coverage is revised as follows:

INTRODUCTION

First paragraph is amended as follows:

This Certificate of Coverage provides Members with coverage for Medically Necessary Covered Services through a Health Maintenance Organization (“HMO”) provided by Vista Healthplan, Inc. (hereinafter referred to as “VISTA”). Coverage will only be provided for care that is rendered by Participating Providers for the Open Access Plan, except in the case of Emergency Medical Conditions or when, in Our sole judgment, the care required is not available from a Participating Provider.

Third paragraph is amended as follows:

To be seen by a Specialist, a Member will not be required to obtain a referral from his/her Primary Care Physician.

SECTION 1 ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

A. Eligibility

1. Subscriber
 - a. For a full-time employee: work twenty-five (25) hours or more during a normal work week and receive wages. For a part-time time employee: must work a minimum of twenty (20) hours during a normal work week and receive wages. Business owners must be noted on the Employers federal income tax Schedule C. Officers and/or Board Members of a company are not eligible for coverage unless they meet the same eligibility requirements specified herein for a full-time employee.
2. Eligible Dependents. Subject to the limitations set forth in this Certificate of Coverage, to be eligible to enroll as a Dependent and remain covered as a Dependent, a person must be:
 - a. The lawful spouse of the Subscriber,
 - b. The Subscriber’s Registered Domestic Partner;
 - c. Child(ren) shall include:
 1. an unmarried child of the Subscriber or
 2. Registered Domestic Partner (while the Registered Domestic Partnership is in-force)
 3. natural born child;
 4. stepchild(ren);
 5. legally adopted child(ren) or foster child(ren) upon placement in the Subscriber’s home;
 6. a child whom the Subscriber has legal guardianship;
 7. grandchild(ren); a dependent of a dependent (child born to an enrolled child dependent) may remain on the plan for up to eighteen (18) months from the newborn’s date of birth.

After the eighteen (18) months, the dependent of a dependent must meet criteria of foster child, adoption or legal guardianship by the Subscriber or spouse/domestic partner by a court of law;

- d. If a dependent child is provided coverage under the Subscriber's Certificate of Coverage after the child reaches age twenty-five (25) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Subscriber's Certificate of Coverage unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.
3. A Subscriber's unmarried child up to the age of nineteen (19) thru age twenty-one (21) if enrolled as a part-time or full-time student (earning a minimum of six (6) credit hours) at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school); age twenty-two (22) through the age of thirty (30) a full-time student (earning a minimum of twelve (12) credit hours) enrolled at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school). Subscriber will be required to provide proof of such student status. Coverage under this provision will remain in effect until the end of the calendar year.

A Subscriber's dependents who live or are enrolled as part-time or full-time students at schools outside the Service Area are covered under this Plan for Emergency Medical Conditions only. To receive full coverage under this Plan, the dependent must return to the Plan's Service Area.

4. Handicapped Child(ren); a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap incurred prior to age nineteen (19), or age 19 through age twenty-one (21) if a part-time or full-time student as defined herein, and age twenty-two through age twenty-five (25) if a full-time student. The child must be chiefly dependent on the Subscriber for support and maintenance. If a claim is denied, the Subscriber will be required to provide proof of mental retardation or handicap as well as from time to time upon request. Coverage will not terminate if the child continues to meet the criteria established herein.

B. Enrollment

6. **General Limitation Period.** If an Eligible Employee and his or her Eligible Dependents enroll for coverage under this Group Agreement during his or her Initial Enrollment Period, Annual Open Enrollment Period, or Special Enrollment Period, pre-existing conditions will be covered. If an Eligible Employee and his or her Dependents do not enroll for coverage during the Initial, Annual or Special Open Enrollment Period, they will be considered a Late Enrollee and subject to the delayed coverage rules as specified in the Late Enrollee Provision.
7. **Special Enrollment Period.** An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:
 - a. The Eligible Employee or Eligible Dependent was covered under other health coverage at the time coverage was previously offered to the Employee or Dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. The Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage.
 - (1) For an Eligible Employee, the previous coverage:
 - (a) Must have been under COBRA or State Continuation and the coverage was exhausted; or
 - (b) Was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.

- (2) For an Eligible Dependent, the coverage:
 - (a) Is newly made available to Dependents;
 - (b) Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;
 - (c) Is for a person who becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption.
- (3) New Dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:
 - (a) The date coverage is made available; or
 - (b) The date of marriage, birth, adoption, or placement for adoption.
- (4) In the case of a Dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if VISTA receives enrollment applications in the time frame specified herein. Other Dependent coverage is effective:
 - (a) In the case of marriage, as of the first of the following month, or
 - (b) In the case of a dependent's birth, as of the date of birth; or
 - (c) In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

8. Late Enrollees. (section shall read as follows): Unless otherwise prohibited by law, an Eligible Employee or Eligible Dependent who tries to enroll outside the Initial Enrollment Period or Annual Open Enrollment Period will be considered a Late Enrollee, unless that person is considered a Special Enrollee as described above. A Late Enrollee who wants to enroll for coverage under this Group Agreement must complete an Enrollment Application during the next Annual Open Enrollment Period, or if eligible, a Special Enrollment Period. Late Enrollees should contact his/her Benefits Department to determine when they are next eligible to enroll after his/her Initial Enrollment Period has expired.

9. Coverage for Retirees

- a. A covered Employee who is eligible for retiree health coverage under Group's eligibility rules, who retires prior to age 65 and who is not eligible for Medicare may remain covered under this Plan. His/her dependents will also remain covered under this Plan as long as they remain eligible for Dependent coverage. The retiree may also switch to the Consumer Driven Plan with Out-of-Network benefits offered by VISTA.
- b. A retiree who is eligible for Medicare shall have the same options described in paragraph 1 above. The retiree may also elect to discontinue coverage under this Plan and enroll in VISTA's Medicare HMO program. If the retiree makes such an election, his/her dependents may remain covered under this Plan as long as they remain eligible for Dependent coverage.

10. Dependent Survivor Benefit

When an employee or a retiree covered under this Plan dies, any of his Dependents who are then covered under this Plan, except those who are eligible for Medicare, will remain covered under this Plan without further payment of premiums, until the earliest of the following dates:

- a. The last day of the twelfth month after the employee's or retiree's death;
- b. The date of remarriage of a surviving spouse or new Domestic Partnership, if any;

- c. The date that Dependent qualifies for Medicare;
- d. The date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by the deceased employee or retiree.

Coverage under this provision shall be the same as that in effect at the employee's or retiree's death.

C. Effective Date of Coverage

2. Newly Eligible Employees: coverage will begin as of the first day of the calendar month following the date the employee becomes eligible, if written application is made on or before that date.
4. Late Enrollee. Coverage will begin as of the first day of the calendar month following the date application is received during an Annual Open Enrollment Period or Special Enrollment Period.

E. Member Status Change Form

2. Proof of Dependent Status
 - a. if a student, a letter from Registrar's Office certifying current hours enrolled; or
 - b. if disabled, a Healthcare Professional's certification stating date and degree of disability.

SECTION 3 COVERAGE PROVISIONS

C. Benefits and Services Excluded from Coverage

1. Members shall not be entitled to the benefits and services set forth in the Exclusions and Limitations Section, nor are Members entitled to benefits and services set forth in this Group Agreement:
 - a. If rendered by a Participating Physician without Prior Authorization for certain Covered Services; or
 - b. If rendered by a Non-Participating Provider without Prior Authorization in writing from VISTA with the exception of services rendered for Emergency Medical Conditions.
2. Copayment Responsibilities

Members may be required to pay Copayment amounts in connection with services and benefits covered under this Agreement. Such Copayments are set forth in the Schedule of Benefits. Copayments must be paid at the time of service unless alternate arrangements are made.

G. Prior Authorization (this section has been amended as follows)

In order to be eligible to receive benefits available under this Group Agreement, VISTA requires Prior Authorization by the Medical Management Department for certain services. If You fail to obtain Prior Authorization when it is required, benefits that may have otherwise been covered will be denied. The following treatment or services are examples, but not an inclusive list of treatments and services that must be authorized by Us as explained below:

1. Hospital confinements and Skilled Nursing Facility confinements;
2. Non-emergent transportation; air ambulance;
3. All non-emergency outpatient hospital services, including but not limited to, surgical, laboratory and diagnostic, except mammograms;
4. Non-emergency wound care procedures;
5. Inpatient rehabilitative services;
6. Outpatient rehabilitative services at a hospital;
7. DME (for North Florida only);
8. DME – customized/specialty items
9. Prosthetics, Braces, Hospice;
10. Pain Management;
11. C-PAP machine (see Sleep Studies benefit).

For a current list of all services requiring Prior Authorization, You may call Customer Service at 1-866-VISTA FL (1-866-847-8235), TDD #: 1-888-444-7352.

SECTION 4 COVERED SERVICES

A. Covered Services

1. Hospital Inpatient Services

- a. Semi-private room and board including special diets, as prescribed and Medically Necessary, use of operating room, anesthesia, intensive care or other special care units, oxygen, and general or private duty nursing when prescribed. If a Member signs a waiver assuming private room charges, the Member will be responsible for the cost. Private hospital room covered if Medically Necessary.

2. Outpatient Services

- d. Immunizations for pneumococcal and flu vaccinations, and immunizations and inoculations which are Medically Necessary in accordance with accepted medical practice and standards from time to time established by VISTA.
- h. Non-Surgical Spine and Back Disorder Treatment: Manual manipulation of the spine to correct subluxation and physiological therapeutic services deemed Medically Necessary.
- i. Rehabilitative Services: (this replaces the language in the COC) Medically Necessary services when ordered by a treating physician and approved by VISTA are limited to the therapy categories listed below. Therapy for a condition if in the determination of VISTA such therapy is expected to result in improvement in the Member's Condition. Therapy which is given to maintain a level of functioning, and which is not expected to result in improvement in the Member's Condition, shall be covered if authorized by VISTA on the basis that such treatment is necessary to prevent deterioration of the Member's Condition.
 1. Occupational Therapy – Services provided by a Healthcare Professional or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Covered Condition are covered.
 2. Speech Therapy – Services of a Healthcare Professional, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Covered Condition are covered.
 3. Physical Therapy – Services provided by a Healthcare Professional or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.
 4. Respiratory Therapy – Services provided for the purpose of aiding in the restoration of normal physical function of the lungs, due to injury, stroke or a surgical procedure while this coverage was in force.

Rehabilitative Therapy services are unlimited for modalities per day. They include:

1. Services of a licensed speech-language pathologist to aid in the restoration of speech loss or swallowing disorders or an impairment resulting from injury, stroke or a surgical procedure while this coverage was in force.
 2. Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to injury, stroke or a surgical procedure while this coverage was in force.
- j. Outpatient cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction, in accordance with a treatment plan written by the Member's Healthcare Provider and approved by VISTA.

- k. PCP office visits and Specialist office visits include services for cessation of smoking, nutritional and periodic health evaluations for preventive diagnostic and therapeutic care including dietary and stress reduction counseling.

3. Additional Services

Artificial Devices

Benefits are available for artificial heart devices.

Dental Services

Benefits are available for the treatment of an Accidental Dental injury to sound natural teeth if the services are rendered, and the treatment is received within:

- a. twelve (12) months from the date of injury
- b. the Member is continuously covered under this Certificate of Coverage from the date of injury to the date the care and treatment is received.

Family Planning:

Benefits are available for the following and may be, subject to Prior Authorization by VISTA:

- a. counseling;
- b. Voluntary sterilizations, tubal ligations and vasectomies.
- c. Services and care related to the termination of pregnancy.
- d. Intrauterine Devices (IUD), insertion and removal. (See Schedule of Benefits for Member Responsibility).
- e. Measurement and fitting for contraceptive diaphragms.

Home Health Care Services

Covered Home Health Care Services include:

- a. Part-time or intermittent nursing care by a registered nurse or licensed practical nurse is unlimited for hours in duration.

Newborns

Unlimited transportation costs.

Sleep Studies

Benefits are available for:

- a. sleep study for diagnostic purposes;
- b. treatment for obstructive sleep apnea (OSA) which includes continuous positive airway pressure (CPAP) machine if confirmed by a sleep study;
- c. treatment for insomnia and/or narcolepsy.

Transplantation

Coverage includes Medically Necessary services related to organ donation and harvesting if the Member is the recipient of the transplant and the donor has no other coverage for such procedures; however, the cost of purchasing an organ or tissue, and incidental services which are not Medically Necessary to the donation, harvesting or procurement, such as travel and lodging expenses of the Member and donor, are not covered. Donor patient costs will be covered to the same extent as costs associated with the Member for bone marrow transplants only, and limitations associated with such transplants that are determined to be scientifically acceptable and non-experimental for certain types of cancer. Testing to find a suitable donor is limited to the reasonable cost of searching for the donor from immediate family members and the National Bone Marrow Program.

B. Emergency Services and Care

Emergency Services and Care for Emergency Medical Conditions are covered. Following discharge from the Emergency Room, any after care or follow-up care, must be provided by the PCP or a Physician referred by the PCP or VISTA.

SECTION 5 EXCLUSIONS and LIMITATIONS

Cosmetic Surgery (language should read)

2. Any professional services and/or hospitalization in connection with elective Cosmetic Surgery, including but not limited to, body piercing and tattooing, tattoo removal, rhinoplasty, liposuction, abdominoplasty, breast reduction mammoplasty unless medically necessary, blepharoplasty, varicose vein injections, removal or injection of skin tags, of cherry angiomas, telangiectasias, spider angiomas.

Infertility Treatment: Benefits are not available unless elected by Rider.

Learning Disorders: Benefits are available through the Testing Learning Disabilities Amendment to the Certificate of Coverage if applicable.

Personal Comfort, Hygiene or Convenience Items: Benefits are not available for services and supplies deemed to be not Medically Necessary by the Member's PCP and not directly related to the care of the Member including, but not limited to personal care kits, guest meals and accommodations, television, telephone charges, photographs, complimentary meals, birth announcements, take-home supplies, and travel expenses (other than ambulance or other transportation services deemed to be Covered Services) unless medically necessary. The following items are excluded: beauty and barber services, radio, massages, allergenic pillows or mattresses or waterbeds, physical fitness equipment.

Sleep Disorders: See Covered Services for Sleep Studies.

Smoking Cessation: Benefits are available for health education services for cessation of smoking.

Transplantation: Artificial heart devices are covered. See Additional Services Section.

SECTION 6 CLAIMS

D. Reimbursement for Participating and Non-Participating Provider Services

VISTA will provide or arrange for services to be received from Participating Providers on a direct service basis. If a Member receives services from a Participating Provider, VISTA will pay the Healthcare Provider directly for all care received. The Member will not have to submit a claim for payment, and will be responsible only for any applicable Copayments, Deductibles and Coinsurance.

In the event the Member has an Emergency Medical Condition that requires services from a Non-Participating Provider while inside or outside the Service Area if a Member receives Covered Services in a foreign country as a result of an Emergency Medical Condition, the bill and supporting medical records must be in English and the amounts charged and paid must be in U.S. currency with the exchange rate attached for validation. It is the Member's responsibility for obtaining the necessary documents and translations.

The notice must be in writing, and any claim will be based on that written notice. The notice must be received by VISTA within twenty (20) days after the date of the injury or the first treatment date for the sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the twenty (20) day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

SECTION 9 TERMINATION OF COVERAGE

E. CONTINUATION OF COVERAGE during an approved leave under the FAMILY AND MEDICAL LEAVE ACT (FMLA)

Insured persons have the option to continue insurance during an approved leave under the Family and Medical Leave Act (FMLA) upon payment of the required contribution.

Continued insurance terminates when a required contribution is not made when due. Medical insurance under the Group Policy will be reinstated, as required under the Act, upon return to

Active Service for an Insured Person whose insurance terminated during an approved leave under FMLA.

SECTION 12 DEFINITIONS

Eligible Employee: an employee of the Group who works for the Group on a full-time basis, with a normal work week of twenty-five (25) hours or more, or a part-time employee who works a minimum of twenty (20) hours during a normal work week and is eligible based on the criteria established by the Group.

Full-Time Student: a Subscriber's unmarried child who is:

1. aged nineteen (19) through age twenty-one (21) earning a minimum of six (6) credit hours at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school), and;
2. aged twenty-two (22) through the age of twenty-five (25) earning a minimum of twelve (12) credit hours enrolled at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school).

Part-Time Student: a Subscriber's unmarried child aged nineteen (19) thru age twenty-one (21) earning a minimum of six (6) credit hours at an accredited recognized institution of higher education (an accredited university, college, secondary school or trade school).

Service Area: the geographic area in which VISTA is authorized to provide health services as approved the Agency for Health Care Administration.

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Qualifying Events

The Agreement between Vista Healthplan, Inc. ("VISTA") and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

Effective date: April 1, 2009

The Certificate of Coverage is revised as follows:

Special Enrollment Period. *An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:*

- a. *The Eligible Employee or Eligible Dependent was covered under other health coverage (as defined by the Federal HIPAA Law) at the time coverage was previously offered to the employee or dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. Except as otherwise set forth herein, the Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage. Enrolling employee/dependent's whose Children's Health Insurance program (CHIP) or Medicaid coverage is terminated, please see below.*
 - (1) *For an Eligible Employee, the previous coverage:*
 - (a) *Must have been under COBRA or State Continuation and the coverage was exhausted; or*
 - (b) *Other group health plan or insurance coverage was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.*
 - (2) *For an Eligible Dependent, the coverage:*
 - (a) *Is newly made available to dependents;*
 - (b) *Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;*
 - (c) *Is for a person who becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption.*
 - (3) *New dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:*
 - (a) *The date coverage is made available; or*
 - (b) *The date of marriage, birth, adoption, or placement for adoption.*
 - (4) *In the case of a dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if VISTA receives enrollment applications in the time frame specified herein. Other dependent coverage is effective:*
 - (a) *In the case of marriage, as of the date of the marriage, or*

- (b) *In the case of a dependent's birth, as of the date of birth; or*
- (c) *In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.*

b. Enrollment Pursuant to Termination of Medicaid or CHIP coverage.

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the dependents of such Eligible Employee, if eligible but not enrolled, may enroll in VISTA if either of the following two conditions are satisfied.

- (1) **Termination of Medicaid or CHIP coverage.** *The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.*
- (2) **Eligibility for Employment Assistance under Medicaid or SCHIP.** *The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).*

Required Length of Special Enrollment Notification. *An Eligible Employee and/or his or her dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.*

Effective Date of Coverage. *Coverage shall become effective on the first (1st) day of the month following the month in which VISTA received the request for Special Enrollment.*

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

The Qualifying Events section is revised as follows:

Types of Qualifying Events

Documentation Required

<i>Marriage</i>	<i>Marriage Certificate</i>
<i>Adoption</i>	<i>Legal Adoption Papers</i>
<i>Birth</i>	<i>Birth Certificate</i>
<i>Change in Legal Guardianship</i>	<i>Court ordered legal papers for Legal Guardianship</i>
<i>Employment Status change of employee or spouse</i>	<i>HIPAA Certificate or employer letter</i>
<i>Medicaid Termination*</i>	<i>Medicaid Termination or Premium Assistance Notification letter</i>

**An eligible, but not enrolled employee or dependent is permitted to enroll for coverage if either of the following conditions are met:*

- 1. *the employee/dependent's Children's Health Insurance Program (CHIP) or Medicaid coverage is terminated due to loss of eligibility and the employee requests coverage with VISTA within sixty (60) days; or*
- 2. *the employee/dependent becomes eligible for premium assistance subsidies and requests coverage with VISTA within sixty (60) days, if applicable.*

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc. Amendment to Certificate of Coverage Self-Inflicted/Suicide Exclusion

The Agreement between Vista Healthplan, Inc. and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Coverage is revised as follows:

Exclusions and Limitations Section

This exclusion has been deleted:
Self-Inflicted/Suicide

VISTA HEALTHPLAN™, INC.



Richard Weiss
Chief Financial Officer

BENEFITS SCHEDULE

Vista Healthplan, Inc.
Commercial Dental Plan

These co-payments are the maximum fees that will be charged by participating GENERAL DENTIST for the specified covered services.

	<i>Member Pays</i>		<i>Member Pays</i>		
DIAGNOSTIC & PREVENTIVE					
0120▲	Periodic oral evaluation.....	5	2954	Prefabricated post and core in addition to crown	130
0140▲	Limited oral evaluation—problem focused	5	2955	Post removal not in conj. with endodontic therapy ..	116
0150▲	Comprehensive oral evaluation	5	2960	Labial veneer (laminate) (chairside).....	219
0160▲	Detailed and extensive oral evaluation— problem focused	5	FIXED CROWN AND BRIDGE		
0210	Intraoral—complete series (1 per 24 months)	53	2510	Inlay—metallic, one surface	315
0220	Intraoral—periapical single film	10	2520	Inlay—metallic, two surfaces	376
0230	Intraoral—periapical each additional film	10	2530	Inlay—metallic, three or more surfaces	414
0240	Intraoral—occlusal film	15	2543	Onlay—metallic, three surfaces	445
0250	Extraoral—first film	20	2544	Onlay—metallic, four or more surfaces	453
0260	Extraoral—each additional film	18	2610	Inlay—porcelain/ceramic, one surface	356
0270▲	Bitewing single film (1 per 6 months)	5	2620	Inlay—porcelain/ceramic, two surfaces	397
0272▲	Bitewings 2 films (1 per 6 months)	5	2630	Inlay—porcelain/ceramic, three or more surfaces ..	440
0274▲	Bitewings 4 films (1 per 6 months)	5	2642	Onlay—porcelain/ceramic, two surfaces	430
0330	Panoramic film (1 per 24 months).....	48	2643	Onlay—porcelain/ceramic, three surfaces	450
0340	Cephalometric film	56	2644	Onlay—porcelain/ceramic, four or more surfaces ...	470
0460	Pulp vitality tests	23	2650	Inlay—composite/resin, one surf. lab processed....	310
0470	Diagnostic casts	40	2651	Inlay—composite/resin, two surf. lab processed	363
0471	Diagnostic photographs	24	2652	Inlay—composite/resin, three surf. lab processed..	400
1110▲	Complete prophylaxis—adult (1 per 6 months)	5	2710	Crown—resin laboratory	285
1120▲	Complete prophylaxis—child (1 per 6 months)	5	2720	Crown—resin with high noble metal	480
1201▲	Fluoride treatment—child (prophylaxis included) (1 per 6 mos)	10	2721	Crown—resin with predominantly base metal	428
1203▲	Fluoride treatment—child (prophylaxis not included) (1 per 6 months)	5	2722	Crown—resin with noble metal	460
1204▲	Fluoride treatment—adult (prophylaxis not included) (1 per 6 months)	5	2740	Crown—porcelain/ceramic substrate	496
1205▲	Fluoride treatment—adult (prophylaxis included) (1 per 6 months)	10	2750	Crown—porcelain fused to high noble metal	478
1330	Oral hygiene instructions	No charge	2751	Crown—porcelain fused to base metal	445
1351	Sealants—per tooth	20	2752	Crown—porcelain fused to noble metal	466
1510	Space maintainer (fixed unilateral).....	134	2790	Crown—full cast high noble metal	475
1515	Space maintainer (fixed bilateral)	175	2791	Crown—full cast base metal	420
1520	Space maintainer (removable unilateral)	163	2792	Crown—full cast noble metal.....	460
1525	Space maintainer (removable bilateral).....	208	2810	Crown—¾ cast metallic	460
1550	Recementation of space maintainer	30	2910	Recement inlay (per unit)	37
▲ The combined charge for these dental procedures shall not exceed \$10 per visit.					
RESTORATIVE (Fillings)					
2140	Amalgam—one surface (primary or permanent)	44	2920	Recement crown (per unit)	39
2150	Amalgam—two surfaces (primary or permanent)	56	2930	Prefabricated stainless steel crown (primary—child) ..	108
2160	Amalgam—three surfaces (primary or permanent)	70	2931	Prefabricated stainless steel crown (permanent).....	125
2161	Amalgam—four+ surfaces (primary or permanent)	86	2932	Prefabricated resin crown	132
2330	Resin—one surface, anterior	55	2933	Prefabricated stain. steel crown w/resin window	152
2331	Resin—two surfaces, anterior	68	6210†	Bridge pontic—cast high noble metal (per unit).....	470
2332	Resin—three surfaces, anterior	85	6211†	Bridge pontic—cast base metal (per unit).....	420
2335	Resin—four or more surfaces or involving incisal angle (tooth reconstruction including incisal edge), anterior .	100	6212†	Bridge pontic—cast noble metal (per unit).....	430
2391	Resin—one surface, posterior	60	6240†	Bridge pontic—porc. to high noble metal (per unit) ..	470
2392	Resin—two surfaces, posterior	82	6241†	Bridge pontic—porcelain to base metal (per unit)	431
2393	Resin—three surfaces, posterior	102	6242†	Bridge pontic—porcelain to noble metal (per unit) ..	445
2394	Resin—four or more surface, posterior	102	6250†	Bridge pontic—resin with high noble metal	460
2940	Sedative filling	40	6251†	Bridge pontic—resin with predom. base metal	431
2950	Core buildup including any pins	105	6252†	Bridge pontic—resin with noble metal.....	454
2951	Pin retention (per tooth, in addition to restoration)	22	6545	Retainer—cast metal for resin bonded fixed pros. ..	265
2952	Cast post and core in addition to crown	165	6720†	Crown—bridge retainer, resin w/high noble metal ..	475
			6721†	Crown—bridge retainer, resin predom. base metal ..	437
			6722†	Crown (resin with noble metal).....	454
			6750†	Bridge abutment—porcelain to high noble metal (per unit)	490
			6751†	Bridge abutment—porcelain to base metal (per unit). 448	
			6752†	Bridge abutment—porcelain to noble metal (per unit)	464
			6780†	Crown—retainer ¾ cast high noble metal	460
			6790†	Bridge abutment—full cast high noble metal (per unit) ...	467
			6791†	Bridge abutment—full cast base metal (per unit)	426
			6792†	Bridge abutment—full cast noble metal (per unit)	460
			6930	Recement fixed partial denture	57

BENEFITS SCHEDULE

Vista Healthplan, Inc.
Commercial Dental Plan

These co-payments are the maximum fees that will be charged by participating GENERAL DENTIST for the specified covered services.

	Member Pays
6970 Cast post and core (in add'n to fixed partial denture retainer) .	161
6971 Cast post as part of fixed partial denture retainer	160
6972 Prefabricated post and core in addition to fixed partial denture retainer	131
6973 Core buildup for retainer including any pins	109
6975 Coping—metal	280
† Per unit, up to six (6) units. Seven (7) or more units, add an additional \$40 per unit. Laboratory processed temporary splint, add an additional \$25 per unit for seven (7) or more units.	

***ENDODONTICS (Root Canal Therapy)**

3110 Pulp cap—direct (excluding final restoration)	28
3120 Pulp cap—indirect (excluding final restoration)	31
3220 Therapeutic pulpotomy (excluding final restoration)	70
3230 Pulpal therapy—resorbable fill, ant. primary tooth	90
3240 Pulpal therapy—resorbable fill, post. primary tooth ...	80
3310 Anterior root canal (excluding final restoration)	270
3320 Bicuspid root canal (excluding final restoration)	335
3330 Molar root canal (excluding final restoration)	428

***PERIODONTICS (Gum Treatment)**

4341 Scaling and root planing (per quadrant) (limit 4 per year) ...	104
4355 Full mouth debridement to enable comprehensive periodontal evaluation & diagnosis	67
4910 Periodontal maintenance (following active therapy)	59
4920 Unscheduled dressing change (not by treating dentist) ..	38
9941 Fabrication of athletic mouthguard	90
9950 Occlusion analysis—mounted case	120
9951 Occlusal adjustment (limited)	67
9952 Occlusal adjustment (complete)	270
9970 Enamel Microabrasion	76

PROSTHETICS (Full & Partial Dentures)

5110 Complete upper denture	600
5120 Complete lower denture	600
5130 Immediate upper denture	650
5140 Immediate lower denture	650
5211 Partial upper—resin base	460
5212 Partial lower—resin base	464
5213 Partial upper—cast metal frmwrk w/resin dent. base ...	680
5214 Partial lower—chrome cast frmwrk w/resin denture base ..	680
5281 Remove unilateral partial dent., 1pc. metal (w/teeth)	360
5410 Adjustments—complete upper	30
5411 Adjustments—complete lower	30
5421 Adjustments—partial upper	30
5422 Adjustments—partial lower	30
5710 Rebase complete upper denture (laboratory)	220
5711 Rebase complete lower denture (laboratory)	220
5720 Rebase partial upper denture (laboratory)	210
5721 Rebase partial lower denture (laboratory)	210
5730 Reline complete upper denture (office)	145
5731 Reline complete lower denture (office)	145
5740 Reline partial upper denture (office)	138
5741 Reline partial lower denture (office)	138
5750 Reline complete upper denture (laboratory)	190
5751 Reline complete lower denture (laboratory)	190
5760 Reline partial upper denture (laboratory)	190
5761 Reline partial lower denture (laboratory)	190
5810 Interim complete upper denture	320

	Member Pays
5820 Interim partial upper denture	280
5821 Interim partial lower denture	280
5850 Tissue conditioning, upper	50
5851 Tissue conditioning, lower	50

REPAIRS TO PROSTHETICS (Full & Partial Dentures)

5510 Repair broken complete denture base	69
5520 Replace missing or broken teeth, comp. dent/ (each tooth) .	50
5610 Repair resin denture base	65
5620 Repair cast framework	117
5630 Repair or replace broken clasp	87
5640 Replace broken teeth—per tooth	55
5650 Add tooth to existing partial denture	75
5660 Add clasp to existing partial denture	100

***ORAL SURGERY**

7111 Extraction, coronal remnants - deciduous tooth	56
7140 Extraction, erupted tooth or exposed root	52
7210 Surgical extraction of erupted tooth	111

***ORTHODONTICS (ADULTS OR CHILDREN)**

8070 Comprehensive orthodontic treatment of the Transitional Dentition	UCR less 20%
8080 Comprehensive orthodontic treatment of the Adolescent Dentition	UCR less 20%
8090 Comprehensive orthodontic treatment of the Adult Dentition	UCR less 20%
8210 Removable appliance therapy	UCR less 20%
8660 Pre-orthodontic treatment visit	UCR less 20%

MISCELLANEOUS

9110 Emergency treatment (palliative treatment for dental pain) -minor procedure ..	40
9210 Local anesthesia, not in conjunction with operative or surgical procedures	20
9211 Regional block anesthesia	22
9215 Local anesthesia	18
9230 Analgesia	22
9310 Consultation—second opinion (arranged by CompBenefits and provided by a Participating Dentist)	47
9430 Office visit for observation (during regularly scheduled hours)—No other services performed ..	29
9440 Office visit—after regularly scheduled hours	55
9910 Application of desensitizing medicament	25

***SPECIALIST CARE:** All dental procedures will be provided to the member in accordance with the Plan Benefits Schedule as long as that procedure is within the scope and competence of general dental practice. For those cases in which the procedure is beyond the scope and competence of the participating general dentist (i.e., certain oral surgery, endodontics, periodontics, pedodontics), the member will be referred to a participating specialist (where participating specialists are available), and receive a 20% discount from the usual, customary and reasonable (UCR) fees of the specialist.

NOTE: Procedures not listed on the Benefits Schedule will be provided at the participating dentist's usual, customary and reasonable (UCR) fees less 20%.

The plan does not cover all procedures which might be provided by general dentist.

*Not all participating dentists perform all listed procedures. Please
2 consult your dentist prior to treatment.*

CERTIFICATE OF COVERAGE

CHOICE OF DENTIST

CompBenefits contracts with established dentists in the community to provide quality care to our members. To receive benefits, you and your dependents must select a dental facility from the CompBenefits list of participating dental offices. Dentists undergo a thorough review process prior to acceptance to our network. Each privately owned office is operated by a licensed general dentist and a staff of professional auxiliaries.

MAKING AN APPOINTMENT WITH YOUR DENTIST

You may schedule an appointment by calling the dental office you selected on or after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the CompBenefits/Vista Healthplan, Inc. dental plan. You will receive a VISTA identification card, but this card is not necessary to receive dental services.

CHANGING YOUR SELECTION OF DENTIST

A situation may occur in which you need to change your dental office selection. Provider transfer requests may be made by calling our Member Support Department. Requests received prior to the 20th of the month will be effective the first of the following month. Transfers can only be processed if you have no balance due or pending appointments at your dental office.

SPECIALIST CARE REFERRALS

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, your general dentist will refer you to a participating specialist (where participating specialists are available). You will be provided a referral form to present to the participating specialist to ensure proper coverage.

WHAT ARE CO-PAYMENT FEES?

Co-payments are reduced fees charged by the participating dental offices for some covered dental procedures as specified in the Benefits Schedule. The reduced fees are 30-50% less than the usual, customary and reasonable fees charged in a dental office. Members are financially responsible for co-payment fees, payable to the dental office.

CANCELLING APPOINTMENTS

The time set aside for a patient is very valuable to the dentist. Therefore, if you cannot keep an appointment, notify the dental office a minimum of 24 hours in advance. If you do not notify the office, charges will be made for broken appointments.

EMERGENCY CARE WITHIN THE SERVICE AREA

In the event of an emergency, contact the participating CompBenefits dental office you selected. If you are unable to reach your dentist, call the CompBenefits 24-Hour Hotline and you will be instructed on how to receive necessary emergency dental care. CompBenefits 24-Hour Emergency Hotline Toll-Free: 800-848-3480

REIMBURSEMENT PROVISION FOR OUT-OF-AREA EMERGENCY CARE

Members and dependents are covered for emergency dental treatment while temporarily more than fifty (50) miles from their participating dental office. In the event of an emergency, obtain treatment to relieve your pain/discomfort only. Pay for the services rendered and submit the receipt to CompBenefits with your name, social security number, address, and phone number. CompBenefits will reimburse no less than 75% of the reasonable charges for covered services and supplies, subject to applicable co-payments, and shall not exceed \$100.00 per claim.

SECOND OPINIONS

CompBenefits can arrange for second opinions to the member. To coordinate second opinions, members should call the CompBenefits Member Support Department. Second opinions not arranged by CompBenefits or rendered by a non-participating dentist will not be covered.

MEMBER SUPPORT

CompBenefits is responsible for all administrative functions of the program. If you have an inquiry or grievance, CompBenefits encourages you to submit it in writing to:

CompBenefits
Grievance & Appeals Dept.
5775 Blue Lagoon Drive #400
Miami, Florida 33126

Or call the Member Support Department, Monday through Friday, 8:00 AM to 6:00 PM at:

Toll-Free: **800-848-3480**

EXCLUSIONS AND LIMITATIONS

The following dental benefits are not covered or offered under the plan:

- Oral surgery requiring the setting of fractures or dislocations.
- Treatment of congenital malformations.
- Treatment of malignancies.
- Dispensing of drugs.
- Any treatment requiring hospitalization.
- Any work which is not able to be performed because of the general health and physical limits of the eligible member, as indicated by said member's personal physician or the CompBenefits dentist.
- Precision attachments or stress breakers.
- Replacement of partial or full dentures within two (2) years after installation unless resulting from the acts or omissions of CompBenefits.
- Any treatment paid by Workers' Compensation or employer's liability laws, by a federal or state government agency, or provided without cost by any municipality, county or other political subdivision.
- Any procedure, implantation and/or any dental procedure considered to be experimental by the providing dentist.
- General anesthesia.
- Surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Replacement of lost or stolen prosthetic devices.
- Any dental care provided by a non-participating general dentist or specialist, except when authorized by CompBenefits.
- Services resulting from any act of war, declared or not, or resulting from military service.
- Charges for broken appointments are not covered.

The following limitations apply:

- The Participating Dentist shall have the right to refuse treatment to a member who fails to follow a prescribed course of treatment.
- Published member co-payments apply only when treatment is performed at a Participating Dental Office.
- If a member obtains dental services from other than a Participating Dentist/Specialist, the member shall be responsible for all costs.

Vista Healthplan™, Inc.
1340 Concord Terrace
Sunrise, Florida 33323

Health Maintenance Organization (HMO)

OPEN ACCESS

**Certificate of Coverage
for
North Florida & South Florida**

This Certificate of Coverage is delivered in the State of Florida.

The Certificate of Coverage is a part of the Group Agreement and is issued in consideration of the application of the Subscriber and payment of the premiums by the Subscriber as provided in the Group Agreement.

The Company agrees to provide the benefits shown in the Covered Services Section to the Subscriber and Eligible Dependents, if any, in accordance with the provisions and conditions of the Group Agreement.

This Certificate of Coverage is subject to all the conditions and provisions set forth on this and the subsequent pages, which are made a part of the Group Agreement.

**For inquiries or information about coverage or assistance in resolving problems call:
Telephone: 1-866-VISTA FL (1-866-847-8235) TDD #: 1-888-444-7352**

IN WITNESS WHEREOF, Vista Healthplan, Inc. has executed this Group Agreement at, Sunrise, Florida.

Primary Care Physician referrals for specialist care are not required.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

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Schedule of Benefits
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INTRODUCTION

This Certificate of Coverage provides Members with coverage for Medically Necessary Covered Services through a Health Maintenance Organization (“HMO”) provided by Vista Healthplan, Inc. (hereinafter referred to as “VISTA”). In an HMO, care must be provided or directed by the Primary Care Physician (“PCP”) and/or approved in advance, by VISTA, or its designee. Also, coverage will only be provided for care that is rendered by Participating Providers for the Open Access Plan, except in the case of Emergency Medical Conditions or when, in Our sole judgment, the care required is not available from a Participating Provider.

Coverage under this Agreement is made as a result of the Subscriber's relationship to a Group, such as an employer or union. Subscribers must meet VISTA's eligibility rules as well as eligibility rules established by the Group. The Group acts on behalf of the Subscriber by remitting premium for this coverage. VISTA will provide the benefits described in this Certificate of Coverage.

Each Member must select a Primary Care Physician (PCP) who will be responsible for providing the Member's primary health care. Should the Member fail to select a PCP, VISTA reserves the right to designate a PCP for the Member to ensure continuity and accessibility of care and the Member shall be so informed. The Member has the right to change his/her PCP by contacting VISTA. Changes will go into effect on the first of each month following such notification. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her Primary Care Physician.

Please note that VISTA is a Health Maintenance Organization that contracts with independently practicing physicians who render medical care and treatment to VISTA members. At all times, these physicians are acting and performing as independent practicing physicians with respect to VISTA, and VISTA does not exercise any control or discretion over the method by which the providers render services to Members. No work, act, commission or omission of any provider, his agents, servants or employees shall be construed to make or render any provider, agent, servant or employee, an agent, servant, representative, or an employee of, or joint venturer with VISTA. Furthermore, the providers render medical care to VISTA Members in accordance with the traditional physician/patient relationship, which in no way is affected or interfered with by VISTA. All judgments and decisions of a medical nature remain within the province of the treating physician and he/she remains solely responsible for all such medical judgments and related treatments.

VISTA shall not be liable for any negligent act or omission committed by any independent practicing physician or hospital, or any of their agents or employees, who may, from time to time, provide medical services to a Member of VISTA. Furthermore, VISTA shall not be vicariously liable for any negligent act or omission of any of these independent Healthcare Professionals who treat a Member of VISTA.

SECTION 1 ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Subject to any Eligibility Exceptions noted in the Binder & Agreement, which is available from the Employer, an employee becomes eligible for coverage on the date he/she completes any waiting period established by the Group, as shown in the Binder & Agreement. The waiting period is the length of time an employee must wait before becoming eligible for coverage.

If an Eligible Employee is covered under any other Large Group Agreement issued to the Group by VISTA, or any other health benefit plan established and maintained by the Group, he/she will not be considered eligible for coverage under this Group Agreement.

All Eligible Employees within a designated "employee class" must be allowed to participate. An Employer has the option to cover part-time employees provided that a minimum employer contribution, as required by VISTA, is made and all part-time employees have the opportunity to participate.

A. Eligibility

1. Subscriber. To be eligible to enroll, You must:
 - a. For a full-time employee: work twenty-five (25) hours or more during a normal work week and receive wages. Business owners must be noted on the Employers federal income tax Schedule C. Officers and/or Board Members of a company are not eligible for coverage unless they meet the same eligibility requirements specified herein for a full-time employee.
 - b. Satisfy any probationary or waiting period requirements established by the Group;
 - c. Be eligible under the eligibility criteria established by the Group and agreed to by VISTA.
2. Dependents. To be eligible to enroll as a Dependent, You must:
 - a. Meet all Dependent eligibility requirements established by the Group, reside with the Subscriber; and
 - b. Be the lawful Spouse of the Subscriber; or
 - c. Be a child, which means the Subscriber's unmarried own child; adopted child or child placed in the Subscriber's home for the purpose of adoption in accordance with chapter 63, Florida Statutes; a stepchild whom the Subscriber claims as an exemption on his or her federal income tax return; a child for whom legal guardianship has been established pursuant to chapter 744, Florida Statutes; or any other unmarried child for whom the Subscriber has been granted temporary or other court-ordered custody. Children are covered:
 - (1) From the date of birth to the end of the month in which the dependent child's 19th birthday occurs; and
 - (2) From the dependent child's 19th birthday to the end of the calendar year in which the dependent child's 25th birthday occurs, if the child is dependent on the Subscriber for support and can be claimed as an exemption on the Subscriber's federal income tax return, and the child is either living in the Subscriber's household or is a full-time or part-time student at a secondary, college, university or trade school which is certified or licensed by a state.
3. A child who has attained the limiting age for a Covered Dependent and continues to be both:
 - a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
 - b. Chiefly dependent on the Subscriber for support and maintenance.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this Group Agreement, the Subscriber has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

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 VISTA terminating such child's coverage for any other reason than the attainment of the limiting age. For newly enrolled handicapped children over the age of nineteen (19), the Subscriber must provide proof of prior coverage and proof of dependency.

4. A newborn child of You or Your Covered Dependent is covered from the moment of birth if VISTA has been notified of the child's birth in writing through the completion and submission of an Enrollment Application, as specified herein:
 - a. If You enroll the child within thirty-one (31) days of birth, a premium will not be charged for the first thirty-one (31) days.
 - b. If You fail to enroll the child within thirty-one (31) days of birth, but enroll the child within sixty (60) days of birth, You will be required to pay the applicable premium for the child from the date of birth.
 - c. If the child is enrolled within sixty (60) days of birth, VISTA will not deny coverage.
 - d. Enrollment of the child more than sixty (60) days after birth but prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and the child will be subject to the delayed coverage rules specified in the Late Enrollee provision.
 - e. A newborn child of a covered dependent child is covered for a period of eighteen (18) months from birth if the newborn child is enrolled within sixty (60) days of birth. Enrollment of the child more than sixty (60) days after birth but prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and the child will be subject to the delayed coverage rules specified in the Late Enrollee provision.
5. All health coverage applicable for children under this Group Agreement will be provided for the adopted child of the Subscriber if the Subscriber has dependent coverage. Coverage is provided to a child the Subscriber proposes to adopt who is placed in the Subscriber's residence in compliance with chapter 63, from the moment of placement. A newborn infant who is adopted by the Subscriber is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in Your residence in compliance with chapter 63. In the event the child(ren) is not placed, the Subscriber will be responsible for repayment of claims paid.

The Subscriber's adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if VISTA is notified of the event in writing through the completion and submission of an Enrollment Application as specified herein:

- a. If the Subscriber enrolls the child within thirty-one (31) days of the moment of birth or placement, a Premium will not be charged for the first thirty-one (31) days.
- b. If the Subscriber fails to enroll the child within thirty-one (31) days of the event, but enrolls the child within sixty (60) days of the event, the Subscriber will be required to pay an additional Premium from the date of birth or placement.
- c. If notice is given within sixty (60) days of the event, VISTA will not deny coverage.

- d. Enrollment of the child more than sixty (60) days after the event or prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and subject to the delayed coverage rules specified in the Late Enrollment provisions.
6. VISTA shall be responsible for requesting, verifying, and maintaining documentation for Eligible Dependents who reach the maximum age requirements to determine school enrollment or handicap status.
7. Military Personnel (per Florida Statute 250.341)

Any health insurance policy, certificate, or evidence of health coverage, which was in effect on April 30, 1991, or which is issued or renewed after such date that provides coverage to a member of the Florida National Guard, or a member of any branch of the United States military reserves who is a resident of this state, called to active military duty, must:

- a. Continue all coverage which were in effect for the person, or the person's dependents covered by the same policy, at the premium in effect for all insured under the same contract, unless the employee requests coverage changes which might alter the premium he or she was paying prior to such activation during the time he or she serves on active duty.
- b. Reinstatement the coverage for any such person who elects not to continue it while on active duty, at the person's request upon return from active duty, without a waiting period or disqualification for any condition, which existed at the time he or she was called to active duty. Such reinstatement must be requested within thirty (30) days after returning to work with the same employer or within sixty (60) days if the policy is an individual policy.
- c. Any coverage available to the insured employee's dependent under the CHAMPUS program will be considered in the payment of any benefits.
- d. The employee must notify his or her employer of his or her reserve or National Guard status and the employee's intent to invoke the provisions of subsections (1) and (2) prior to leaving his or her employer to report for active military duty.
- e. Nothing in this section is intended to require an employee group health insurance policy to provide coverage to a person serving on active military duty.

B. Enrollment

No person meeting eligibility requirements will be refused enrollment or re-enrollment by VISTA because of health conditions, age, need for health services or mental condition or pre-existing physical condition, including pregnancy.

1. **Initial Enrollment Period.** As an employee of the Group, You are entitled to apply for coverage for Yourself and Your Eligible Dependents during the initial Group Open Enrollment Period. Enrollment starts on the employee's initial date of eligibility and ends no less than thirty (30) days later. All persons included for coverage must be listed on the Enrollment Applications provided. No proof of insurability will be required.
2. **Annual Open Enrollment.** An Annual Open Enrollment Period shall be held at least once every twelve (12) months and no less than thirty (30) days prior to the Group's anniversary date during which an eligible Employee and any Eligible Dependents may enroll as a Member if:
 - a. You did not enroll during the Initial Enrollment Period, or
 - b. You maintained coverage under another employer sponsored plan and You change coverage to this Group Agreement.

No proof of insurability will be required.

3. **Newly Eligible Employees.** As a new employee of the Group who becomes eligible for coverage, You may enroll Yourself and Your Eligible Dependents within thirty-one (31) days of becoming eligible.
4. **Newly Eligible Dependents.** You may enroll a person who becomes newly eligible as a Dependent due to marriage, birth, adoption or legal guardianship by completing and submitting to VISTA signed Enrollment Applications along with supporting documentation within thirty-one (31) days of becoming eligible. If You have family coverage the addition of a Dependent will not change Your coverage type, although You must complete required forms within thirty-one (31) days of the event or be subject to the delayed coverage rules specified in the Late Enrollee provision. If You have single or two-person coverage, Your coverage type and associated premium will change. A newborn or adopted child as a Dependent added after the Employee's effective date, must be enrolled within the time frames specified in this Group Agreement. If a newly Eligible Dependent is not enrolled as specified herein, the Dependent will be considered a Late Enrollee and subject to the Late Enrollee provision.
5. **Changes in Eligibility.** It is Your responsibility to notify the Group Employer and VISTA in writing of any changes, which will affect Your eligibility or the eligibility of Your Dependents within thirty-one (31) days of the event.
6. **General Limitation Period.** If an Eligible Employee and his or her Eligible Dependents enroll for coverage under this Group Agreement during his or her Initial Enrollment Period, Annual Open Enrollment Period, or Special Enrollment Period, pre-existing conditions will be covered. If an Eligible Employee and his or her Dependents do not enroll for coverage during the Initial, Annual or Special Open Enrollment Period, they will be considered a Late Enrollee and subject to the delayed coverage rules and coverage for Pre-existing Conditions will be limited as specified in the Late Enrollee Provision.
7. **Special Enrollment Period.** An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:
 - a. The Eligible Employee or Eligible Dependent was covered under other health coverage at the time coverage was previously offered to the Employee or Dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. The Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage.
 - (1) For an Eligible Employee, the previous coverage:
 - (a) Must have been under COBRA or State Continuation and the coverage was exhausted; or
 - (b) Was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.
 - (2) For an Eligible Dependent, the coverage:
 - (a) Is newly made available to Dependents;
 - (b) Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;
 - (c) Is for a person who becomes an Eligible Dependent through marriage, birth,

adoption, or placement for adoption.

- (3) New Dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:
 - (a) The date coverage is made available; or
 - (b) The date of marriage, birth, adoption, or placement for adoption.
- (4) In the case of a Dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if VISTA receives enrollment applications in the time frame specified herein. Other Dependent coverage is effective:
 - (a) In the case of marriage, as of the date of the marriage, or
 - (b) In the case of a dependent's birth, as of the date of birth; or
 - (c) In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

8. **Late Enrollees.** Unless otherwise prohibited by law, an Eligible Employee or Eligible Dependent who tries to enroll outside the Initial Enrollment Period or Annual Open Enrollment Period will be considered a Late Enrollee, unless that person is considered a Special Enrollee as described above. A Late Enrollee who wants to enroll for coverage under this Group Agreement must complete an Enrollment Application. Coverage will be for all conditions except for Pre-existing Conditions. The Pre-existing Condition exclusion relates to a physical or mental condition regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period prior to the enrollment date. Pre-existing Conditions will not be covered by this Group Agreement until the Late Enrollee has been enrolled for eighteen (18) months from the date of enrollment. An Eligible Employee and his or her Eligible Dependents enrolling for coverage as a Late Enrollee may receive credit for the partial or full satisfaction of a Pre-existing Condition waiting period if the individual had Creditable Coverage as specified below.
 - a. **Creditable Coverage.** Creditable Coverage means benefits or coverage which is continuous to a date within sixty-three (63) days of enrollment under this Group Agreement, exclusively of any waiting period, and which was provided under any health plan, public or private. Accident or disability income policies, policies for supplements to liability insurance, Workers' Compensation, auto medical payments, credit-only insurance, coverage provided by pre-paid health clinics, and others as defined by Florida Department of Financial Services rules are not considered Creditable Coverage.

If offered separately, the following are not considered Creditable Coverage:

- (1) Limited scope dental or vision benefits.
- (2) Long term care, nursing home care, home health care, community-based care; or any combination.
- (3) Coverage for Medicare Supplement insurance and other limited benefits as specified by department rules.

If offered independently and as non-coordinated benefits, the following are also not considered Creditable Coverage:

- (1) Coverage for specified disease or illness-only insurance; and
 - (2) Hospital indemnity or other fixed indemnity insurance.
- b. **Late Enrollees with Creditable Coverage.** A Late Enrollee who has Creditable Coverage continuous to a date sixty-three (63) days before the individual's enrollment date under this Group Agreement, will be given credit for the partial or full satisfaction of a Pre-existing Condition limitation waiting period. An Eligible Employee or Dependent whose Creditable Coverage was in effect for twelve (12) months or longer, will not be subject to a Pre-existing Condition waiting period if he or she was covered under Creditable Coverage continuous to a date sixty-three (63) days before the enrollment date in this Group Agreement. If an Eligible Employee's or Dependent's Creditable Coverage was in effect less than twelve (12) months, it will be applied to the eighteen (18) month pre-existing period and reduced accordingly.
- c. **Late Enrollees without Creditable Coverage.** A Late Enrollee will be subject to the full Late Enrollee Pre-existing Condition waiting period if he or she does not have Creditable Coverage.

C. Effective Date of Coverage

After VISTA receives completed Enrollment Applications and the appropriate Premium arrangements are made, coverage under this Group Agreement shall begin on the earliest of the following dates:

1. Initial Enrollment and Annual Open Enrollment. Coverage shall begin on the date agreed upon by the Group and VISTA.
2. Newly Eligible Employees. Coverage will begin as of the first day of the calendar month following the date the employee becomes eligible, if written application is made on or before that date or within thirty-one (31) days after the date he or she becomes eligible.
3. Newly Eligible Dependents and Special Enrollees. Coverage will begin as of the first day of the calendar month following the date he or she becomes eligible (e.g. date of event such as guardianship, etc.), if written application is made on or before that date or within thirty-one (31) days after the date he or she becomes eligible. Newborn and adopted children are covered as specified in this Group Agreement.
4. Late Enrollee. Coverage will begin as of the first day of the calendar month following the date application is received.
5. The Effective Date of Coverage as noted in 1 through 4 above, may be changed by agreement of the Group and VISTA and only in accordance with applicable state and federal laws.

D. Enrollment Application

Newly Eligible Employees must complete a VISTA-approved Enrollment Application available from the Employer within thirty-one (31) days of the date of his/her eligibility to assure timely coverage. Eligible Employees who choose not to elect group coverage for themselves or any Eligible Dependents must complete and sign a Waiver of Coverage within thirty-one (31) days of initial eligibility. A newly eligible employee who does not complete an Enrollment Application (or waive coverage) within thirty-one (31) days of initial eligibility, and requests coverage at a later date, may be considered a Late Enrollee and subject to the delayed coverage rules specified in the Late Enrollee provision.

To assure timely issuance of initial coverage, VISTA should receive an Enrollment Application from all Eligible Employees by the 10th day of the month prior to the Group Effective Date.

Enrollment Applications and Premiums received by VISTA after the 10th day of the month, but before the Group's Effective Date may result in delayed coverage and/or an inaccurate invoice for the following month. Inaccurate invoices will be appropriately adjusted by VISTA during the next billing cycle.

For an Eligible Employee and his/her Eligible Dependent(s) enrolling during an Initial, Annual, or if applicable, Special Enrollment Period, VISTA should receive his/her Enrollment Applications by the 10th day of the month prior to the individual's Effective Date (or for Group renewal, the Anniversary Date), to assure timely coverage.

The following documentation will be required to be submitted with the Enrollment Application when enrolling a newly Eligible Dependent:

<u>Type of Qualifying Events</u>	<u>Documentation Required</u>
Marriage	Marriage Certificate
Birth	Birth Certificate
Adoption	Legal Adoption Papers
Employment Status Change of Employee or Spouse	HIPAA Certificate or Employer Letter
Change in Legal Guardianship	Court Ordered Legal Papers for Legal Guardianship

E. Member Status Change Form

For any change in coverage for existing Members, the Employer must submit a completed Member Status Change Form. The Member Status Change Form must be used when terminating a Member's coverage and the form must be signed by the Employer. The Member Status Change Form must be completed and sent by the Employer, under separate cover to VISTA Enrollment Department:

Vista Healthplan, Inc.
Attention: Enrollment Department
1340 Concord Terrace
Sunrise, Florida 33323
Phone: 1-866-VISTA FL (1-866-847-8235)

1. Additions

Notification of newly Eligible Dependent additions must be submitted to VISTA using a Member Status Change Form. Verification of such change (see required documents), must accompany the Member Status Change Form. A Member Status Change Form which is not completed in the time frames specified in this Group Agreement but submitted at a later date may be considered a Late Enrollment and the individual may be subject to the delayed coverage rules specified in the Late Enrollee provision.

2. Proof of Dependent Status

If a dependent has a different last name than that of the employee, You must attach copies of supporting documents showing evidence of his/her dependent status (e.g. Birth Certificate, Court Order for Guardianship, Marriage Certificate).

If adding a dependent, who is unmarried and age 19 or older, You must attach the following documents to show proof of dependent status:

- a. a copy of your last IRS 1040 form; and
- b. if a student, a letter from Registrar's Office certifying current hours enrolled; or
- c. if not a student but living in the household, provide proof that dependent maintains his/her primary residence with the Subscriber (e.g. driver's license, etc.); or
- d. if disabled, a Healthcare Professional's certification stating date and degree of disability.

After enrollment, VISTA may from time to time require proof of dependent eligibility.

F. Notification of Ineligibility

A condition of membership in VISTA is the Subscriber's agreement to notify VISTA of any changes in status that affects the Subscriber or his/her Eligible Dependent's ability to meet the eligibility criteria set forth in this Group Agreement within thirty-one (31) days of such change.

G. Restrictions upon Expulsion or Refusal to Issue or Renew Contract

VISTA shall not expel or refuse to renew the coverage nor refuse to enroll any eligible individual Member of a group on the basis of the race, color, creed, marital status, sex or national origin of the individual. VISTA shall not expel or refuse to renew the coverage of any eligible individual Member of a group on the basis of the age, health status, health care needs, or prospective costs of health care services of the individual. Nothing in this Section shall prohibit VISTA from requiring that, as a condition of continued eligibility for coverage, dependents of a Subscriber, upon reaching a specified age, convert to COBRA or a conversion contract. VISTA may also require that individuals entitled to have payments for health costs made under Title XVIII of the United States Social Security Act, as amended, be offered a VISTA contract for Medicare beneficiaries so long as VISTA is authorized to issue contracts for Medicare beneficiaries.

SECTION 2 MEDICARE ELIGIBLES

Medicare Part A: the Social Security Program that provides hospital health benefits.

Medicare Part B: the Social Security Program that provides Healthcare Professional services and outpatient health benefits.

A. The Effect of Medicare Coverage/Medicare Secondary Payer

When a Member becomes covered under Medicare and continues to be eligible and covered under the Group Agreement, the benefits of the Group Agreement shall be primary and the Medicare benefits shall be secondary as set forth below, but only to the extent required by law. In all other instances, the benefits under this Group Agreement shall be secondary to any Medicare benefits. To the extent VISTA is primary payer, claims for Covered Services should be filed with VISTA first.

In order to ensure compliance with the Medicare Federal regulations, the Employer shall advise VISTA, without delay, of any Member who is covered under Medicare prior to or immediately following the date such Member becomes so covered (e.g., prior to the Member's 65th birthday). Additionally, the Employer shall advise VISTA, without delay, of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date. The Employer shall indemnify and hold VISTA harmless to the extent of any liability, including attorney fees and costs that results directly or indirectly from the Employer's failure to so advise VISTA.

In any circumstances under which the Medicare secondary payer requires that the Benefits under the Group Agreement be primary for any Member, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individual. Also, the Employer may not induce such Member to decline or terminate his or her group health coverage and elect Medicare as primary payer.

B. Working Elderly

1. If the Employer employs:
 - a. 20 or more persons for 20 or more weeks of the current or preceding Calendar Year, or
 - b. is a member of a multi-employer group health plan that includes at least one (1) employer with 20 or more employees,

the Group Agreement provides primary coverage for employees and/or their spouses, age 65 or older. These names, along with any other identifying information requested by VISTA shall be provided to VISTA on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls under the Group Agreement pursuant to the following terms:

- (1) The Employer shall provide VISTA without delay, the names of employees, age 65 or older:
 - (a) Who are covered under this Group Agreement;
 - (b) Who are employed (not retired);
 - (c) Who are not eligible for Medicare due to end stage renal disease (ESRD).
- (2) The Employer shall provide VISTA, without delay, the names of spouses, age 65 or older, of current employees of any age:
 - (a) Who are covered under the Group Agreement;
 - (b) Who are not eligible for Medicare due to ESRD.

- (3) For an enrolled individual who meets one of the descriptions set out above, VISTA will provide group health coverage, as set forth in the Group Agreement, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is age 65 or over at the time of enrollment.
 - (4) Individual entitlement to primary coverage under this Section will terminate automatically.
2. Under the Medicare Federal Regulations, the Employer may not offer, subsidize, procure, or provide a Medicare supplement insurance policy to such individual. Also, the Employer may not induce such individual to decline or terminate his or her group health coverage and elect Medicare as primary payer.
 - a. Entitlement of the employee and/or spouse to primary coverage under this Section will terminate automatically when:
 - (1) The employee retires; or
 - (2) The employee no longer meets the employer eligibility requirements.
 - b. The primary coverage described in this Section will not be provided in the case of a member of a multi-employer group health plan where that Employer has fewer than 20 employees and the plan has elected treatment of that member's employees under the exception for Employers described in 42 U.S.C. 1395y(b)(1)(A)(iii).
 - c. A person becomes entitled to Medicare on the basis of disability after the individual has been entitled to Social Security disability for twenty-four (24) months. There is a five (5)-month waiting period. Once a disabled individual turns age 65, he or she may be entitled to benefits on the basis of age. This does not apply to an individual who is covered under Medicare due to ESRD.

NOTE: Changes in the number of employees to fewer than 20 employees or from fewer than 20 employees to 20 or more employees, including pertinent changes in multi-employer group health plans, must be immediately reported by the Employer to VISTA.

C. Individuals with End Stage Renal Disease (ESRD)

1. Primary coverage is provided for the Employer's current and former employees and/or their dependents who are covered under the Group Agreement and who are entitled to Medicare coverage because of ESRD, pursuant to the following terms:
 - a. The Employer shall provide VISTA, without delay, the names of any individuals covered under the Group Agreement who are or will be undergoing a regular course of renal dialysis, or who will receive or already have received a kidney transplant, including the beginning date of such dialysis or the date of such transplant, and any other identifying information requested.
 - b. For an enrolled individual who is entitled to Medicare coverage because of ESRD, VISTA will provide group health insurance coverage, as set forth in this Group Agreement, on a primary basis for thirty (30) months beginning with the earlier of:
 - (1) The month in which the individual becomes entitled to Medicare Part A ESRD benefits; or
 - (2) The first month in which the individual would have become entitled to Medicare Part A ESRD benefits if a timely application had been made.

2. If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD prior to March 1, 1996, VISTA will provide group health coverage, as set forth in the Group Agreement, on a primary basis for eighteen (18) months, on or after March 1, 1996, for thirty (30) months.
3. Under the Medicare Federal Regulations, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individuals. Also, the Employer may not induce such individuals to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

D. Miscellaneous

1. This Medicare Secondary Payer Section shall be subject to, modified 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 the Group Agreement.
2. VISTA shall not be liable to the Employer or to any individual covered under this Group Agreement on account of any non-payment of primary benefits resulting from any failure of performance of the Employer's obligations as set forth in this Section.
3. If VISTA should elect to make primary payments covering services rendered to an employee or dependent described in this Section in a period prior to receipt of the information required by the terms of this Section, VISTA may require the Employer to reimburse VISTA for such payments. Alternatively, VISTA may require the Employer to pay the rate differential that resulted from the Employer's failure to provide the required information in a timely manner.
4. The Employer shall indemnify and hold VISTA harmless to the extent of any liability that the Employer may be charged as a result of any failure of performance of the Employer's obligations as set forth in this Section.

NOTE: The federal laws described in this Section are directed at the Employer. Individuals with questions regarding their rights under those laws should direct their questions to the Employer.

SECTION 3 COVERAGE PROVISIONS

A. How the Plan Works - Benefits and Services

1. VISTA agrees to arrange for the Covered Services as listed in the Schedule of Benefits in accordance with these procedures and subject to the limitations and exclusions specified in this Agreement. Covered Services will be rendered by Participating Providers under reasonable standards of quality of care, as certified by the Agency for Health Care Administration.
2. Each Member must select a Primary Care Physician (PCP). If a Member fails to choose a Primary Care Physician when enrolling, VISTA will assign one to the Member and notify the Member of that assignment. The Primary Care Physician will be responsible for providing the Member's primary health care. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her Primary Care Physician.

A Member may select or change their Primary Care Physician by calling the VISTA Customer Service Department at 1-866-847-8235, TDD # 1-888-444-7352.

3. Except in the case of an Emergency Medical Condition, only benefits and services set forth in the Schedule of Benefits that are rendered by a Participating Provider will be covered.
4. Except in cases of an Emergency Medical Condition, Medically Necessary Covered Services as set forth in the Schedule of Benefits and subject to the limitations and exclusions specified in this Agreement shall be available and covered only when provided by a Participating Physician, a Participating Hospital or by another Participating Provider under contract with VISTA to provide health care services to Members, and subject to Prior Authorization requirements described herein.
5. In case of an Emergency Medical Condition, Members shall be entitled to the benefits and services set forth in the Covered Services Section and the Schedule of Benefits.
6. If a Participating Provider terminates his/her contract with VISTA or is terminated by VISTA for any reason other than for cause, a Member receiving active treatment may continue coverage and care with that provider when authorized by VISTA. Coverage will continue through completion of treatment of a condition for which the Member was receiving care at the time of the termination until:
 - a. the Member 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; or
 - b. the Member, 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 may refuse to continue to provide care to a Member who is abusive, non-compliant, or in arrears in payment for services provided.

7. A female Member is allowed to visit a participating obstetrician/gynecologist for one (1) annual visit as specified in this Group Agreement, as well as medical services provided by a general GYN & OB/GYN, excluding Sub-Specialty GYN & OB/GYN services without authorization from the Member's Primary Care Physician. Any care required at that visit does not require a referral but is subject to Prior Authorization by VISTA.

B. Payment for Covered Services

VISTA will pay for Covered Services per Calendar Year, after satisfaction of the applicable Copayments if any, provided:

1. The service is rendered while covered under this Group Agreement.
2. The service is rendered for Covered Services specified in this Section.
3. The service is not paid or payable under another benefit of this Group Agreement.
4. Such payment:
 - a. Will not exceed any Maximum Benefit set forth in the Schedule of Benefits of this Group Agreement.
 - b. Will be subject to the Covered Services Section, Exclusions and Limitations Section and Schedule of Benefits of this Group Agreement.

C. Benefits and Services Excluded from Coverage

1. Members shall not be entitled to the benefits and services set forth in the Exclusions and Limitations Section, nor are Members entitled to benefits and services set forth in this Group Agreement:
 - a. If rendered by a Participating Physician without a referral from the Member's Primary Care Physician, or
 - b. If rendered by a Non-Participating Provider without Prior Authorization in writing from VISTA with the exception of services rendered for Emergency Medical Conditions.
2. Copayment Responsibilities

Members may be required to pay Copayment amounts in connection with services and benefits covered under this Agreement. Such Copayments are set forth in the Schedule of Benefits. Copayments must be paid at the time of service unless alternate arrangements are made.

D. Role of the Primary Care Physician (PCP)

The PCP will be responsible for providing the Member's primary health care. Members may self-refer to Participating Providers for Covered Services.

E. Copayment

Some services may be subject to a nominal Copayment that must be paid to the Healthcare Professional at the time a service is rendered. Copayment amounts are specified in the Schedule of Benefits.

F. Copayment Maximum

1. Individual

In each Calendar Year, the individual maximum amount of Copayments to be paid by any Member for Covered Services rendered to such Member is the amount specified in the Schedule of Benefits. If during a Calendar Year the Individual Copayment Maximum is met for a Member, such Member shall have no further obligation to pay additional Copayments for Covered Services rendered to that Member for the remainder of that Calendar Year.

2. Family

In each Calendar Year, the total Copayment Maximum for Covered Services rendered to each Subscriber and all of his/her Dependents (collectively, a "Family") is the amount specified in the

Schedule of Benefits. If during a Calendar Year, the Family Maximum has been reached, no individual in the Family shall have any further obligation to pay additional Copayments for Covered Services rendered to that individual or any other individual in the Family for the remainder of that Calendar Year; provided, however, that unless and until the Family Maximum has been achieved, each individual in the Family shall be obligated for Copayments for Covered Services up to the amount of his/her Individual Maximum.

G. Prior Authorization

In order to be eligible to receive benefits available under this Group Agreement, VISTA requires Prior Authorization by the Medical Management Department for certain services. If You fail to obtain Prior Authorization when it is required, benefits that may have otherwise been covered will be denied. The following treatment or services are examples, but not an inclusive list of treatments and services that must be authorized by Us as explained below:

1. Hospital confinements and Skilled Nursing Facility confinements;
2. Non-emergent transportation; air ambulance;
3. All non-emergency outpatient hospital services, including but not limited to, surgical, laboratory and diagnostic;
4. Wound care procedures;
5. Inpatient rehabilitative services;
6. Outpatient rehabilitative services at a hospital;
7. DME (for North Florida only);
8. DME – customized/specialty items
9. Prosthetics, Braces, Hospice;
10. Pain Management;
11. C-PAP machine (see Sleep Studies benefit).

For a current list of all services requiring Prior Authorization, You may call Customer Service at 1-866-VISTA FL (1-866-847-8235), TDD #: 1-888-444-7352.

It is Your responsibility to verify with Your Healthcare Professional that Prior Authorization has been received before the service is rendered. However, Prior Authorization is not a guarantee of coverage. Members must be eligible for coverage at the time the services are rendered.

Prior Authorization Procedures:

For those services that require Prior Authorization, the Member or his/her attending Healthcare Professional must request Prior Authorization from Us as follows:

1. At least ten (10) days prior to the start of any treatment requiring Prior Authorization.
2. Within forty-eight (48) hours or as soon as reasonably possible after the start of and prior to discharge for emergency Hospital confinement.
3. Within ten (10) days for a planned inpatient Hospital admission.

4. In the case of pregnancy, within twenty-four (24) hours or as soon as reasonably possible after the date of a maternity delivery or maternity-related admission.

We will conduct Prior Authorization review for certain services. For requests for **urgent care services**, We will notify the Member and the requesting Healthcare Professional as soon as possible given the medical circumstances of the case, but not later than seventy-two (72) hours after We receive the request for such urgent care services, unless sufficient information to conduct the Prior Authorization review is not provided to Us. In such case, We will contact the Member or the requesting Healthcare Professional within the first twenty-four (24) hours after the Prior Authorization request is made. The necessary documentation being requested shall be submitted to Us within the following forty-eight (48) hours so that the Prior Authorization review can be completed within the earlier of forty-eight (48) hours of Our receipt of such information or forty-eight (48) hours after our request for such information in the event such information is not received.

For purposes of this section, a request for an urgent care service is one in which medical care or treatment is being requested and the application of non-urgent timeframes for conducting Prior Authorization could seriously jeopardize the life/health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is being requested. Requests for urgent care services are reviewed by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, except that when a physician with knowledge of the Member's medical condition specifically requests urgent Prior Authorization, the request will be deemed as such.

Prior Authorization for **non-urgent care services** will be completed within fifteen (15) business days of VISTA's receipt of the request. We may request for a one-time extension of this timeframe, for up to fifteen (15) days, if such extension is necessary due to matters beyond Our control. If We need to request an extension, We will let the Member know before the end of the initial 15 day period. If We need an extension because additional information is needed from the Member or requesting Healthcare Professional, we will notify the Member or provider and explain the process for submitting such information to Us for review.

When responding to the request for Prior Authorization We will:

1. Advise the requesting Healthcare Professional and Member that the treatment or service is authorized; or
2. Deny Prior Authorization and advise Member, PCP and Specialist, if applicable, as to the alternative treatment or service that will be authorized; or
3. Deny Prior Authorization entirely. If We deny an authorization, We will send the denial in writing to the Member, the attending Healthcare Professional, and if applicable, the Hospital.

If authorization is given only for outpatient care but you obtain inpatient care without notification prior to discharge, We will only pay for services at the outpatient benefit level, unless authorized by VISTA. If services are not authorized there is NO COVERAGE for the bills you incur.

If You need to be admitted to a hospital, VISTA will authorize Your admissions, and monitor Your stay. Each day will be reviewed and authorized when appropriate. We will send written confirmation of Your direct/scheduled authorized admission to the Healthcare Professional and/or hospital. Your Healthcare Professional's staff may sometimes assist with obtaining Prior Authorization, but it is Your responsibility to be sure it has been obtained to maximize Your benefits.

The Member or his/her attending Healthcare Professional may at any time ask Us to reevaluate Our decision on Prior Authorization or extend the number of days of Hospital confinement deemed to be appropriate for the treatment of the Member's Condition.

Prior Authorization is not a guarantee of payment and will not result in payment of benefits that would not otherwise be payable.

H. Semi-Private Room Rate

In the case of a Hospital which does not have semiprivate accommodations; the standard daily semiprivate room rate will, for purposes of this benefit, be 80% of the daily charges for regular Hospital services at its lowest rate for private accommodations. If the Hospital charges for a private room, We will not pay more than the rate for a semi-private room.

I. Second Medical or Surgical Opinion

A Member is entitled to request a second medical or surgical opinion by a Physician of his/her choice, subject to the following conditions:

1. The Member feels that he/she is not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the condition being treated.
2. The Member disagrees with Our opinion or a Physician's regarding the reasonableness or necessity of a surgical procedure; or, the treatment is for a serious injury or illness.
3. The Physician chosen by the Member for the second opinion is located in VISTA's Service Area.
4. The second surgical opinion coverage is limited to the consultation, physical examination and any laboratory work and diagnostic tests not already performed. VISTA retains the right to have any tests that may be required by a Non-Participating Physician administered by a Participating Physician.
5. The Member is responsible for the Physician's office visit Copayment when the second opinion is received from a Participating Physician.
6. The Member's Participating Physician or VISTA's Medical Director's judgment concerning the treatment shall be controlling, after review of the second opinion, as to the obligations of VISTA.
7. Any treatment, including follow-up treatment pursuant to the second opinion is authorized by the Member's Participating Physician or VISTA.
8. Reimbursement for a second opinion by Non-Participating Physician may be limited to a maximum of two (2) in a Calendar Year. VISTA will reimburse the Member for the second opinion in an amount equal to sixty percent (60%) of all charges which are usual, reasonable, and customary, in the community for the second opinion services performed by a Non-Participating Physician, as determined by VISTA. The Member shall be responsible for the balance of charges for services performed by a Non-Participating Physician.

VISTA will cover the second surgical opinion for a Member who has received a recommendation to have elective surgery which is covered under this Contract if in addition to the conditions listed above the following conditions are also met:

1. The consulting Physician must personally examine the Member and VISTA and the Member's PCP must receive a copy of the written opinion.
2. The consulting Physician must not be affiliated in practice with the surgeon who first recommended surgery.
3. The consulting Physician must not perform the surgery to correct the condition for which the second opinion was sought.

SECTION 4 COVERED SERVICES

Members are entitled to receive the services and benefits set out in this section. Except for preventive health care, services and benefits must be Medically Necessary and are subject to the Exclusions and Limitations, and specified Copayments, Deductibles and Coinsurance if applicable. Some services, as specified herein, or in the Schedule of Benefits, are subject to a maximum benefit amount per Calendar Year.

You may be eligible to receive the following medical care and services from Participating Healthcare Professionals in the Service Area including medical, surgical, diagnostic, therapeutic and preventive services (subject to the provisions of the Exclusions and Limitations Section). Some services require You to pay a Copayment to the Participating Healthcare Professional. Copayments must be made at the time services are received. Copayment amounts are included in Your Schedule of Benefits and on Your ID card.

VISTA shall make all determinations that are required for the administration of this Agreement, including determinations, regarding medical necessity and Covered Services, at its discretion. In accordance with the Grievance Procedure Section, the Member has the right to file a Grievance regarding decisions made by VISTA. In all cases, medical necessity is to be determined in accordance with generally accepted standards of medical care as determined by VISTA.

A. Covered Services

A Member is entitled to receive Covered Services when provided, prescribed or directed by a Healthcare Professional.

1. Hospital Inpatient Services

VISTA covers the Inpatient Hospital Services when the Healthcare Professional receives authorization from VISTA in advance of the inpatient hospitalization. We encourage you in the case of an Emergency Medical Condition, to notify Us within forty-eight (48) hours or as soon as reasonably possible after the start of Emergency Services and Care treatment or an Emergency Hospital confinement. Covered Hospital Services include, but are not limited to:

- a. Semi-private room and board including special diets, use of operating room, anesthesia, intensive care or other special care units, oxygen, and general or private duty nursing when prescribed. If a Member signs a waiver assuming private room charges, the Member will be responsible for the cost.
- b. Healthcare Professional services including surgery, delivery and administration of anesthesia.
- c. Laboratory, X-Ray, and diagnostic services.
- d. Acute dialysis.
- e. Blood, blood plasma, blood derivatives and blood factors.
- f. Drugs, medications and biologicals, dressings and casts.
- g. Reconstructive Surgery:

Benefits are available for reconstructive surgery if it is incidental to or follows surgery from trauma, infection or other diseases of the part of the body involved. With respect to a child covered under this Contract, benefits are available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.

h. Rehabilitative Services (speech, occupational, physical, respiratory):

Rehabilitative services provided while the Member is Hospital confined will be covered for the duration of the Hospital confinement, subject to the conditions listed herein.

Speech, occupational, physical and respiratory therapy services received during an admission to a Hospital do not reduce the number of outpatient rehabilitative therapy visits as indicated on the attached Schedule of Benefits.

i. Inpatient Neonatal Intensive Care Unit (NICU) admission and subsequent inpatient care.

2. Outpatient Services

Office visits to include:

- a. Routine adult check-up and physical examination. See Schedule of Benefits for Member Responsibility and limitations.
- b. Pediatric examinations and well-child care. Visits include hearing and vision screening and preventive care services when ordered and performed by a Healthcare Professional for health maintenance and preventive care. Services include Healthcare Professional delivered or Healthcare Professional -supervised visits from birth to sixteen (16) years which include a history, a physical examination, developmental assessment and anticipatory guidance, and laboratory tests. Services and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Benefits are limited to one visit payable to one provider for all of the services provided at each visit.
- c. Annual OB/GYN visit (breast exam, pelvic exam and Pap smear) with a Healthcare Professional, Gynecologist or Obstetrician/Gynecologist. See Schedule of Benefits for Member Responsibility and limitations.
- d. Immunizations required because of an injury or immediate risk of infection.
- e. Immunizations for routine preventive care as recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (CDCACIP) and subsequently published in the CDC Morbidity and Mortality Report and approved by VISTA.
- f. Allergy serum.
- g. Newborn hearing screening at birth and any follow-up re-evaluations leading to diagnosis is covered through age twelve (12) months. Treatment and services covered under this Group Agreement and delivered or authorized by the child's Healthcare Professional will be provided to any Covered dependent child diagnosed as having a permanent hearing impairment.
- h. Non-surgical Spine and Back Disorder Treatment: Manual manipulation of the spine to correct subluxation. See Schedule of Benefits for Member Responsibility and limitations.
- i. Rehabilitative Services: ordered by a treating physician and approved by VISTA are limited to the therapy categories listed below. VISTA must specifically pre-approve a written plan of treatment submitted by the Member's Physician and agree that the Member's Condition will improve significantly within sixty (60) days of the date therapy begins.

Covered Rehabilitative Therapy Services are limited to four (4) modalities per day not to exceed the benefit maximum set forth in the Schedule of Benefits. They include:

- (1) Services of a licensed speech-language pathologist to aid in the restoration of speech loss or swallowing disorders or an impairment resulting from injury, stroke or a surgical procedure while this coverage was in force.
- (2) Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to injury, stroke or a surgical procedure while this coverage was in force.

Outpatient therapies listed below may be Covered Services when ordered by a Healthcare Professional licensed to perform such services. The outpatient therapies listed below are in addition to the Cardiac Rehabilitation, Occupational Therapy, Physical Therapy and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

- (1) Cardiac Rehabilitation – Services provided under the supervision of a Healthcare Professional, or a Healthcare Professional trained for Cardiac Rehabilitation, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.
- (2) Occupational Therapy – Services provided by a Healthcare Professional or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Covered Condition are covered.
- (3) Speech Therapy – Services of a Healthcare Professional, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Covered Condition are covered.
- (4) Physical Therapy – Services provided by a Healthcare Professional or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.
- (5) Respiratory or Inhalation Therapy – Services provided for the purpose of aiding in the restoration of normal physical function of the lungs, due to injury, stroke or a surgical procedure while this coverage was in force.

3. Additional Services

Alcohol and Substance Abuse Care

Detoxification: Coverage is available for the medical services relating to short duration medical detoxification and alcohol or drug abuse treatment on an inpatient basis, subject to Prior Authorization by Us. See Schedule of Benefits for Member Responsibility and limitations.

Ambulance Services

Ambulance services for an Emergency Medical condition are covered. Non-emergency transportation between healthcare facilities for receipt of Covered Services is subject to Prior Authorization by VISTA. Air ambulance requires a Prior Authorization.

Breast Cancer Treatment

Coverage for breast cancer treatment includes inpatient Hospital care and outpatient post-surgical follow-up care for mastectomies in accordance with prevailing medical standards and authorized by VISTA.

Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include the Hospital, treating Healthcare Professional's office, outpatient center, or the Member's home.

Inpatient Hospital treatment for mastectomies will not be limited to any period that is less than that determined by the attending Physician.

The Federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- a. reconstruction of a surgically removed breast;
- b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including Copayments, Deductible and Coinsurance provisions.

Chemotherapy

Any drug prescribed for the treatment of cancer will not be excluded from coverage if the drug is not approved by the FDA for a particular indication but the drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature. Coverage includes medically appropriate services associated with the administration of the chemotherapy agent.

Cleft Palate and Cleft Lip

Treatment is provided for a dependent under age eighteen (18). Benefits are available for medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the Healthcare Professional. Coverage is subject to benefit and benefit limitations listed in the Covered Services and Exclusions and Limitations Sections of this Group Agreement.

Dental Services

Benefits are available for the treatment of an Accidental Dental Injury to sound natural teeth if the services are rendered, and the treatment is received within six (6) months of the accident. This benefit does not include coverage for expenses for services related to an injury occurring while, and as a result of biting or chewing. Bite splints are covered.

Dental Treatment in a Hospital or Ambulatory Surgical Center

Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or surgery, subject to Prior Authorization by VISTA.

- a. A dependent child under age eight (8) whose treating Healthcare Professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

- b. A Member who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any 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. Use of general anesthesia in a hospital or Ambulatory Surgical Center is subject to Prior Authorization by VISTA.

Dermatologic Services

A Member is limited to five (5) visits every twelve (12) months. Visits exceeding the maximum of five (5) visits in a twelve (12) month period and services or testing not considered minor or routine in nature, require an authorization from VISTA.

Diabetes Treatment

Benefits are available for services including all medical equipment, supplies and diabetes outpatient self-management training and educational services used to treat diabetes when the Member's Healthcare Professional or a Healthcare Professional that specializes in the treatment of diabetes certifies that such services are necessary and Prior Authorization is received from VISTA. We may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes instructor or a board-certified endocrinologist. We may require that a licensed dietitian provide nutrition counseling. Supplies will be obtained from a vendor designated by VISTA.

Durable Medical Equipment (DME) for Outpatient Use

Benefits are available for DME as prescribed by a Healthcare Professional and subject to Prior Authorization by Us, as per the Prior Authorization section, up to the maximum benefit allowed. DME must meet Medicare Guidelines as defined in the Medicare DME manual. See Schedule of Benefits for Member Responsibility and limitations. Benefits include:

- a. Repair, replacement and maintenance of authorized durable medical equipment. Coverage is limited to normal wear and use and body growth or change.
- b. Equipment for the treatment of diabetes.
- c. Drug infusion pumps and release devices.

Enteral (Elemental) Nutrition

Benefits are available for home Enteral (Elemental) Nutrition made up of single amino acids and simple sugars and if the following requirements are met:

- a. It is the primary source of nutrition (at least 50% of his/her daily nutritional requirements);
- b. Adequate nutrition must not be possible with dietary adjustment and/or oral supplements; and
- c. A Participating Physician must see the Member within thirty (30) days prior to initial Prior Authorization and any subsequent re-authorization.

Coverage for inherited diseases of amino acid and organic acids includes food products modified to be low protein.

Eye Care

Benefits are available for initial prescription lenses (eye glasses or contact lenses) following an operation for cataracts. See Schedule of Benefits for Member Responsibility and limitations.

Family Planning:

Benefits are available for diagnostics, counseling and planning for problems of fertility and infertility subject to Prior Authorization by Us.

- a. Services and supplies for the purpose of diagnosing the cause of infertility, including examinations, diagnostic surgical services and related hospital or facility costs in connection with such surgery.
- b. Voluntary sterilizations, tubal ligations and vasectomies.
- c. Testing for problems of infertility will be provided, subject to Prior Authorization by Us and any applicable Member Responsibility.
- d. Diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography (HSG) and diagnostic laparoscopy (limited to one (1) sequence per Member per lifetime).
- e. Prescribed Contraceptives filled by a Pharmacist.
- f. Intrauterine Devices (IUD), insertion and removal. See Schedule of Benefits for Member Responsibility).
- g. Measurement and fitting for contraceptive diaphragms.

Foot Care

Benefits are available for the treatment of a disease or injury of the foot, including infection, bony malformation, tendonitis, hammertoes and treatment of bunions.

Foot Care (routine) for Diabetics only

Benefits are available for removal of warts, corns or calluses or trimming of toenails.

Gene Testing

Subject to Prior Authorization, coverage is limited to chromosome analysis when there is a risk of a genetic defect.

Genetic Counseling

Subject to Prior Authorization, services are provided for counseling with trained Healthcare Professionals before testing begins and when Members receive the test results, as well as appropriate post testing follow-up, if the medical indication of significant potential for occurrence of genetic defects exists.

Government Hospital

Benefits are available for Covered Services in a Government Hospital if, because of serious injury or sudden illness, the Member is taken to one of these Hospitals for an Emergency Medical Condition. In this instance, We will continue to cover services only for as long as

Emergency Services and Care, is appropriate and it is not possible for the Member to be transferred to a Participating Hospital.

Hearing

1. Benefits are available for hearing screening in a licensed Healthcare Professional's office. Services of a licensed audiologist to determine and measure the hearing function loss and aid in the restoration of hearing function loss, if such loss has occurred while this coverage was in force.
2. Cochlear implants are covered subject to Prior Authorization by VISTA.

Home Health Care Services

Benefits are available if the Member is confined at home and requires Home Health Care Services in lieu of hospitalization.

Services must be provided:

- a. by a licensed home health agency or
- b. through a licensed nurse registry or
- c. by an independent nurse licensed under Section 464 of the Florida Statutes.

Covered Home Health Care Services include:

- a. Part-time or intermittent nursing care by a registered nurse or licensed practical nurse which shall consist of a visit not to exceed four (4) hours in duration.
- b. Physical therapy by a licensed physical therapist; occupational therapy by a licensed occupational therapist; and speech therapy by a licensed speech-language pathologist.
- c. Medical appliances, equipment, laboratory services, supplies, drugs and medicines prescribed by the Member's Healthcare Professional and other services provided by the home Healthcare Professional.

Home peritoneal dialysis

Benefits are available for home peritoneal dialysis.

Hospice Care

Benefits are available for terminally ill Members. Hospice services must be pre-authorized and provided by a licensed Hospice organization:

- a. A Member is considered terminally ill if the Healthcare Professional has certified the Member as having a life expectancy of one (1) year or less, should the illness run its normal course.
- b. Care relating to the terminal condition may be provided on an inpatient basis (in either a Hospice or a Hospital as directed by Hospice) or an outpatient basis.

- c. Coverage includes drugs and medical supplies, bereavement counseling and respite care provided by Hospice. Bereavement counseling must be received within three (3) months after the Member's death.

Laboratory Testing

Mammography Screening

Benefits are available for:

- a. one (1) or more mammograms a year at any age for any woman who is at risk for having breast cancer, because of having a personal or family history of breast cancer, having a history of biopsy-proven benign breast disease, having a mother, sister or daughter who has or has had breast cancer, and because a woman has not given birth before the age of thirty (30) based upon the recommendation of the treating Healthcare Professional; and
- b. a single baseline mammogram for women age thirty-five (35) through thirty-nine (39), inclusive; and
- c. mammograms shall be covered every two (2) years, or more frequently upon the recommendation of a Healthcare Professional, for women age forty (40) through forty-nine (49), inclusive; and
- d. an annual mammogram for women age fifty (50) and older. Except with respect to mammograms performed more frequently than one every two years from ages forty (40) through forty-nine (49).

Mammograms performed pursuant to the above are covered in full and not subject to a deductible, copayment or coinsurance.

Maternity Services (See Schedule of Benefits for Member Responsibility)

Benefits are available for:

- a. maternity care received on an inpatient or outpatient basis including pre-natal and post-natal care of the mother and child authorized by VISTA;
- b. the performance of any clinical tests and immunizations in keeping with prevailing medical standards;
- c. the use of Hospital delivery rooms and related facilities or affiliated birthing centers;
- d. the use of newborn nursery and related facilities;
- e. special procedures as may be authorized by VISTA and performed by a Healthcare Professional;
- f. complications of pregnancy; and
- g. Specialist and Sub-Specialty Obstetrics and Gynecology (See Schedule of Benefits for Member Responsibility.)

Post-delivery care may be provided:

- a. at the Hospital,

- b. at the attending Healthcare Professional's office,
- c. at an outpatient maternity center, or
- d. in the home by a qualified licensed Healthcare Professional trained in mother and baby care.

Services provided by affiliated licensed birthing centers, certified nurse-midwives and licensed midwives working within the scope of his or her license are covered.

The Newborns' & Mothers' Health Protection Act of 1996 (the Newborns' Act) provides that health plans that offer maternity coverage, may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than forty-eight (48) hours of inpatient care following a vaginal delivery or ninety-six (96) hours of inpatient care following a cesarean delivery.

Members have the option, with the Healthcare Professional's authorization, to leave the Hospital earlier than stated above and receive a home health visit within seventy-two (72) hours of leaving the Hospital. If you choose to leave the Hospital early and receive a home health visit, the postpartum home health visit shall not be subject to Copayments or Coinsurance, if any.

Neuropsychological Testing

Benefits are available subject to Prior Authorization by VISTA.

Newborns

The coverage, benefits, or services for newborns shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or pre-maturity, and up to \$1,000 transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the treating Healthcare Professional as necessary to protect the health and safety of the newborn child.

If a newborn is admitted to a Neonatal Intensive Care Unit (NICU) there is a separate hospital admission with applicable Copayments or Coinsurance and authorization.

Benefits are available for a circumcision performed within the first month in either a hospital setting or in a physician's office. See the Schedule of Benefits for Member Responsibility.

Oral Surgery

Benefits are available for diagnostic and surgical procedures involving bones or joints of the jaw and facial region, to treat conditions caused by congenital or developmental deformity, , or injury. This coverage does not include coverage for care or treatment of the teeth or gums, temporomandibular joint (TMJ) or craniomandibular (CMJ) disorders, intra-oral prosthetic devices, removal of wisdom teeth or for surgical procedures for cosmetic purposes.

Orthognathic Surgery

Benefits are available for the surgical procedures involving bones or joints of the jaw and facial region, to treat conditions caused by congenital or developmental deformity. This coverage does not include coverage for care or treatment of the teeth or gums,

temporomandibular disorders, intra-oral prosthetic devices, or for surgical procedures for cosmetic purposes.

Orthotic Devices (as authorized by VISTA)

Benefits are available for:

- a. customized devices such as braces and trusses.
- b. other supports for the feet are not a Covered Benefit unless they are an integral part of the leg brace or a Healthcare Professional prescribes therapeutic shoes for a Member with diabetes.

The appliance must be an Orthotic Device as defined by the Medicare DME Manual and subject to Prior Authorization by VISTA.

Osteoporosis Screening

Benefits are available for the diagnosis and treatment of osteoporosis, subject to Prior Authorization by Us for estrogen-deficient Members who:

- a. are at clinical risk for osteoporosis,
- b. have vertebral abnormalities,
- c. are receiving long-term glucocorticoid (steroid) therapy,
- d. have primary hyperparathyroidism, or
- e. have a family history of osteoporosis.

Outpatient Facility Services

The place of service determines the applicable Member Responsibility as set forth in the Schedule of Benefits and subject to Prior Authorization by VISTA, where applicable.

1. Ambulatory Surgical Care Services

Benefits are available for diagnostic services received on an outpatient basis at a Hospital, an Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. Benefits include, but are not limited to:

- a. Use of operating room and recovery room
- b. Respiratory or inhalation therapy
- c. Drugs and medicines administered (except for take home drugs)
- d. Intravenous solutions
- e. Dressings, including casts
- f. Anesthetics and their administration

2. Outpatient Diagnostic Services

Benefits are available for diagnostic services received on an outpatient basis at a Hospital, an Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. Benefits include, but are not limited to:

- a. Laboratory and pathology

- b. Radiology
- c. Ultrasound
- d. Nuclear medicine
- e. Chest x-rays
- f. Blood tests
- g. Urinalysis
- h. EKG and EEG
- i. MRI and CT scans

3. Endoscopic Procedures

Benefits are available for the following procedures when received on an outpatient basis at a Hospital, an Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. Benefits include, but are not limited to:

- a. Colonoscopy
- b. Endoscopy
- c. Sigmoidoscopy

4. Outpatient Surgery

Benefits are available in a Hospital, licensed Ambulatory Surgical Center, Outpatient Diagnostic Center or Physician's office. The place of service determines the applicable Member Responsibility as set forth in the Schedule of Benefits and subject to Prior Authorization by VISTA.

Prosthetic Devices

Benefits are available for:

- a. Special features prescribed by the Healthcare Professional are subject to Prior Authorization by Us. See the Schedule of Benefits for Member Responsibility and limitations.
- b. Devices are limited to standard/evaluated internal and external devices such as artificial limbs, organic lenses, pacemakers, heart-valve replacements, artificial joints, and external breast prostheses.
- c. Repair, replacement and maintenance of authorized prosthetic devices. Coverage is limited to normal wear, and use and body growth or change.
- d. Special appliances and surgical implants required by a Member for an illness or injury when they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue of the human body.

The appliance must be a Prosthetic Device as defined by the Medicare DME Manual and subject to Prior Authorization by VISTA.

Radiology and Diagnostic Testing

For a current list of radiology and diagnostic tests that require Prior Authorization, contact Customer Service at 1-866-VISTA FL (1-866-847-8235).

Skilled Nursing Facility Care

Benefits are available for Skilled Nursing Facility Services subject to Prior Authorization by Us (excluding nervous and mental conditions and alcohol/substance abuse) when a Member requires skilled nursing care twenty-four (24) hours per day and when rendered in a licensed Hospital or Skilled Nursing Facility:

- a. Services must be provided in lieu of hospitalization or continued hospitalization.
- b. Covered Services 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), and chemotherapy treatment for proven malignant disease.
- c. A Member is entitled to a limited number of days, as indicated on the attached Schedule of Benefits, for short-term speech therapy, occupational therapy, physical therapy and respiratory therapy upon admission to a Skilled Nursing Facility. Such coverage is available only for rehabilitation following injuries, surgery or other Medical Conditions and is intended to improve or restore bodily functions within a reasonable and generally predictable period of time. Coverage is not provided to maintain the Member at his/her present level or to prevent further deterioration.
- d. Services must be skilled level services and must be ordered by and provided under the direction of a Healthcare Professional.
- e. Services are limited as specified in the Schedule of Benefits.

If a Member is a resident of a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the Member's PCP (if applicable) must refer the Member to that facility's skilled nursing unit or assisted living facility if requested by the Member, agreed to by the facility and subject to final authorization by VISTA. The facility must meet all guidelines established by VISTA related to quality of care, utilization, referral authorization, risk assumption, use of VISTA's HMO provider network, and other criteria applicable to Participating Providers for the same services and supplies. If the request for referral or authorization is denied, the Member may use the grievance process described in the Grievance Procedure section of this Certificate of Coverage.

Sleep Studies

Benefits are available for:

- a. sleep study for diagnostic purposes;
- b. treatment for obstructive sleep apnea (OSA) which includes continuous positive airway pressure (CPAP) machine if confirmed by a sleep study.

Surgical Procedures in a Healthcare Professional's Office

Temporomandibular Joint (TMJ)

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. Coverage does not include coverage for care or treatment of the teeth or gums, for intraoral prosthetic devices or for surgical procedures for cosmetic purposes.

Transplantation

Organ transplants are covered when Prior Authorized by VISTA and performed at a transplant facility when such facility is participating in VISTA's designated transplant network to perform such type of transplant.

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications related to transplantation. The Member or the Member's Healthcare Professional must notify Us in advance of the Member's initial evaluation for the transplant procedure. VISTA will cover services received in connection with the transplantation of the following human tissue or organs:

- a. Cornea
- b. Heart
- c. Lung
- d. Liver
- e. Kidney
- f. Pancreas
- g. Bone Marrow Transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental in accordance with applicable Florida law. As used in this Certificate of Coverage, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the Member in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.
- h. Other transplants as approved by Vista in its sole discretion consistent with nationally established guidelines.

Vista will cover organ acquisition and donor costs. Testing to find a suitable donor is limited to the reasonable costs of searching for the donor and is limited to the immediate family members and the national donor programs.

The Member or the Member's Healthcare Professional must notify Us in advance of the Member's initial evaluation for the transplant procedure. Prior Authorization is required for a transplant procedure.

Hospital services and medical services will be paid under provisions set forth in this Agreement, in accordance with the same terms and conditions as VISTA will cover benefits for care and treatment of any other covered condition.

Transportation costs for the Member to and from the approved facility where the transplant is to be performed if the facility is more than one-hundred (100) miles from the Member's home.

Direct, non-medical costs for one (1) member of the Member's immediate family, two (2) Members if the patient is under age eighteen (18), for:

- a. transportation to and from the approved facility where the transplant is performed, but no more than one (1) round trip per person per transplant and
- b. temporary lodging at a prearranged location during the Member's confinement in the approved transplant facility, not to exceed \$75 per day. Costs listed above are only

payable if the Member lives more than one-hundred (100) miles from the approved transplant facility. The maximum benefit for these services is \$5,000 per transplant.

Wigs and Cranial Prosthesis

Benefits are available when related to restoration after cancer or brain tumor treatment with a \$250 limit per calendar year.

B. Emergency Services and Care

Emergency Services and Care for Emergency Medical Conditions are covered in accordance with applicable law. When time and circumstances permit, a Member is encouraged to contact his/her PCP within forty-eight (48) hours, or as soon as reasonably possible, of receiving Emergency Services and Care. A Member's PCP provides access to coverage twenty-four (24) hours-a-day, 365 days a year.

VISTA will pay for the screening, evaluation and examination that are reasonably calculated to assist the provider in arriving at the determination as to whether the Member's condition is an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination may be denied.

1. In the Service Area

In the case of an Emergency Medical Condition inside VISTA's Service Area, the Member should contact his/her PCP if possible. If the Member cannot contact his/her PCP prior to Emergency Services and Care being rendered, the Member should notify the PCP as soon as reasonably possible, from the onset of the Emergency Medical Condition. VISTA will pay for or reimburse Members for costs incurred for Covered Services subject to the payment and reimbursement provisions set forth in this Certificate of Coverage.

2. Out of the Service Area

- a. Emergency Medical Conditions which require Emergency Services and Care before the Member can reasonably return to VISTA's Service Area are covered on the same basis as in-area Emergency Medical Conditions. The Member should notify VISTA or his/her PCP as soon as reasonably possible.
- b. Coverage or treatment out of VISTA's Service Area is limited to Emergency Services and Care for an Emergency Medical Condition. The Member shall obtain all continuing or follow-up treatment from their PCP.
- c. Benefits are payable for Emergency Medical Conditions for which Emergency Services and Care is provided. Elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from VISTA's Service Area may not be covered.

3. Emergency Room follow-up Care

A Member is covered for any follow-up care necessary after receiving Emergency Services and Care in accordance with this Certificate of Coverage. All follow-up care must be provided or arranged by a Member's PCP in accordance with this Certificate of Coverage. If the Member receives follow-up care in the Emergency Department, the Member may be responsible for payment for such services.

SECTION 5 EXCLUSIONS and LIMITATIONS

Any and all services not specifically listed as a Covered Service in this Certificate of Coverage or in any rider, unless such services are required by applicable state or federal law, are excluded. In addition to certain exclusions and limitations already described in this Certificate of Coverage, benefits will not be provided under this Certificate of Coverage if they fall within any of the below-listed categories, unless provided for by a separate rider or amendment. Except as otherwise provided herein, any service or supply that is not provided or arranged through Participating Providers in accordance with our utilization management policies and procedures will be excluded. In addition, VISTA does not cover any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service.

The fact that a Healthcare Professional may prescribe, recommend, approve or furnish a service or supply does not, of itself, make it Medically Necessary or a Covered Service, under this Group Agreement, even though the service or supply is not specifically listed as an exclusion.

Abdominoplasty and/or Panniculectomy.

Acupuncture Services.

Alcoholism or Substance Abuse: Benefits are not available for treatment services and supplies except as specifically stated in the Covered Services Section or provided for by Rider, if elected by the Group.

Alternative Medicine: Benefits are not available for services, testing, equipment, and supplies associated with alternative modalities of care including, but not limited to acupuncture, hypnosis, hypnotic anesthesia, naturopathy, homeopathy, massage therapy, and aromatherapy.

Ambulance Services: Benefits are not available for Ambulance services obtained for a non-emergency, or if the service is determined by VISTA to be for the convenience of the Member, except those services specifically provided for in the Covered Services Section.

Arch Supports: Benefits are not available for orthopedic shoes, sneakers, support hose, or similar type therapeutic devices/appliances regardless of intended use.

Athletic Event-Related: Benefits are not available for care and treatment for injuries sustained by a Member in the course of any athletic event, or while training for such athletic event, for which the Member is to receive remuneration in cash or in kind.

Autopsy or Post Mortem Examination Services.

Biofeedback: Benefits are not available for services and other forms of self-care or self-help training or educational programs and any related diagnostic testing, meditation, pain control, pain management therapies, (except for medically-related conditions that receive Prior Authorization).

Breast Reduction Mammoplasty: Benefits are not available for breast reduction mammoplasty regardless of medical necessity.

Childbirth and Surrogate Parenting Classes.

Complications: Benefits are not available for medical or surgical complications, such as wound infections, during or as a result of a non-covered surgical procedure or service including, but not limited to services rendered for cosmetic purposes including any body piercing and tattooing, gastric bypasses, gastric stapling, breast reductions, breast implants, hypertrophic scars, breast asymmetry.

Contraceptives: Benefits are not available for over-the-counter contraceptives.

Cosmetic Surgery: Benefits are not available for:

1. Any service and supply to improve the Member's appearance or self-perception, including but not limited to, electrolysis, procedures or supplies to correct baldness or the appearance of skin, face lifts, scar reduction (except as related to surgery that has received Prior Authorization), or ear lobe repair.
2. Any professional services and/or hospitalization in connection with elective Cosmetic Surgery, including but not limited to, body piercing and tattooing, tattoo removal, rhinoplasty, liposuction, blepharoplasty, varicose vein injections, removal or injection of skin tags, of cherry angiomas, telangiectasias, spider angiomas.
3. Diagnosis and treatment of any medical complications as a result of previous elective Cosmetic Surgery, regardless of how long ago such services were performed.
4. Removal of breast implants related to Cosmetic Surgery.
5. Excess skin surgery and treatment of complications arising from this procedure.

Costs Rendered for Sickness and Injury: Benefits are not available for:

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.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Counseling: Benefits are not available for marriage or relationship counseling, services or adoption agencies, pastoral counseling, family counseling, social, occupational, religious, or other social maladjustments; chronic behavior disorders; codependency; impulse control disorders; organic disorders; learning disabilities; hyperkinetic syndromes. This exclusion includes any prescription medications prescribed for treatment associated with any of the above conditions.

Court-Ordered Services: Benefits are not available for Court ordered care or treatment, unless otherwise listed as Covered Services.

Criminal Activities: Benefits are not available for:

1. Care and treatment rendered in connection with injuries which occurred during a crime committed by a Member or which the Member tries to commit including, without limitation, treatment and care for any injuries sustained when the Member's blood alcohol content is in excess of the legal limit whether or not the Member is charged with or convicted of any criminal offenses.
2. Care and treatment for injuries sustained while the Member is under the influence of any illegal or illicit drug, or any controlled or legend drug or substance if the drug or substance is not then subject to a valid prescription issued in the name of the Member by a Healthcare Professional and being administered to treat a current episode of illness.

Custodial Care (Residential Care): Benefits are not available for any service or supply of a custodial nature primarily intended to assist the Member in the activities of daily living. This includes rest homes, home health aides (sitters), home mothers, domestic maid services, and health resorts and spas and respite care. This includes services provided by a non-eligible institution and which is primarily a place of rest or for the aged or similar institution.

Dental Care: (unless covered by a Dental Endorsement, if applicable), Benefits are not available for routine dental procedures including, but not limited to:

1. extraction of teeth,
2. restoration of teeth with fillings,
3. crowns or other materials,
4. bridges,
5. cleaning of teeth,
6. dental implants,
7. dentures,
8. periodontal or endodontic procedures,
9. orthodontic treatment including palatal expansion devices,
10. bruxism appliances,
11. dental x-rays,
12. routine intra-oral surgical procedures,
13. orthodontics and fixed and removable prosthetics, and
14. services related to an injury occurring while, and as a result of biting or chewing

except as otherwise specifically referenced in this Certificate of Coverage as covered.

Benefits are not available for:

1. all procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaw as a result of temporomandibular joint (TMJ) or craniomandibular (CMJ). disorders.
2. diagnosis or treatment of dental disease, or the services of the dentist or oral surgeon, nor are the services set forth in this provision covered if provided in a dental office.

Diagnostic Admissions: Benefits are not available for diagnostic services that could have been provided in a Healthcare Professional's office, an outpatient department of a Hospital, or some other setting without adversely affecting the Member's condition.

Dietary Regimens: Benefits are not available for dietary regimens, treatments, food, food substitutes or vitamins.

Disposable Medical Supplies and Personal Convenience: Benefits are not available for supplies, equipment, or personal convenience items such as, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags or the use of telephones or television while an inpatient.

Durable Medical Equipment: Benefits are not available for the following:

1. Devices and equipment used for environmental control, convenience functions or physical fitness.
2. Lost, abused or improperly cared for equipment.
3. Customized equipment.
4. Deluxe or motorized equipment.
5. Wheelchair lifts or ramps.
6. Support hose and compression hose.

Educational Materials and Supplies: Benefits are not available for educational materials and supplies commonly available for purchase, except in the treatment of diabetes.

Enteral (Elemental) Nutrition: Benefits are not available for home Enteral (Elemental) Nutrition for the treatment of eating disorders, such as anorexia or bulimia. The following are not considered Enteral (Elemental) Nutrition:

1. food thickeners, dietary supplements;
2. nutritional support puddings, protein shakes and powders;
3. gluten or lactose free food products;
4. baby food;
5. weight loss foods and products.

Experimental and/or Investigational Treatments and Procedures.

Eye Care: (unless covered by Vision Rider, if applicable) Benefits are not available for:

1. Eyeglasses and/or contact lenses unless indicated on the attached Schedule of Benefits.
2. Training or orthoptics, including eye exercises.
3. Prescription inserts for diving masks or other protective eyewear.
4. Nonstandard items for lenses including tinting and blending.
5. Refractive eye surgery to correct visual acuity problems.

Family Planning Services: Benefits are not available for any service other than those specified in the Covered Services Section of this Group Agreement.

Foot Care (routine): Benefits are not available for any service or supply in connection with foot care in the absence of disease, injury, or accident. This exclusion includes, but is not limited to, clipping of nails, soaking the feet, removing calluses, treatment of flat feet, fallen arches, chronic foot strain and weak feet.

Gastric Bypass, Gastric Stapling, Gastric Balloon and Cylastic Bands: Benefits are not available regardless of medical or psychological condition.

Gene Therapy.

Government Hospital: Benefits are not available for care in any Hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless for an Emergency Medical Condition.

Government Programs: Benefits are not available for any service that is received and payment made on behalf of the Member, under any federal, state or local government program.

Health Care Services: Benefits are not available for consultations, treatment or services or supplies received at a penal facility or outside a penal facility while a Member is incarcerated.

Hearing Aids: Benefits are not available for hearing aids (external and implantable), and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Home Hemodialysis: Benefits are not available for any furniture, plumbing, electrical or other fixtures needed to perform dialysis treatments at home.

Home Oxygen Equipment: Benefits are not available for certain home oxygen equipment items including, but not limited to, emergency oxygen inhalators, portable preset oxygen units, and oxygen administration equipment.

Hypnotism or Hypnotic Anesthesia.

Illegal Actions: Benefits are not available for treatment of a condition resulting from participating in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony; includes care and treatment rendered in connection with injuries suffered in a fight in which the Member is the aggressor.

Immediate Relatives and Self Imposed Treatment: Benefits are not available for charges for physicians' services provided by an immediate relative, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation. This exclusion also precludes a Member that is also a physician from treating himself or herself and submitting claims to VISTA for such coverage. For the purpose of this exclusion, "Immediate Relative" means any of the following:

1. Husband or wife;
2. Natural or adoptive parent, child or sibling;
3. Stepparent, stepchild, stepbrother or stepsister;
4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;
5. Grandparent or grandchild;
6. Spouse of grandparent or grandchild.

Immunizations: Benefits are not available for immunizations and autogenous vaccines related to foreign travel.

Impotence Treatment: Benefits are not available for penile prosthesis, medications such as Viagra, and other devices except as specifically provided for in the Prescription Drug Benefit Rider to this Group Agreement, if elected by the Group.

Infertility Treatment.

Learning Disorders: Benefits are not available for non-medical conditions related to hyperkinetic syndromes and learning disabilities (including ADD and ADHD disorders), autism, mental retardation, developmental delay, and adult onset of attention deficit disorder and treatment for Tourette's syndrome.

Medical Care or Surgery not Prescribed.

Mental Health Treatment: Benefits are not available for treatment, services and supplies, except as specifically provided for by Rider, if elected by the Group.

Military-Related: Benefits are not available for Military service-related medical care, for which the Member is legally entitled to service from military or government facilities and for which facilities are reasonably accessible.

Non-Prescription Drugs: Benefits are not available for any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin or mineral supplements, appetite suppressants, fluoride products, or health foods.

Oral Surgery: Benefits are not available for coverage for care or treatment of the teeth or gums, temporomandibular joint (TMJ) or craniomandibular (CMJ) disorders, intra-oral prosthetic devices, or for surgical procedures for cosmetic purposes.

Orthognathic Surgery: Benefits are not available for:

1. care or treatment of the teeth or gums;
2. temporomandibular disorders;
3. for intra-oral prosthetic devices; or
4. for surgical procedures for cosmetic purposes.

Orthomolecular Therapy: Benefits are not available for therapy including nutrients, vitamins, and food supplements.

Orthotic Devices: Benefits are not available for Dynamic Orthotic Cranioplasty (DOC) – bands or similar devices and helmets or any other type of devices to treat plagiocephaly except when Medically Necessary.

Personal Comfort, Hygiene or Convenience Items: Benefits are not available for services and supplies not directly related to the care of the Member including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, allergenic pillows or mattresses or waterbeds, physical fitness equipment, travel expenses other than authorized ambulance services that are specifically provided for under the Covered Services section.

Physical Examinations: Benefits are not available specifically for obtaining or continuing employment or required for, travel, immigration, insurance, government licensing or premarital purposes.

Prescription Drugs: Benefits are not available for prescription drugs, except medications administered in the course of covered treatment by the Member's Healthcare Professional during an office visit and drugs administered in the course of covered treatment. A Member is entitled to prescription drugs as delineated by a Prescription Drug Rider.

Prosthetic Devices: Benefits are not available for:

1. Deluxe equipment.
2. Devices related to erectile dysfunction except if due to an organic cause. This includes, but is not limited to penile implants.

Rehabilitation: Benefits are not available for:

1. Inpatient rehabilitation services if outpatient services are appropriate.
2. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Member's Condition within a sixty (60) day period.
3. Long-term therapy.

Self-Inflicted/Suicide: Benefits are not available for treatment for a condition resulting from intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Member.

Services Outside the Service Area: Benefits are not available for services rendered outside the Service Area except for treatment of an Emergency Medical Condition.

Services or Supplies: Benefits are not available for services or supplies received prior to a Member's effective date or received on or after the date a Member's coverage terminates under this Group Agreement, unless coverage is extended in accordance with the Extension of Benefits provision.

Sexual Dysfunction: Benefits are not available for sex therapy and drug therapies except certain injectable drugs approved by Us and only to treat erectile dysfunction due to an organic cause.

Sexual Reassignment (gender transformation) or modification services: Benefits are not available for any services or supplies related to such treatment including psychiatric services.

Sleep Disorders: Benefits are not available for insomnia, and/or narcolepsy, treatment, services and supplies for the purpose of treating or diagnosing sleep disorders or any related condition thereof, medical or surgical treatment for snoring, except when provided as part of treatment for documented sleep apnea.

Smoking Cessation: Benefits are not available for smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco; including, but not limited to, nicotine withdrawal programs and treatments such as Nicorette gum or patch.

Specific Therapies and Treatments as follows: Benefits are not available for hypnotherapy, biofeedback, acupuncture, sleep therapy, behavioral training, and hair analysis, unless used as a diagnostic tool for heavy metal poisoning.

Sterilization Reversals: Benefits are not available for reversal of voluntary, surgically induced sterility, including the reversal of tubal ligations and vasectomies and complications thereof.

Temporomandibular Joint (TMJ) Syndrome: Benefits are not available for:

1. Treatment for symptoms (e.g. headaches, clicking, etc.) characterized as TMJ Syndrome, in which the joint is anatomically intact.
2. All procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as craniomandibular joint disorders (CMJ).
3. Physical therapy as a primary treatment for TMJ syndrome.
4. Occlusal orthopedic appliances-orthotics, occlusal splints, bite appliances/planes/splints, mandibular occlusal repositioning appliances (MORAs).

Transplantation: Benefits are not available for:

1. The services related to the transplantation of any nonhuman organ or tissue;
2. The services related to the donation or acquisition of an organ for a recipient who is not covered by VISTA;
3. Services, follow-up care and immunosuppressive drugs, for non-covered transplants and complications from such transplants;
4. Artificial heart devices.

Transportation Services: Benefits are not available for non-emergency transportation between institutional care facilities, and/or to and from the Member's residence unless Prior Authorized by Us.

Treatment of Obesity: Benefits are not available for weight control and weight loss programs; including, but not limited to dietary supplements, appetite suppressants, dietary regimens or treatments, exercise programs or equipment, laboratory testing, examinations and prescription drugs. Gastric stapling, gastric balloon, gastric bypass, liposuction and related procedures, or reversal there of, including treatment of the complications resulting from surgical treatment; regardless of associated medical or psychological conditions.

Vocational Rehabilitation: Benefits are not available for training and educational programs.

War-Related Treatment: Benefits are not available for treatment of a condition resulting, from war or an act of war, whether declared or not.

Wigs or Cranial Prosthesis: Benefits are not available except when related to restoration after cancer or brain tumor treatment with a \$250 limit per Calendar Year.

Workers' Compensation: Benefits are not available for care and treatment of any injury, illness, or condition which arises out of, or in the course of, any occupation for wage or for-profit, any injury, illness, or condition for which the Member is paid or receives benefits under any Workers' Compensation policy law, employer's liability policy, or any similar policy.

SECTION 6 CLAIMS

A. Assignment

The Member may authorize Us to pay benefits under this Group Agreement directly to the provider on whose charges a claim is based.

B. Discharge

Any payment by Us in accordance with these provisions will discharge Us from all further liability to the extent of the payment made.

C. Facility of Payment

If Member dies while benefits under this Group Agreement remain unpaid, We may, at Our option, make payments directly to the provider on whose charges the claim is based; or to the surviving spouse of the Member; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Member's estate.

D. Reimbursement for Participating and Non-Participating Provider Services

VISTA will provide or arrange for services to be received from Participating Providers on a direct service basis. If a Member receives services from a Participating Provider, VISTA will pay the Healthcare Provider directly for all care received. The Member will not have to submit a claim for payment, and will be responsible only for any applicable Copayments, Deductibles and Coinsurance.

In the event the Member has an Emergency Medical Condition that requires services from a Non-Participating Provider while inside or outside the Service Area: if a Member receives Covered Services in a foreign country as a result of an Emergency Medical Condition, the bill and supporting medical records must be in English and the amounts charged and paid must be in U.S. currency with the exchange rate attached for validation. It is the Member's responsibility for obtaining the necessary documents and translations.

When a Non-Participating Provider renders services as a result of an Emergency Medical Condition, notice of a claim for benefits must be given to VISTA. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by VISTA within twenty (20) days after the date of the injury or the first treatment date for the sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the twenty (20) day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

E. Time Payment of Claims

After receiving written proof of claims, VISTA will reimburse all claims or any portion of any claim from a Member or a Member's assignees, for payment under this Group Agreement within forty (40) days after receipt of the claim by VISTA. If a claim or portion of a claim is contested by VISTA, the Member or the Member's assignees will be notified, in writing, that the claim is contested, within forty (40) days after the receipt of the claim by VISTA. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim.

VISTA, upon receipt of the additional information requested from a Member or the Member's assignees, will pay or deny the contested claim or portion of the contested claim within sixty (60) days.

VISTA will pay or deny any claim no later than one hundred twenty (120) days after receiving the claim.

Payment will be treated as being made on the date a draft or valid instrument, which is equivalent to payment, was placed in the United States mail in a properly addressed post-paid envelope or, if not so posted, on the date of delivery.

All overdue payments will bear simple interest at the rate of twelve percent (12%) per year.

F. Notice

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

Vista Healthplan, Inc.
1340 Concord Terrace
Sunrise, Florida 33323

G. Legal Actions

No legal action may be brought to recover under this Group Agreement until at least sixty (60) days after written proof of claim has been filed with VISTA. If such action is taken after the sixty (60) day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

H. Clerical Error

Clerical error, whether of the Group or VISTA in keeping any record pertaining to the coverage under this Agreement, will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

I. Examination

VISTA, at its own expense, shall have the right to examine the person whose Sickness or Injury is the basis of a claim when and as often as it may be reasonably required during the pended status of the claim.

J. Subrogation

Immediately upon paying or providing any benefit hereunder, VISTA shall be subrogated to all rights of recovery a Member has against any third party, to the full extent of benefits provided by VISTA. In addition, if a Member receives any payment from any third party as a result of an injury, VISTA has the right to recover from, and be reimbursed by the Member for all amounts paid hereunder and will pay as a result of that injury, less the pro rata share of attorney's fees and cost, up to the amount the Member has received from all third parties.

As used throughout this provision, the term "third party" means any party possibly responsible for making any payment to the Member for any injuries or any insurance coverage, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, Workers' Compensation coverage or no-fault automobile insurance coverage. As used throughout this provision, the term "Member" means the injured person or persons or any of their agent, representatives, assignees, guardians, heirs, or beneficiaries.

The Member shall do nothing to prejudice VISTA's subrogation and reimbursement rights and shall, when requested, cooperate with Our efforts to recover its benefits paid. It is the duty of the Member to notify VISTA within forty-five (45) days of the date when any notice is given to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the Member.

The Member acknowledges that VISTA's subrogation and reimbursement rights are a first priority claim against all potential third parties and are to be paid to VISTA before any other claim for the Member's damages. VISTA shall be entitled to reimbursement first from any third party payments,

even if the remainder is insufficient to make the Member whole or compensate the Member in part or in whole for the damages sustained. VISTA is limited to the actual amount of damages recovered by the claimant minus its pro rata share of costs and attorney's fees incurred by the claimant in recovering such damages. In determining VISTA's pro rata share of the costs and attorney's fees VISTA shall have deducted from its recovery a percentage amount equal to the percentage of the judgment or settlement which is for costs and attorney's fees.

This entire subrogation and reimbursement provision will apply regardless of whether liability for payment is admitted by the third party and regardless of whether the settlement or judgment received by the Member identifies the medical benefits the plan provided. In the event any claim is made that any part of this subrogation and reimbursement clause is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Member and this plan agree that VISTA shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. The right of subrogation provided to VISTA under this paragraph will be determined in accordance with Florida Statutes or the Courts of Florida.

SECTION 7 GRIEVANCE PROCEDURE

A. Introduction

At VISTA, We are committed to Member satisfaction. We will try to resolve any problems You may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, We have a Grievance Procedure available that provides channels for You, or an Authorized Representative acting on Your behalf (including Your treating provider) to voice Your concerns and have them reviewed and addressed by VISTA.

VISTA's Grievance Procedure is designed to provide prompt, meaningful and confidential resolution of Member concerns regarding quality of care, physician behavior, office waiting times, claims payment, coverage of services, and other similar matters.

The Grievance Procedure includes informal and formal steps. You have one (1) year from the date of the occurrence of the action that initiated the Grievance (which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date you receive initial notice of the Adverse Benefit Determination) to submit a Grievance to Us, verbally or in writing.

B. Definitions

The following definitions will be used for purposes of this Grievance Process described in this Section.

Adverse Benefit Determination: means a denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay, or other health care service does not meet VISTA's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. As Adverse Benefit Determination based in whole or in part on medical judgment, includes the failure to cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate. The denial of payment for services or charges (in whole or in part) pursuant to VISTA's contracts with network providers, where the Member is not liable for such services or charges, are not Adverse Benefit Determinations.

AHCA: means the Florida Agency for Health Care Administration.

Authorized Representative: means an individual authorized in writing or verbally by the Member or state law to act on the Member's behalf in requesting a health care service, obtaining claim payment, or during the Grievance process. A provider may act on behalf of a Member without the Member's express consent when it involves an Urgent Grievance.

Clinical Peer: means a health care professional in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, who was neither involved in the initial Adverse Benefit Determination nor a subordinate of such individual. A Clinical Peer may include a VISTA medical director not involved in the initial Adverse Benefit Determination with the appropriate expertise.

Complaint: means any oral expression or dissatisfaction including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a provider pursuant to VISTA's contract and which is submitted to VISTA or to a State agency. A Complaint is part of the informal steps of a Grievance procedure and is not part of the formal steps of a Grievance procedure, unless it is a Grievance as defined below.

Concurrent Review: means utilization review conducted during a Member's hospital stay or course of treatment.

DOL: means the United States Department of Labor.

Grievance: means an oral or written Complaint submitted by or on behalf of a Member to VISTA or a State agency regarding the:

- (a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an Adverse Benefit Determination made pursuant to utilization review;
- (b) Claims payment, handling, or reimbursement for health care services; or
- (c) Matters pertaining to the contractual relationship between a Member and VISTA.

A Grievance includes both Pre-Service Grievances and Post-Service Grievances (as defined below). A Grievance does not include a written complaint submitted by or on behalf of a Member eligible for a grievance and appeals procedure provided by VISTA pursuant to contract with the Federal Government under Title XVIII of the Social Security Act or other government programs.

Grievance and Appeals Committee (Committee): means a panel comprised of a majority of Clinical Peers, established to review second level Grievances related to Adverse Benefit Determinations made by VISTA. In cases in which there was a denial of coverage, persons previously involved with the Adverse Benefit Determination will not be a Member of the Committee but may appear before the Committee to present information or answer questions. The Committee has the authority to bind VISTA to its decisions. Committee Members, Clinical Peer or otherwise, shall not be subordinate to those person(s) who made the initial Adverse Benefit Determination, or those person(s) who made the first level Grievance review decision. The Committee may consist of:

- Grievance and Appeals Manager
- Grievance and Appeals Administrator(s) (**Important note:** The role of the Grievance and Appeal Administrator(s) is solely to impartially present the facts of the case at hand. The Grievance and Appeal Administrator does not vote or otherwise influence the proceeding.);
- Quality Management Director (or designee);
- Provider Operations Director (or designee);
- Customer Service Director (or designee);
- Claims Director (or designee);
- Sales and Marketing Director (or designee);
- Utilization Management Director (or designee);
- Benefits Director (or designee); and
- VISTA's Medical Director that was not involved in the initial Adverse Benefit Determination or first level review.

The Committee shall conduct regular meetings on at least a biweekly or monthly basis (unless there is no business to be transacted at such meeting).

Member: means an individual who has contracted, or on whose behalf a contract has been entered into, with VISTA for health care services.

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

Post-Service Grievance: means a Grievance for which an Adverse Benefit Determination was rendered for a service that was already provided, and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.

Pre-Service Grievance: means any Grievance for which a requested service requires prior authorization, an Adverse Benefit Determination was rendered and the requested service was not

provided and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.

Relevant: means a document, record or other information that:

- a. was relied upon in making a benefit determination;
- b. was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- c. demonstrates compliance with the federal requirements for safeguards designed to ensure and to verify that benefit claim determinations were made in accordance with governing plan documents and that, where appropriate, the plan provisions were applied consistently with respect to similarly situated Members; or
- d. constitutes a statement of policy or guidance with respect to VISTA concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Retrospective Review: means a review, for coverage purposes, of medical necessity conducted after services were provided to the Member.

SAP: means the Subscriber Assistance Program.

Urgent Grievance: means a Grievance for which a requested service requires prior authorization, or an extension of concurrent care is being requested; an Adverse Benefit Determination was rendered; the requested service has not been provided; and the application of non-urgent care Grievance time frames could seriously jeopardize: (a) the life or health of the Member or the Member's unborn child; or (b) the Member's ability to regain maximum function. An Urgent Grievance is also a Grievance where application of the non-Urgent timeframes would, in the opinion of a physician with knowledge of the Member's medical condition, subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

C. Complaints

To advise VISTA of a Complaint, the Member should first contact Customer Service, either by telephone or in person. The Customer Service telephone is listed on the Member identification card. The Member must provide to the Customer Service Representative all of the facts relevant to the Complaint. The Member's failure to provide any requested or relevant information may delay VISTA's review of the Complaint. Consequently, the Member is obliged to cooperate with VISTA in its review of the matter.

The Customer Service Representative, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction.

If the Complaint cannot be resolved to the Member's satisfaction, and the Member remains dissatisfied, the Member may submit a Grievance for formal review.

D. Grievances

The Member, or an Authorized Representative of the Member, may submit a Grievance. VISTA will provide the Member the forms necessary to initiate a Grievance. The Member may request these forms by contacting the Customer Service telephone number listed on their Member ID card. While the Member is not required to use VISTA's pre-printed form, VISTA strongly encourages that Grievances be submitted on such a form to facilitate logging, identification, processing, and tracking of the Grievance through the review process.

If the Member needs assistance in preparing the Grievance, or in submitting a Grievance verbally, the Member may contact VISTA for such assistance. Hearing impaired Members may also contact VISTA via TDD at 1-888-444-7352.

Members (or their Authorized Representatives) must file a first level Grievance within **1 year** from occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination. If the decision of the first level Grievance is still unfavorable to the Member, the Member may:

- In the case of an Urgent Grievance, directly request review by the state Subscriber Assistance Program;
- In the case of a Grievance not involving an Adverse Benefit Determination, directly request review by the state Subscriber Assistance Program; or
- In the case of a Grievance involving an Adverse Benefit Determination, request a second level Grievance within 31 days of the date on VISTA's first level Grievance decision letter.

Within 5 business days of receiving a first or second level Grievance, VISTA will send the Member (or Authorized Representative) a letter acknowledging receipt of the Grievance. Except as stated below regarding Grievances related to non-Adverse Benefit Determinations, VISTA will respond to all first and second level Pre-Service Grievances within fifteen (15) calendar days, and all first and second level Post-Service Grievances within thirty (30) calendar days.

The timeframes in which VISTA must review Grievances may be extended if VISTA needs to collect information from outside the service area in order to properly review the Grievance. If this extension is necessary, VISTA will notify the Member in writing. The extension will not be longer than 30 days. Once the information is collected, VISTA will resume review of the Grievance according to the applicable timeframes.

If the first or second level Grievance is resolved in the Member's favor, the notice to the Member ("Grievance Decision Letter") will advise of the favorable determination and further instructions on authorization of services and/or claims payment.

If the first or second level Grievance is not resolved in the Member's favor, the Grievance Decision Letter will be drafted clearly and include the following information:

- The specific reason(s) for the Grievance decision;
- Reference to the specific plan provision on which the Grievance decision is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the Member's Grievance;
- A statement describing any further procedures for review rights offered by VISTA, if any, and the Member's right to obtain information about the procedures and a statement of the Member's right to bring action under the Employee Retirement Income Security Act of 1974, if applicable;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Grievance decision, a statement that such rule, guideline, protocol or other criterion was relied upon in making the Grievance decision and that a copy of such rule, guideline, protocol or other criterion will be provided upon request and free of charge;
- If the Grievance decision is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the specific clinical judgment for the decision, applying the terms of the benefit plan to the Member's medical circumstances, or notice that a written explanation of the clinical rationale is available upon request and free of charge;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. DOL office and your State insurance regulatory agency; and
- In any case when VISTA issues a first level Grievance Decision Letter related to (a) an Urgent Grievance; or (b) a non-Adverse Benefit Determination; or a second level Grievance

Decision Letter, VISTA will notify the Member of (1) the Member's right to request a review of VISTA's decision concerning the Grievance to the SAP, as provided in Section 408.7056 of the Florida Statutes, within **365 days** after receipt of the final decision letter; (2) how to initiate such review; (3) the addresses and toll-free number of AHCA and SAP; and (4) the name of the appropriate employees or a list of grievance departments responsible for implementing the Grievance procedure and their address and toll-free number. This right of SAP review extends to both standard and expedited Grievances. The Member can initiate a review by communicating to: AHCA, Bureau of Managed Health Care, Building 1 Room 339, 2727 Mahan Drive, Tallahassee, FL 32308, (850) 921-5458 in accordance with Section 408.7056, F.S

➤ **Grievances Regarding Non-Adverse Benefit Determinations**

Grievances regarding such issues as: (1) quality of service; (2) allegations of VISTA agent misrepresentation or provider discrimination; or (3) non-clinical potential provider issues will be researched by VISTA and VISTA will send the Member written notice of investigation results and actions taken by VISTA within an appropriate amount of time, not to exceed **30 calendar days** from the date the Grievance was received by VISTA.

➤ **Grievances Regarding Adverse Benefit Determinations**

Grievances involving Adverse Benefits Determinations based, in whole or in part, on medical judgment will be reviewed by a Clinical Peer, or by a Committee that is comprised of a majority of persons who are Clinical Peers.

Upon request, the Member may present their case, in person or via telephone, to the Committee hearing the second level Grievance. The Member's presentation will be limited to a maximum of **15 minutes** (mirroring the State of Florida's guidelines for SAP review) and such time limit shall include presentations offered by others on behalf of the Member, such as the treating provider, an attorney, or other representative.

➤ **Expedited Review of Urgent Grievances**

1. Members may request expedited review of an Urgent Grievance if the application of the standard Grievance review timeframes would seriously jeopardize the Member's life or health (or in the case of a pregnant woman, the life/health of the unborn child), or the Member's ability to regain maximum function. Expedited review may also be applied where application of the standard Grievance review timeframes would, in the opinion of a physician with knowledge of the Member's medical condition, subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.
2. The Member, or an Authorized Representative acting on the Member's behalf, must specifically request the expedited review. For example, the request may be made by stating, "I want an expedited review" or "Please review this request in an expedited manner." Only services subject to pre-authorization, or requests for extension of concurrent care services made within twenty-four (24) hours prior to the termination of authorization for such on-going services, may be subject to expedited review.
3. A Member may request an Urgent Grievance for the first time (similar to a first level Grievance). If VISTA's decision on review of the Urgent Grievance is unfavorable to the Member, the Member must then request a review by the Subscriber Assistance Program. Second level reviews are not offered by VISTA for Urgent Grievances. However, if a Member initially requested a first level Grievance (non-Urgent) related to an Adverse Benefit Determination and VISTA upheld its initial Adverse Benefit Determination, the Subscriber will not be precluded from requesting second level Grievance as an Urgent Grievance, if relevant.
4. Generally, in determining whether a Grievance will be subject to the expedited timeframes applicable to Urgent Grievances, VISTA must apply the judgment of a

prudent layperson that possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Member's medical condition requests an Urgent Grievance, the Grievance shall be deemed as such.

5. Within **24 hours** after receiving an Urgent Grievance, VISTA's Grievance and Appeal Administrator will collect and forward all relevant information to an appropriate Clinical Peer(s) who shall perform the expedited review. The Clinical Peer will not have been involved in making the initial Adverse Benefit Determination, or if applicable, the first level Grievance decision, nor be a subordinate to someone who was.
6. VISTA will notify the Member (or their Authorized Representative) of VISTA's benefit determination on review as expeditiously as the Member's medical condition requires, but no more than **72 hours** after VISTA's receipt of the request for review of the Urgent Grievance. If the expedited review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member is notified of the determination. Written notice of the final decision concerning expedited review of an Urgent Grievance will be provided to the Member or their Authorized Representative within **2 working days**, if the initial notification was not already provided in writing.
7. If the Member's request for expedited review arises out of an Adverse Benefit Determination that a continued hospitalization or continuation of a course of treatment is not Medically Necessary, coverage for the course of treatment or hospitalization shall continue until the Member is notified of the Grievance decision.
8. VISTA will not honor a request for expedited review that relates to services that have already been performed, rendered, or provided to the Member, or a request that is not eligible for expedited review (Urgent Grievance). VISTA will process any such Grievances in accordance with its standard Grievance time frame.
9. **If it is VISTA's decision to uphold the initial Adverse Benefit Determination, the Member will be notified of their right to request review by the Subscriber Assistance Program, as discussed below. No second level review of Urgent Grievances is available through VISTA's internal Grievance process.**

E. Subscriber Assistance Program

The Member may, at any time, send a copy of his/her Grievance to the OIR, or AHCA, or the SAP. However, the Member must exhaust, and receive a final disposition from, VISTA'S internal Grievance Program, as described in this Section, before requesting review by the SAP. The Member must submit Grievances for review by the SAP within three-hundred and sixty-five (365) days of VISTA's second level Grievance Decision Letter.

F. General Rules and Information

General rules regarding VISTA's Complaint and Grievance Process include the following:

1. The Member must cooperate fully with VISTA in Our effort to promptly review and resolve a Complaint or Grievance. In the event the Member does not fully cooperate with VISTA, the Member will be deemed to have waived the Member's right to have the Complaint or Grievance processed within the time frames set forth above.
2. VISTA will offer to meet with the Member if the Member believes that such a meeting will help VISTA resolve the Complaint or Grievance to the Member's satisfaction. For the Member's convenience, and at the Member's option, the Member may elect to meet with Our representatives in person or by telephone conference call. VISTA will not reimburse the Member for travel or lodging in connection with any such meeting. Appropriate arrangement will be made to allow telephone conferencing to be held at Our administrative offices. VISTA will make these telephone arrangements with no additional charge to the Member. The Member must notify

VISTA that the Member wishes to meet with its representatives concerning the Complaint or Grievance.

3. VISTA will not honor a request for expedited review that relates to Services that have already been performed, rendered, or provided to the Member or a request that is not eligible for expedited review of an Urgent Grievance. VISTA will process any such Grievance, however, in accordance with the standard Grievance procedure.
4. VISTA must receive all Grievances within one (1) year after the date of the occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.
5. If the Grievance involves a determination that the Services did not meet VISTA's guidelines for coverage of a Service or that the Service is excluded because it meets the definition of an Experimental or Investigational Service or a similar exclusion or limitation, then the Member may request an explanation of the scientific or clinical judgment relied upon, if any, for determination, that applies the terms of the Contract to the Member's medical circumstances.
6. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
7. The member may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

G. Telephone Numbers and Addresses

The member may contact a VISTA Grievance Coordinator at the number listed on the acknowledgement letter or Grievance Decision Letter. If a Grievance is unresolved, or at any time, the Member may contact an agency at the telephone numbers and addresses listed below.

Department of Financial Services

Division of Consumer Services
200 E. Gaines St.
Tallahassee, FL 32399-0322
1-800-342-2762

Subscriber Assistance Program

2727 Mahan Drive, Building 1, Room 339 Mail Stop-27A
Tallahassee, FL 32308
1-850-921-5458
1-888-419-3456

VISTA

In person or in writing:

Attention: Grievance Department
1340 Concord Terrace
Sunrise, FL 33323
Customer Service: 1-866-VISTA-FL (1-866-847-8235)
Hours: Monday through Friday, 8 a.m. – 6 p.m.
TDD: 1-888-444-7352

SECTION 8 COORDINATION OF BENEFITS

A. Avoidance of Duplicate Payment

The Coordination of Benefits provision is intended to assure that a Member covered under any other Health Plan receives as much of his/her medical services as possible, while avoiding duplicate payment of Covered Services. Health Plans include:

1. Coverage under government programs (excluding Workers' Compensation and Medicaid) required or provided by a statute unless law forbids coordination of benefits with any such program.
2. Group coverage (other than group automobile insurance) or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including any prepayment coverage, group practice or individual practice coverage and any coverage for students which is sponsored by, or provided through, a school or other educational institution above the high school level and individual and family (or non-group) plans.

B. Definition of Health Plan

The term "Health Plan" shall be construed separately with respect to:

1. Each policy, contract or other arrangement for benefit or services.
2. The portion of any such policy, contract or other arrangement which reserves the right to take the benefits of other Health Plans into consideration in determining its benefits and that portion which does not.

C. Rules

Should a Member be covered by or under any other Health Plan, in addition to coverage under this Group Agreement, the following provisions and rules shall determine whether VISTA or the other Health Plan is primarily responsible for paying the costs of benefits and services.

1. Benefits Subject to this Provision

All of the benefits and services, which VISTA is obligated to provide under this Group Agreement, are subject to the provisions of this Section. Copayments, Deductibles and/or Coinsurance are required, even if a Member is covered under other health insurance.

2. Determination of Benefits

a. Wherever the sum of all benefits available under this Group Agreement determined without regard to this provision and all benefits available under all other Health Plans determined without regard to provisions similar to this exceed the amount payable by VISTA under this Agreement, and in accordance with applicable law, during the Claim Determination Period, the benefits that would otherwise be payable by VISTA in the absence of this provision shall be reduced by such excess. Benefits payable under other health insurance include the benefits that would have been payable had claim been duly made therefore.

b. The following rules apply to determination of benefits:

- (1) The benefits of a policy or plan which covers the person as an employee, Member, or Member and not as a dependent are determined before those of the policy or plan which covers the person as a dependent.

- (2) Except as stated below, when two (2) or more policies or plans cover the same child as a dependent of different parents:
 - (a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time. However, if a policy or plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan shall determine the order of benefits.
- (3) If two (2) or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) First, the policy or plan of the parent with custody of the child;
 - (b) Second, the policy or plan of the spouse of the parent with custody of the child; and
 - (c) Third, the policy or plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if such parent has actual knowledge of those terms, the benefits of that parent's policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.
- (4) The benefits of a policy or plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph shall not apply.
- (5) If none of the rules set forth in this Group Agreement determine the order of benefits, the benefits of the policy or plan which covered a Member for a longer period of time are determined before those of the policy or plan which covered that person for the shorter period of time.
 - (a) None of the above coordination of benefits rules shall serve as a barrier to the Member first receiving direct health care services under VISTA where such services are covered under this Group Agreement.
 - (b) Whenever an VISTA Member is also a Medicaid recipient, VISTA's coverage shall be primary to the recipient's Medicaid benefits and VISTA shall be a third party subject to the provisions of Florida Statute 409.266(3)(c).

D. The Effect of COBRA

The Plan which covers the person as an employee (or as that employee's dependent) is the primary Plan; the Plan which covers the person pursuant to COBRA is the secondary Plan.

E. The Effect of Medicare

This Plan will be primary to Medicare as required by the Tax Equity and Fiscal Responsibility Act (TEFRA/DEFRA), the Omnibus Budget Reconciliation Act (OBRA), and other laws and regulations applicable to GROUP.

F. The Effect of Automobile Coverage

This Group Agreement is not in lieu of and does not affect any requirement for, or coverage by, or benefits paid by Automobile Insurance. VISTA will not pay for benefits that are covered under the Automobile Insurance. The rules of this Group Agreement should be followed in the event Automobile Insurance is exhausted or does not pay for the injury.

G. Right to Receive and Release Necessary Information

VISTA may release any information considered to be necessary for VISTA Coordination of Benefits with respect to any person claiming benefits under this Group Agreement without consent of, or notice to, the Member or any other person or organization. However, VISTA shall not be required to determine the existence of any other Group Agreement or insurer or the benefits payable under such plan or insurer when computing services or benefits due a Member covered under this Group Agreement.

H. Facility of Payment

Whenever payments which should have been made under VISTA coverage in accordance with this provision have been made under any other health plan or insurer, VISTA will have the right to pay over to such health plan or insurer any amount VISTA will determine to be warranted in order to satisfy the intent of this provision. Any amounts so paid shall be deemed to be benefits under this Group Agreement, and to the extent of such payments, VISTA will be fully discharged from liability under this Group Agreement.

I. Right of Recovery

Whenever VISTA payment for Covered Services exceeds the maximum amount of payment necessary to satisfy the intent of this provision, VISTA shall have the right to recover such payment to the extent of such excess, from any insurer, any organization, or any person(s) to whom such payments were made.

J. Disclosure

Each Member agrees to disclose to VISTA at the time of enrollment, at the time of receipt of services and benefits, and from time to time as requested by VISTA the existence of other health insurance coverage, the identity of the carrier, and the group through whom provided.

SECTION 9 TERMINATION OF COVERAGE

A. Upon Notification

This Group Agreement may be terminated by either VISTA in accordance with the terms of this Group Agreement or by the Group upon written notice to VISTA at least sixty (60) days prior to the termination date. Such termination by VISTA or the Group shall occur at midnight of the day preceding the termination date. In the event either party gives no such notice, this Group Agreement shall continue in effect for another Contract Year unless terminated pursuant to other provisions of this Group Agreement.

B. Termination of Subscriber's Coverage

Unless otherwise prohibited by law, if in VISTA's opinion any of the following events occur, VISTA may terminate a Covered Person's coverage as specified below:

1. The date specified by VISTA due to the Covered Person's disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Covered Person's continued Membership in the Group Plan, impairs Our ability to provide coverage and/or benefits or to arrange for the delivery of health care services to such Covered Person or to other Covered Persons. Prior to disenrolling a Covered Person for any of the above reasons, VISTA will:
 - a. make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of VISTA'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 VISTA that all coverage will terminate due to: (a) fraud or material misrepresentation in applying for or presenting any claim for benefits under this Group Plan; or (b) permitting the use of his or her Membership Card by any other person or (c) furnishing of false or incomplete information on the enrollment forms, or other forms completed for VISTA, by or on behalf of the Member for the purpose of fraudulently obtaining coverage. False, material information includes, but is not limited to information relating to residence and/or employment, information relating to another person's eligibility for coverage or status as a Dependent. VISTA has the right to rescind coverage back to the effective date, in accordance with s. 641.31(23), Florida Statutes, *Time Limit on Certain Defenses*.
3. The date specified by VISTA if the Member is no longer eligible for coverage, based upon the Group's eligibility requirements, or due to the Member leaving VISTA's Service Area with the intention to relocate or establish a new residence.
4. The date specified by VISTA if a Covered Dependent reaches the limiting age as specified in the Eligibility Section of this Group Plan or if a court order, including a qualified medical child support order, covering a dependent child is no longer in effect.
5. If the Member or the Group does not pay premiums, such termination, and notice thereof, to be in accordance with the terms and conditions of the Group Agreement.
6. The date that the Group Agreement between the Group and VISTA terminates for any reason whatsoever.

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

NOTE: "Time Limit on Certain Defenses", Relative to a misstatement in the application, after two (2) years from the issue date, only fraudulent misstatements in the application may be

used to void the policy or deny any claim for loss incurred or disability starting after the two (2) year period.

C. Termination of a Dependent's Coverage

Unless otherwise prohibited by law, a Covered Dependent's coverage may be terminated by VISTA for any of the following reasons:

1. The Group Agreement between the Subscriber and VISTA ends for any reason;
2. The Subscriber's coverage ends for any reason;
3. The Dependent fails to continue to meet each of the Dependent eligibility requirements under this Group Agreement;
4. The Dependent becomes covered under another health benefit plan that is offered through or in connection with the Subscriber as an alternative to this Group Agreement; or
5. A court order, including a qualified medical child support order covering a Dependent is no longer in effect.

D. Ineligibility for Coverage

1. Death of Subscriber

Upon the death of the Subscriber, coverage under this Group Agreement shall automatically terminate as of the date of his death and as to his Covered Dependents, as of the date to which Premiums have then been paid. In the event that the Group and VISTA determine that a surviving family member shall remain as a Covered Dependent in accordance with the Group's eligibility rules, then such Member's coverage shall continue in effect as if the Subscriber were not deceased, except that no Premiums shall be due with respect to the deceased Subscriber and any action with reference to VISTA required to be taken by the Subscriber shall be taken by the Covered Dependent who is the deceased Subscriber's spouse or, if none, then by the eldest Covered Dependent (or his legal guardian if such Covered Dependent is a minor or legally incapacitated).

2. Severance of family relationship or retirement if the Group's health benefits do not extend to retirees.

3. Subscriber No Longer Eligible

If the Subscriber ceases to be eligible (other than by reason of death), his/her coverage and that of the Covered Dependent's coverage under this Group Agreement shall automatically terminate as of the date to which Premium charges have then been paid.

4. Covered Dependent no Longer Eligible

If a Covered Dependent ceases to be eligible, his/her coverage under this Group Agreement shall automatically terminate in accordance set forth in this Group Agreement.

Upon termination of the Individual's coverage for any reason, VISTA shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Group Agreement.

NOTE: VISTA has the right to terminate coverage back to the effective date, in accordance with s. 627.607, Florida Statutes, "Time Limit on Certain Defenses" states, "Relative to a misstatement in the applications, after two (2) years from the issue date, only fraudulent misstatements in the applications may be used to void the coverage or deny any claim for loss incurred or disability starting after the two (2) year period."

SECTION 10 CONTINUATION OF COVERAGE

If coverage for a Member ends, the Member may, depending on his/her situation, have the right to have coverage extended under the extension of benefits provision. Also, the Member may be eligible for coverage under the federal coverage provisions or a health benefit plan under the conversion privilege provision.

A. Extension of Benefits (Post Termination Disability Coverage)

If VISTA's Group Agreement with the Group terminates for any reason and the Member is Totally Disabled on the effective date of termination, he or she may be entitled to continue to receive the benefits under this contract for the treatment of the condition or illness or injury resulting in the total disability until the earlier of:

1. Twelve (12) months from the effective date of the termination of coverage;
2. The Member receives the maximum benefit payable under this Agreement; or
3. A succeeding carrier elects to provide replacement coverage without limitation as to the disabling condition; or
4. The Member is no longer totally disabled as a result of the condition or illness that existed and manifested itself as of the effective date of the termination of coverage.

In the case of maternity coverage, an extension of benefits is provided. The extension is for the period of the pregnancy and is not based on total disability.

For the purposes of this section, an individual is totally disabled if the individual has a condition resulting from an illness or injury which prevents an individual from engaging in any employment or occupation for which the individual is or may become qualified by reason of education, training, or experience, and the individual is under the regular care of a physician.

Except as provided in above, no subscriber is entitled to an extension of benefits if the termination of the contract by VISTA is based upon:

1. Fraud or intentional misrepresentation, subject to the limitations of "Time limit on certain defenses";
2. Disenrollment for cause as outlined in Florida Statute; or
3. The subscriber has left VISTA's geographic area with the intent to relocate or establish a new residence outside VISTA's geographic area.

B. COBRA

Federal law (the Consolidated Omnibus Budget Reconciliation or "COBRA"), as amended, permits Members to continue coverage under an employer-established health benefit plan under certain circumstances. This provision does not apply to employers with fewer than twenty (20) employees. Covered Employees should consult with the Employer regarding the availability of this option. It is the Employer's responsibility to make employees aware of any COBRA rights they may have.

A qualified beneficiary must make timely election of COBRA coverage. An election is considered timely if it is made during the election period. The COBRA election period begins on or before the date that the qualified beneficiary would lose coverage due to a qualifying event. The election period ends sixty (60) days from the later of:

1. The date coverage is lost due to the qualifying event; or

2. The date the qualifying beneficiary is given notice of the right to elect COBRA coverage.

Member responsibilities include:

1. A Member must contact the Group to determine if he/she is entitled to COBRA continuation coverage.
2. If a Member is eligible for COBRA, he/she may elect to continue group health benefits if he/she qualifies under one (1) of the circumstances specified in COBRA and satisfies all of the requirement for such coverage, including payment of required Premiums.
3. The Member must provide the Group with all required notices, in the form and within the time period required by COBRA and the Group, including but not limited to, notice of:
 - a. Medicare entitlement, divorce or legal separation, or the failure of a Covered Dependent child to meet eligibility requirements of the Group Agreement.
 - b. Coverage under another group Health Plan.
 - c. With respect to the Member's ability to receive additional periods of coverage under COBRA in the event that the Member is disabled, a determination by the Social Security Administration that the Member is disabled, or a determination by the Social Security Administration that the Member has ceased to be disabled.

A Member must apply for continuation coverage under COBRA. Upon exhaustion of coverage, or if the Member is not eligible for COBRA, he or she may be eligible to apply for coverage under the Conversion privilege. A request for conversion coverage must be made no later than sixty-three (63) days from termination of coverage under this health benefit plan.

C. Conversion Plans

In the event a Member's Group coverage terminates for any reason other than those set forth in this Group Agreement, the Member may elect to apply immediately for conversion. Neither VISTA nor the Group has any obligation to notify any such individual of the conversion privilege. Such individual has the sole responsibility to exercise this conversion privilege.

The Member should contact VISTA Enrollment Department at 954-962-3008 x1804 immediately following termination and give Us notification of interest in conversion. VISTA will mail to the eligible individual within fourteen (14) days, an Election and Premium Notice Form including Outlines of Coverage for the conversion plans available. The individual must return the completed application and the first monthly premium to VISTA no later than sixty-three (63) days after termination of Group coverage.

Members' eligibility for conversion coverage shall be strictly subject to the following requirements and conditions set forth below:

1. Member must have been a Member (or have been covered under any group contract providing similar benefits hereto) for at least three (3) months immediately prior to termination of Member's coverage hereunder;
2. Member must not be covered or be eligible for coverage under Medicare;
3. Member must not be 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 any other plan;

4. Member must not be eligible for similar benefits, whether or not covered thereby, under any arrangement of coverage for individuals in a group, whether on an insured basis or uninsured basis;
5. Member must not be entitled to receive similar benefits pursuant to or in accordance with the requirements of any state or federal law.
6. To be eligible for conversion, the Member must not have lost his or her eligibility for coverage hereunder for any of the following reasons:
 - a. failure to pay any require premium or contribution unless such nonpayment of premium was due to acts of an employer or person other than the individual;
 - b. replacement of any discontinued group coverage by similar group coverage within thirty-one (31) days;
 - c. fraud or intentional misrepresentation in applying for any benefits under this Group Agreement.

D. Scope of Conversion Coverage

At the time of application, the individual will be offered a choice of at least two (2) conversion plans; the Standard conversion plan and at least one other plan in which benefits are substantially similar to the level of benefits of this Group Agreement. The conversion plan shall cover only the Subscriber and those dependents covered by this Group Agreement on the date of termination of Member's coverage hereunder. Such conversion coverage may continue in effect, provided that each individual who has converted to the conversion contract continues to meet all applicable eligibility requirements, pay all premiums, and otherwise complies with all requirements set forth in the conversion contract.

VISTA's conversion plans are monthly policies whereby a Member is required to pay monthly for coverage. Pro-rated refunds are not available under these policies. Conversion plan Members contract directly with VISTA and have no further interaction with their former employer. The premium for conversion coverage shall be determined in accordance with premium rates applicable to the age and class and risk of each person to be covered and shall be paid in advance on a quarterly basis to VISTA.

Upon receipt of an application not later than sixty-three (63) days after termination of Group coverage and payment of the first monthly premium, the effective date of the conversion contract shall be the day following termination of coverage hereunder.

Issuance of conversion coverage shall not be subject to evidence of health qualification of the Member. Furthermore, conversion coverage shall not exclude a Pre-existing Condition not excluded by the Group Agreement. The conversion contract will provide that any benefits thereunder shall be reduced by the amount of any coverage or benefits afforded under this Group Agreement after the Member's termination of coverage. During the first coverage year, the coverage or benefits under the converted contract shall not exceed those that would have been provided had the individual's coverage or benefits under the Group Agreement remained in force.

Please note that if the employee qualifies for COBRA or State of Florida Continuation Coverage, conversion benefits take place at the end of the federal or state continuation period, if written application is made and the first monthly payment is made within sixty-three (63) days of the date coverage under the continuation plan ends.

SECTION 11 MISCELLANEOUS

A. Records and Information

1. It is the Member's responsibility to insure that any Healthcare Professional, Hospital, insurance company, employee benefit association, governmental body or program, or any other person or entity with knowledge of or records relating to:
 - a. any illness or injury for which benefits are claimed under this Group Agreement,
 - b. any medical history which might be pertinent to such illness or injury or claim or
 - c. any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such claim,to furnish VISTA, at any time upon its request, any and all information and records (or copies of records) relating to such illness, injury or claim.
2. VISTA may furnish similar information and records (or copies of records) to any insurance company, governmental body or program or other entity providing insurance type benefits requesting the same.

B. Notices

1. Any notice under this Group Agreement, required of the Subscriber or the Group may be mailed to the following address:

Vista Healthplan, Inc.
1340 Concord Terrace
Sunrise, Florida 33323
2. Any notice required of VISTA shall be sufficient if mailed to the holder of this Group Agreement, at the address appearing on the records of VISTA.

C. Civil Remedy

In any civil action brought to enforce the terms and conditions of a VISTA contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. This Section shall not be construed to authorize a civil action against the Department of Financial Services.

D. Entire Group Agreement

This Group Agreement and any attached riders and the Binder and Agreement constitute the entire contract between the Group and VISTA. To be valid, any change in the form must be approved by an officer of VISTA and attached to the affected form and no agent has the authority to change the form or waive any of the provisions.

E. Member's Copy

A copy of this Group Agreement, all Attachments, Applications, and forms hereto will be provided to the Member.

F. Workers' Compensation

This Group Agreement is not in lieu of and does not affect any requirement for, or coverage by, or benefits paid by Workers' Compensation Insurance. VISTA will not pay for benefits that are covered under Workers' Compensation. The rules of this Group Agreement should be followed in the event Workers' Compensation and/or Automobile Insurance does not pay for the injury.

G. Refusal to Accept Treatment from Participating Healthcare Professionals

For personal reasons, You may refuse to accept procedures or treatment from a Participating Healthcare Professional. The Healthcare Professional may regard such refusal to accept his or her recommendation as incompatible with continuance of the physician-patient relationship and if no acceptable alternative exists for what the physician believes to be proper medical care, You will be so advised in writing. If You still refuse to accept the recommended treatment, neither VISTA nor the Participating Healthcare Professional will be responsible for treatment of the condition.

H. Relationship of Parties

Healthcare Providers, including Participating Providers under an independent contract, are not agents or employees of VISTA, nor is VISTA or any of its employees, an employee or agent of Healthcare Providers. VISTA shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You in connection with the furnishing of, or failure to furnish services by any Healthcare Providers.

I. General Limitation

In the event that, due to circumstances not within the control of VISTA, including but not limited to: a major disaster; epidemic; the complete or partial destruction of facilities; riot; civil insurrection; disability of a significant part of VISTA's Participating Provider's personnel or similar causes, the rendering of Professional Services or Hospital Services provided under this Contract is delayed or rendered impractical, VISTA shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, VISTA and Participating Providers shall render the Hospital and Professional Services provided under this Contract insofar as practical, and according to their best judgment. VISTA and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

J. Termination

This Group Agreement shall remain in effect for the first Contract Year and thereafter for successive Contract Years unless terminated earlier as provided herein. The effective time for any dates used is 12:01 A.M. at the address of the Subscriber.

K. Amendment

This Group Agreement may be amended at any time, without the consent of the Members, or any other person having a beneficial interest in it, upon written request made by the Group and agreed to by VISTA. Any such amendment shall be without prejudice to any claim arising prior to the date of such amendment.

L. Force Majeure

No party to this Agreement shall be liable for any default or delay in the performance of its obligations hereunder if and to the extent the default or delay is caused, directly or indirectly, by strikes, picketing, insurrection, acts of God, military actions, terrorist attacks, war, emergencies, shortages or unavailability of materials or other causes beyond a party's reasonable control (a "Force Majeure Event"), and such party shall be excused from performance and shall not be considered to be in default hereunder in respect to the affected obligation. The suspension of performance due to a Force Majeure Event shall be of no greater scope and no longer duration than that which is reasonably necessary. The excused party shall use its reasonable best efforts to remedy its inability to perform as soon as possible.

M. Performance Outcomes and Financial Data

You may obtain information regarding performance outcomes and financial data for VISTA published by the State of Florida Agency for Health Care Administration by accessing the VISTA website www.vistahealthplan.com. This website includes the link to FloridaHealthStat where this information is published, or You can go directly to www.floridahealthstat.com.

N. Third Party Beneficiary

This Group Agreement is entered into exclusively between VISTA and the Subscriber. This Group Agreement is intended only to benefit the individual Subscribers and their dependents covered under this Group Agreement and does not confer any rights to any third parties. There are no intentional or incidental third-party beneficiaries to this agreement.

O. Construction

VISTA shall interpret this Agreement including any terms or provisions which may otherwise be or appear to be ambiguous, whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions, and interpretations made by VISTA, and in accordance with applicable law, shall be binding upon the Member.

SECTION 12 DEFINITIONS

As used in this Certificate of Coverage, the following words and phrases shall apply:

Accredited Institution: a secondary, college, university or trade school which is certified or licensed by a state.

Acute: sudden onset, acting keenly on the senses; sharp, brief and severe.

Administrator: VISTA and/or its designated agents who perform a number of administrative duties, including processing all claims occurring under this Agreement.

Allowed Amount: the amount that a Participating Provider has agreed to accept as payment in full for Covered Services.

Ambulatory Surgical Center: a facility duly licensed and billing as a freestanding ambulatory surgical center pursuant to applicable state and federal law, the primary purpose of which is to provide surgical care to a patient, admitted to and discharged from such facility within the same working day, as listed on VISTA's internet website www.vistahealthplan.com.

Anniversary Date: the yearly return of the Effective Date.

Annual Open Enrollment Period: an annual thirty (30) day period, beginning no less than thirty (30) days prior to the Anniversary Date of the Group's health benefits program, during which:

1. If the Group has established and maintained more than one health coverage plan for their Eligible Employees, an Eligible Employee who had elected another plan, and maintained coverage under that plan up to the beginning of the Annual Open Enrollment Period, can change to this Group Agreement.
2. Employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under this Group Agreement during the Initial or Special Enrollment Periods can enroll.

Birthing Center: an outpatient facility, as listed on VISTA's internet website www.vistahealthplan.com which:

1. complies with licensing and other legal requirements in the jurisdiction where it is located;
2. is engaged mainly in providing a comprehensive birth services program to pregnant individuals who are considered normal low risk patients;
3. has organized facilities for birth services on its premises;
4. has birth services performed by a Healthcare Professional specializing in obstetrics and gynecology, or at his or her direction, by a midwife or nurse midwife; and
5. has a twenty-four (24)-hour-a-day Registered Nurse service.

Calendar Year: a period of one (1) year that starts January 1 and ends December 31.

Chronic: lasting a long time, lingering, long duration involving very slow changes.

Coinsurance: the sharing of expenses for Covered Services between VISTA and the Member. Coinsurance is expressed in a percentage rather than a dollar amount.

Complications of Pregnancy: is a Condition diagnosed as separate from a pregnancy. Complications means a condition, requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, therapeutic abortion, non-elective Caesarean section, tubal pregnancy which is terminated; miscarriages; or medical and surgical conditions of similar severity. Complications of pregnancy do not include false labor, occasional spotting, Healthcare Professional prescribed bed rest during the period of pregnancy, morning sickness, uncontrolled vomiting; convulsions and high blood pressure; or similar conditions associated with a difficult pregnancy.

Condition: the state in which a person has any sickness, illness, injury, bodily dysfunction or pregnancy.

Copayment: a specific dollar amount, except as otherwise provided for by statute that the Member must pay upon receipt of Covered Services. Healthcare Professionals have the obligation to collect these Copayments.

Cosmetic Services and Surgery: plastic or reconstructive surgery: (1) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

Covered Dependent: an Eligible Dependent who receives health care benefits through VISTA and meets the dependent criteria specified in the Eligibility Section of this Group Agreement.

Covered Services: those Medically Necessary professional services of Healthcare Professionals or other Providers, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services and supplies specified in the Covered Services Section of this Group Agreement, listed on the Schedule of Benefits or any rider, amendment or endorsement attached.

Custodial Care: care primarily provided to assist a patient in meeting the activities of daily living such as help in walking; getting out of bed; bathing; dressing; feeding and preparation of special diets; and supervision of medications which are ordinarily self-administered.

Deductible: the amount a Member must pay before VISTA will make any payment toward Covered Services.

Disease: a condition of an organism that impairs normal physiological functioning.

Disposable Medical Supplies: those supplies that are not meant to be re-used by another individual and include, but are not limited to, gauze, tape, syringes, needles, I.V., plastic tubing, canvas/Velcro splints, and blood pressure cuffs.

Durable Medical Equipment (DME): medical equipment furnished by a supplier or a Home Health Agency that:

1. can stand repeated use;
2. is primarily and usually used to serve a medical purpose;
3. is not for comfort or convenience;
4. is appropriate for use in the home; and
5. is generally not useful to You in the absence of a Condition.

Effective Date: the date on which coverage begins for this Group Agreement.

Eligible Dependent: the Subscriber's spouse, natural child, adopted child, stepchild, or child for whom legal guardianship has been established where such child is primarily dependent on the Subscriber for support and lives with the Subscriber in a permanent parent-child relationship.

Eligible Employee: an employee of the Group who works for the Group on a full-time basis, with a normal work week of twenty-five (25) hours or more and is eligible based on the criteria established by the Group.

Eligible Retiree: a retiree of the Group who is eligible for retiree health coverage from the Group based on criteria established by the Group.

Emergency Medical Condition: 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:

1. Serious jeopardy to the health of the patient, including a pregnant woman or fetus;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care: medical screening, examination, and evaluation by a Healthcare Professional to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Healthcare Professional, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Healthcare Professional necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

Enrollment Applications: the forms prescribed by VISTA which the Subscriber shall be required to complete and submit to the Employer for the purpose of enrolling him or herself and any Eligible Dependents for coverage hereunder.

Expenses: the cost incurred for healthcare services and supplies.

Experimental and Investigational Treatment: a drug, device, health service or health product or service is deemed experimental and investigational if one or more of the following criteria are met:

1. any drug, device, health service or product not approved for use by the FDA; any FDA approved drug, device, health service or product prescribed for an off-label use whose effectiveness is unproven based on clinical evidence as reported in peer-reviewed medical literature; or, any drug, device, health service or product that is classified as IND (Investigational New Drug) by the FDA;
2. any drug, device, health product or service that is subject to Investigational Review Board (IRB) review or approval;
3. any drug, device, health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;
4. any drug, device, health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.

Extended Care or Skilled Nursing Facility: an institution or a distinct part thereof, including an intermediate nursing facility, as listed on VISTA's internet website www.vistahealthplan.com which:

1. is licensed pursuant to state and local laws;
2. is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness;
3. is approved by and is a participating facility with Medicare;
4. has organized facilities for medical treatment;
5. provides twenty-four (24)-hours-a-day nursing service under the full-time supervision of a Healthcare Professional or Registered Nurse;
6. maintains daily clinical records on each patient;
7. has available the services of a Healthcare Professional under an established Policy;
8. provides appropriate methods for dispensing and administering drugs and medicines;
9. has transfer arrangements with one (1) or more Hospitals; a utilization review plan in effect; and operational policies developed with advice of and reviewed by a professional group including at least one (1) Healthcare Professional; and
10. is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

Full Time Student: a Member who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Full Time Student status. A student is considered full time during normally scheduled school vacations if he/she is registered to return to that or a similar institution at the end of the vacation. A Member is considered enrolled during summer or holiday vacations when school is not in session.

Gene Testing: examining a sample of blood or other body fluid or tissue for biochemical, chromosomal, or genetic markers that indicate the presence or absence of a genetic abnormality.

Gene Therapy: treatment of disease, condition or genetic abnormality by replacing, altering, or supplementing a gene that is absent or abnormal and is responsible for the disease, condition or pre-disposition to disease.

General Obstetricians and Gynecologists: physicians as listed on VISTA's internet website www.vistahealthplan.com that manage women's care during normal pregnancies. Their obstetric patients are women who are in good health or who have common medical conditions. These physicians also provide preventive and routine gynecologic care including, but not limited to, the treatment of endometriosis, pelvic pain, sexually-transmitted diseases, the symptoms of menopause, and uterine fibroids. They counsel their patients on family planning/contraception and perform gynecologic surgeries including, but not limited to, laparoscopy and endoscopy.

Genetic Counseling: meeting with trained Healthcare Professionals before testing begins, when Members receive the test results, and for appropriate post-testing follow-up.

Group: an employer or other party that has entered into an agreement with VISTA, and through which an employee, retiree and/or his or her Eligible Dependents, if any, may enroll in this Group Agreement.

Group Agreement: the Certificate of Coverage, Binder and Agreement, and all applicable attachments and riders thereto, as duly executed by and between VISTA and the Group.

Health Intervention: an activity taken for the primary purpose of preventing, improving, or stabilizing a Medical Condition. Activities that are primarily Custodial Care, part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered Health Interventions.

Health Outcomes: outcomes of Medical Conditions that directly affect the length or quality of a person's life.

Healthcare Professionals: Physicians, dentists, nurses, midwives, nurse midwives, certified registered nurse anesthetists, advanced registered nurse practitioners, audiologists, podiatrists, osteopaths, chiropractors, ophthalmologists, Physician assistants, clinical psychologists, social workers, mental health counselors, pharmacists, nutritionists, physical therapists, speech therapists and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, are certified, or practice under the authority of a Physician or legally constituted professional association, or other authority consistent with the laws of the State of Florida.

Home Health Agency: an organization licensed by the State and certified by Medicare to render home health services at an outpatient facility, as listed on VISTA's internet website www.vistahealthplan.com.

Hospice: an organization that meets the standards outlined by the National Hospice Association and is licensed, certified and registered as required by Florida law, as listed on VISTA's internet website www.vistahealthplan.com. A Hospice primarily provides services for pain relief, symptom management, and supportive services to terminally ill persons and their families. A Member is considered terminally ill if the Healthcare Professional has certified the Member as having a life expectancy of twelve (12) months or less.

Hospice Care Program: a coordinated, interdisciplinary program:

1. to meet the physical, psychological, spiritual and social needs of terminally ill persons and their families;
2. that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
3. for persons who have a terminal illness and for the families of those persons.

Hospital: an institution, as listed on VISTA's internet website www.vistahealthplan.com which is operated pursuant to law, is accredited by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, and is primarily engaged in providing, on an inpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which services must be provided on its premises under the supervision of a staff of Healthcare Professionals and with twenty-four (24)-hour-a-day nursing service.

Hospital Services: (except as limited or excluded herein) those services furnished and billed by a Hospital or skilled nursing facility.

Identification Card: the card that VISTA issues to a Member upon enrollment. When a Member arrives at a Participating Healthcare Professional to receive Covered Services, the Member must show the Healthcare Professional his/her Identification Card to verify coverage by VISTA.

Infertility: the inability of a woman to conceive a pregnancy after six (6) months of unprotected intercourse or the inability of a woman to carry a pregnancy to live birth.

Infertility Treatment: all services, supplies and drugs related to the diagnosis and treatment of infertility, including but not limited to counseling, testing, semen analysis, ferning, spinbarkeit and Huhner's test, sperm agglutination or penetration studies, hysterosalpingography, endometrial biopsy, laparoscopy,

laparotomy, myomectomy, dilation and curettage, tuboplasty, microsurgical procedures of the female pelvis or male genital tract, ovulation induction and artificial intercervical or intrauterine insemination.

Initial Enrollment Period: the period of time during which an employee or dependent is first eligible to enroll. It starts on the employee's and/or dependent's initial date of eligibility and ends no less than thirty (30) days later.

Injury: an accidental bodily condition that:

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

Large Group Employer: an organization that is actively engaged in business and employs more than fifty (50) Eligible Employees as of the Effective Date and subsequent Agreement Anniversary Dates.

Late Enrollee: any Member who applies for coverage under this Group Agreement other than during the first period in which the Member is eligible to enroll or during a Special or Annual Open Enrollment Period.

Late Enrollment: that enrollment period that is provided for employees and/or their dependents who do not enroll in a timely manner as specified in this Group Agreement and does not meet the requirements of special enrollment.

Medical Condition: a disease, an illness, or an injury. A biological or psychological condition which lies in the range of normal human variation is not considered a disease, illness, or injury.

Medical Services: (except as limited or excluded under this Group Agreement) those professional services of Healthcare Professionals or other Participating Providers, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services.

Medically Necessary: those services and supplies that are not expressly excluded under this Agreement and that are determined by VISTA to be:

1. Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;
2. Necessary to meet the basic health needs of the Member as a minimum requirement;
3. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
4. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan;
5. Consistent with the diagnosis of the condition;
6. Required for reasons other than the comfort or convenience of the Member or his or her physician; and
7. Of demonstrated value based on clinical evidence reported by peer reviewed medical literature and by generally recognized academic medical experts; that is, it is not experimental (investigational; unproven).

Medicare: Title XVIII of the Social Security Act and regulations there under.

Member: the Subscriber or an Eligible Dependent who is covered under this Group Plan and for whom payment has been received.

Member Responsibility: Deductibles, Coinsurance and Copayments, in connection with Covered Services, in accordance with the Member's benefit plan.

Mental Health and Nervous Disorders: disorder that impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin.

Modalities: a form, method, or apparatus of therapy, especially physiotherapy or electrotherapy.

Non-Participating Provider: Healthcare Professional, organization, supplier of healthcare items, or a healthcare facility who does not have a written contract at the time services are provided with VISTA to provide Covered Services to VISTA Members.

Orthognathic Surgery: the surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw) or the maxilla (upper jaw). These malformations may be present at birth, or they may become evident as the patient grows and develops.

Orthotic Devices: devices must (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity, protect against injury or assist with function; and (ii) be rigid or semi-rigid and correct a diagnosed musculoskeletal mal-alignment of a weakened or diseased body part: or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part.

Outpatient: a person who receives care at a Hospital or other facility that does not last longer than twenty-three (23) hours.

Outpatient Diagnostic Center: a facility duly licensed and billing as a freestanding outpatient diagnostic center pursuant to applicable state and federal law, the primary purpose of which is to provide diagnostic services to a patient as listed on VISTA's internet website www.vistahealthplan.com.

Part Time Student: a Member who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Part Time Student status. A student is considered part time during normally scheduled school vacations if he/she is registered to return to that or a similar institution at the end of the vacation. A Member is considered enrolled during summer or holiday vacations when school is not in session.

Participating Provider: any physician or Healthcare Professional, organization, supplier of healthcare items, or a healthcare facility having a written contract at the time services were provided with VISTA to provide medical services to a VISTA Member.

Physician: an individual who is (a) licensed to practice medicine and/or surgery; or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose services are required to be covered under this Contract by the laws of the jurisdiction where treatment is given; or is a partnership or professional association or corporation of such individuals in (a) or (b) above.

Pre-Admission Tests: laboratory tests or x-ray examinations done on an outpatient basis in a Hospital or other facility no more than seven (7) days before a Member is scheduled to be admitted to the Hospital or receives outpatient surgery.

Pre-existing Condition: any condition related to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be treated as a condition in the absence of a diagnosis of the condition related to such information.

Primary Care Physician (PCP): the physician (licensed under Chapter 458, 459, 460 and 461 of the Florida Statutes) who has a written contract with VISTA to be primarily responsible for the overall medical care of a Member.

Prior Authorization: an advance approval that a Member must receive from VISTA, before the Member receives certain Covered Services under this Group Agreement. Prior Authorization does not guarantee payment or coverage if the member is not eligible for services under the Agreement at the time the service is provided.

Prosthetic Appliances: appliances must: (i) replace all or part of a missing body organ and its adjoining tissue or all or part of the function of a permanently useless or malfunctioning body organ; and (ii) be an implantable prosthetic appliance or equivalent external device.

Psychiatric Treatment Program: services offered by programs licensed for the treatment of Mental and Nervous Disorders, or Substance Abuse Rehabilitation.

Rehabilitative Outpatient Therapy long-term (except as limited or excluded under this Contract): treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy, respiratory therapy and occupational therapy that would take longer than sixty (60) days.

Rehabilitative Outpatient Therapy short-term (except as limited or excluded under this Contract): treatment modalities that are part of a rehabilitation program which will not exceed sixty (60) days from date therapy begins and includes physical therapy, speech therapy, respiratory therapy and occupational therapy.

Room and Board: services provided by a Hospital that include room, meals and all general services and activities needed for the care of regular bed patients.

Service Area: the geographic area within the State of Florida where VISTA has Participating Providers under contract. The counties in North Florida are: Alachua, Bradford, Calhoun, Columbia, Dixie, Escambia, Franklin, Gadsden, Gilchrist, Hamilton, Jefferson, Lafayette, Leon, Levy, Liberty, Madison, Marion, Santa Rosa, Suwannee, Union and Wakulla. The counties in South Florida are: Miami-Dade, Broward, and Palm Beach.

Sickness: a physical illness or disease, including a pregnancy and any resulting complications of such pregnancy. The term "sickness" does not include mental illness or substance abuse.

Special Enrollment Period: an enrollment period that is provided for employees and/or their dependents due to special circumstances as described in the Special Enrollment provision.

Specialist: any Healthcare Professional duly licensed to practice medicine or osteopathy in the State of Florida.

Subscriber: the Eligible Employee of the Employer whose Enrollment Applications have been accepted by VISTA in accordance with the enrollment requirements of this Group Agreement, and for whom the Premium charges required under this Group Agreement have been received by VISTA.

Sub-Specialty Obstetrics and Gynecology: Obstetrician-Gynecologists who are board certified in this specialty and who have completed fellowship training in Reproductive Endocrinology & Infertility, Gynecologic Oncology, Maternal Fetal Medicine, or Uro-Gynecology.

Sufficient Evidence: evidence is considered to be sufficient to draw conclusions if it is peer reviewed, is well controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Total Disability (Totally Disabled):

1. for the Subscriber and covered spouse, the person's inability to perform any work or occupation for which the person is reasonably qualified or trained; and

2. for a covered Dependent child, the inability to engage in the normal activities of a person of like age or sex in good health.

Urgent Care Facility: a licensed, non-hospital facility, as listed on VISTA's internet website www.vistahealthplan.com, that has a written contract with Us as an independent contractor to provide services for treatment of conditions which, although not life threatening, could result in serious injury or disability if left untreated.

VISTA: Vista Healthplan™, Inc. a Florida corporation licensed by the State of Florida Department of Financial Services.

Waiting Period: the period, if any that must pass with respect to an individual before the individual is eligible to be covered for benefits under this Group Agreement.

We, Us, Our, Company: Vista Healthplan™, Inc.

Website: www.vistahealthplan.com

Well-Child Care: office visits for Covered Dependent children that include, but are not limited to, routine physical exams, pediatric immunizations, developmental assessments and anticipatory guidance, vision screening, lab procedures, health education and counseling, and hearing testing.

You, Yours: refers to You (Subscriber) and Your eligible enrolled Dependents.

Vista Healthplan™, Inc.
Rider to Certificate of Coverage
Broward County Board of County Commissioners
Domestic Partner

In consideration of the payment of all applicable Premiums, the Vista Healthplan™, Inc. Group Master Contract and Certificate of Coverage are hereby amended, as follows:

A Subscriber may add a Domestic Partner and his/her dependent children, if any, if the Subscriber enrolls in the applicable tier of coverage. A Domestic Partner of the Subscriber is an eligible Dependent if:

1. each party is at least 18 years of age and competent to contract;
2. neither person is married, nor a partner to another domestic partnership relationship;
3. consent of either person to the domestic partner relationship has not been obtained by force, duress or fraud;
4. each person agrees to be jointly responsible for each other's basic food and shelter; and
5. both parties must be domiciled in Broward County OR one of the parties must be employed by the Broward County Board of County Commissioners.

The domestic partner may be the same or opposite sex as the Subscriber.

To add a domestic partner, the Subscriber and domestic partner must register their domestic partnership with the Broward County Records Division and the Subscriber must enroll the domestic partner as his/her dependent within 31 days of such registration. The effective date of coverage is the 1st of the month following the date of submission of the Domestic Partner Registration. A Subscriber may not elect coverage for more than 2 registered domestic partners in each calendar year.

A dependent of the registered domestic partner is also eligible for coverage if:

1. the dependent meets eligibility criteria for dependent children as defined in the Certificate of Coverage;
2. a copy of the child's birth certificate showing the partner is the parent of the child is provided;
3. if the domestic partner is the legal guardian of the child, a copy of the court order is provided;

Coverage for the domestic partner and dependents, if any, terminates 30 days following the date a certificate of termination of domestic partnership is issued by the Broward County Records Office. Upon such termination, the domestic partner and dependents may continue the coverage they were receiving immediately prior to the termination of the domestic partnership for up to 18 months upon timely election and payment of the premium.

All of the other terms, conditions, limitations and exclusions of the Group Master Contract and Certificate of Coverage applies.

This Rider is effective as of the Effective Date of the Certificate to which it is attached.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
Rider to Open Access Contract/Certificate of Coverage
Broward County Board of County Commissioners
CDH - High and Low Options
Mental Health Services

Mental Health Services	Member Responsibility
Inpatient Treatment	Refer to Schedule of Benefits
Outpatient Treatment	Refer to Schedule of Benefits

In consideration of the payment of all applicable Premiums, the Vista Healthplan™, Inc. Open Access Certificate of Coverage is hereby amended and supplemented by the terms and conditions of this Rider.

A. Definitions

All terms used in this Rider shall have the respective meanings specified in the Group Agreement, unless the context otherwise requires.

Further, as used in this Rider:

1. "Mental Health Conditions" shall mean mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.
2. "Partial Hospitalization" shall mean outpatient treatment offered by a program accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or in compliance with equivalent standards.

B. Conditions

1. The benefits and services covered by this Rider are set forth herein which are for the treatment of Mental Health Conditions deemed by the VISTA Participating Providers to be subject to significant clinical improvement through short-term therapy. All services must be provided, prescribed, directed, authorized, or approved by VISTA and/or its Participating Providers, in accordance with the terms and conditions of the Group Agreement.
2. The Premium for this Rider is set forth in the Binder and Agreement comprising part of the Group Agreement. The terms and conditions regarding payment of the Premium for this Rider are as set forth in the Group Agreement.
3. Nothing contained in this Rider shall be held to vary, alter, waive, supplement, or extend any of the terms, conditions, provisions, agreements or limitations of the Group Agreement, other than as specifically set forth below, and the provision of the Covered Services contemplated in this Rider shall be governed by the terms and conditions of the Group Agreement.
4. Coverage under this Rider shall commence and terminate in accordance with the terms of the Group Agreement.

C. Benefits and Limitations

1. Inpatient Benefits: Inpatient benefits will be provided for those Mental Health Conditions which are deemed by the VISTA Participating mental health provider to be responsive to short-term treatment and not to be chronic or organic in nature. All admissions must be approved in advance.
2. Partial Hospitalization Benefits: Partial Hospitalization benefits shall be available in lieu of Hospital confinement on the basis of 2 partial hospital days for each inpatient day, if the Member's Participating mental health provider deems partial hospitalization to be appropriate for the member. In any benefit year, if Partial Hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid shall not exceed the cost of the number of days of inpatient benefits for psychiatric services, including fees.
3. Outpatient Benefit: Outpatient services shall be provided for consultations, treatment, evaluation and/or crisis intervention. Coverage is for mental health conditions as listed in the Diagnostic and Statistical Manual, (DSM), unless specifically excluded. These diagnoses shall be inclusive of all DSM V-code diagnoses. Benefit will provide initial authorization of 10 visits with subsequent visits subject to treatment plan review by a health plan mental health designee. Services must be provided by a VISTA Participating physician, psychologist licensed pursuant to Chapter 490, Florida Statutes, or mental health counselor, clinical social worker or other clinician licensed pursuant to Chapter 491, Florida Statutes.
4. The benefits available to members hereunder shall not include coverage for treatment pursuant to voluntary or involuntary confinement under Florida's Baker Act, Florida Statutes 394.451-394.4789, whether such confinement is considered to be routine or an Emergency, except within the limits of paragraphs C(1) and C(2) above.

D. Exclusions

1. Psychotherapy for organic conditions including mental retardation.
2. Psychoanalysis.
3. Evaluation or treatment for forensic purposes.
4. Short-term evaluation, diagnosis, treatment or crisis intervention.
5. Treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
6. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice.
7. Services utilizing methadone treatment as maintenance, L.A.A.M.(1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
8. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized.
9. Residential treatment services.

This Rider will be effective as of the Effective Date of the Certificate to which it is attached.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista HealthplanTM, Inc.

Rider to Open Access Contract/Certificate of Coverage Broward County Board of County Commissioners CDH - Low Option

In consideration of the payment of all applicable Premiums, the Vista Healthplan, Inc. (hereinafter referred to as "VISTA") Group Master Contract and Certificate of Coverage is hereby amended and supplemented by the terms and conditions of this Rider.

A. New Definitions

The following definitions are added:

1. **"Annual Deductible"**: the amount you must pay each Calendar Year before VISTA will make payment toward specified Covered Services.
2. **"Coinsurance"**: the sharing of health care expenses for specified Covered Services between you and VISTA. The Coinsurance is expressed as a percentage rather than as a dollar amount.
3. **"Coinsurance Maximum"**: the amount of Coinsurance you will pay each Calendar Year before VISTA pays the Allowed Amount at 100% for Covered Services. Expenses used to satisfy the coinsurance percentage apply toward satisfying the Coinsurance Maximum.
4. **"Enteral Formulas"**: low protein food products for home use which are physician prescribed as appropriate for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.
5. **"Lifetime Maximum Benefit"**: the lifetime maximum amount payable by VISTA per Member for Covered Services during the entire time a Member is enrollee in VISTA, including benefits provided under additional coverage Riders.

B. New Benefit Provisions

The following provisions are added to the Benefit Section:

1. **Annual Deductible**: before VISTA will begin paying health care expenses for specified Covered Services, you must satisfy the Annual Deductible of \$2,100 per Individual and \$4,200 per Family. The following Covered Services are not subject to the Annual Deductible:
 - a. Outpatient Physician Services;
 - b. Outpatient Speech, Physical, Occupational, Respiratory and Cardiac Therapy Services;
 - c. Outpatient Diagnostic Services excluding Therapeutic services: CAT Scans, PET Scans, MRI and Nuclear Medicine when rendered in a Freestanding Facility;
 - d. Human Organ Transplants;
 - e. Emergency, Urgent Care and Ambulance Services;
 - f. Inpatient/Outpatient Mental Health and Substance Abuse Services;
 - g. Family Planning Services: Voluntary Counseling, Abortions and Elective Sterilizations at a physician's office or freestanding facility;
 - h. Durable Medical Equipment; and
 - i. Insulin/diabetic supplies.

Deductible amounts satisfied under previous plans, will not count towards the satisfaction of your annual deductible.

2. **Coinsurance:** once the Annual Deductible is met for specified Covered Services, you are responsible for paying 20% Coinsurance.
3. **Coinsurance Maximum:** the maximum amount of Coinsurance you will pay each Calendar Year before VISTA pays the Allowed Amount at 100% for Covered Services is \$1,500 per Individual and \$3,000 per Family.

Expenses that will not count towards the Coinsurance Maximum:

- a. Copayments;
 - b. Services that are not considered covered under this Group Policy or are specifically excluded;
 - c. Expenses used to satisfy the Annual Deductible;
 - d. Charges that are not considered a covered expense;
 - e. Charges in excess of the Allowed Amount;
 - f. Expenses for services that exceed treatment limitations explained in the Certificate of Coverage; and
 - g. Amounts due to failure to obtain Prior Authorization for a specified service or supply.
4. **Enteral Formulas:** Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein for Covered Persons through the age of 24. Coverage of low protein food products is limited to \$2,500 per calendar year.
 5. **Lifetime Maximum Benefit:** the lifetime maximum benefit is \$2 million.

All the terms, conditions, limitations and exclusions of the Contract/Certificate of Coverage apply to the benefits provided by this Rider.

This Rider will be effective as of the Effective Date of the Contract/Certificate of Coverage to which it is attached.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.

**Rider to Open Access Contract/Certificate of Coverage
Broward County Board of County Commissioners
CDH - High and Low Options
Alcohol and Substance Abuse Services**

Alcohol and Substance Abuse Services	Member Pays
Inpatient Detoxification and Rehabilitation Treatment	Refer to Schedule of Benefits
Outpatient Rehabilitation Treatment	Refer to Schedule of Benefits

In consideration of the payment of all applicable Premiums, the Vista Healthplan™, Inc. Open Access Certificate of Coverage is hereby amended and supplemented by the terms and conditions of this Rider.

A. Definitions

All terms used in this Rider shall have the respective meanings specified in the Group Agreement, unless the context otherwise requires.

Further, as used in this Rider, the term "Substance Abuse Impaired" shall have the meaning specified in Florida Statutes 397.311.

B. Conditions

1. The benefits and services covered by this Rider are limited to those set forth herein which are for substance abuse treatment. All services must be provided, prescribed, directed, authorized, or approved by VISTA or its Participating Providers, in accordance with the terms and conditions of the Group Agreement.
2. The Premium for this Rider is set forth in the Binder and Agreement comprising a part of the Group Agreement. The terms and conditions regarding payment of the Premium for this Rider are as set forth in the Group Agreement.
3. Nothing herein contained shall be held to vary, alter, waive, supplement or extend any of the terms, conditions, provisions, agreements or limitations of the Group Agreement to which this Rider is attached, other than as specifically stated below, and the provisions of the Covered Services contemplated by this Rider shall be governed by the terms and conditions of the Group Agreement.
4. Coverage under this Rider shall commence and terminate in accordance with the terms of the Group Agreement.

C. Benefits

1. Inpatient Benefits: Covered Services provided under this Rider consist solely of the diagnosis, medical treatment and services to appropriate alcohol and drug abuse treatment and rehabilitation programs for the abuse or addiction to alcohol and/or drugs for the care and treatment of substance abuse impaired persons. The hospital treatment facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a similar organization and all admissions must be authorized by the VISTA participating provider.
2. Outpatient Benefits: Treatment must be provided by, or under the supervision of, a VISTA Participating provider who is a licensed physician, licensed psychologist or other provider duly licensed to provide substance abuse treatment. The treatment program must be approved by the State of Florida, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a similar organization.

D. Limitations

1. The benefits described in Subsection C(1) of this Rider will only be deemed Covered Services to the extent that treatment is approved by the VISTA Participating Physician, and provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if such services are provided in a program accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or in compliance with equivalent standards.
2. Members shall be financially responsible for charges not paid by VISTA hereunder. Such obligations incurred on the part of the Member shall be paid directly to the Participating Provider.

E. Exclusions

1. Outpatient Detoxification under the program.
2. Evaluation or treatment for forensic purposes.
3. Short-term evaluation, diagnosis, treatment or crisis intervention.
4. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized.
6. Residential treatment services.

This Rider will be effective as of the Effective Date of the Certificate to which it is attached.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
Rider to Certificate of Coverage
HMO Large Group
Vision

➤ Eye Examinations	Copayment
Basic examination once per calendar year by a participating optometrist for:	
Eyeglasses .....	..... \$0
Contact Lenses (includes fitting for regular daily wear, extended wear and disposable lenses, 3 months of follow-up care and starter kit)	..... \$69
➤ Prescription Eyeglasses	Copayment
One pair each calendar year from the VISTA Standard Collection at a participating provider:	
Frame and Plastic Single Vision Lenses .....	..... \$29
Frame and Plastic Bifocal Lenses (FT 25 - 35 or Executive Lenses) .....	..... \$49
Frame and Plastic Trifocal Lenses (FT 25 - 35 or Executive Lenses) .....	..... \$59
The following lens options are available:	
Progressive No Line Bifocals and Trifocals .....	..... \$95
Lenticular .....	..... \$95
High Index Plastic .....	..... \$50
Polycarbonate .....	..... \$30
Glass .....	..... \$10
Photo Chromatic .....	..... \$20
Tints .....	..... \$10
UV Coating .....	..... \$12
Scratch Coating .....	..... \$15
Transitions .....	..... \$70
Polarized .....	..... \$45
Anti-Reflective Coating .....	..... \$36
➤ Contact Lenses	Copayment
Daily Wear .....	..... \$35 per pair
Daily Wear Replacement Lenses .....	..... \$20 per lens
Extended Wear .....	..... \$39 per pair
Extended Wear Replacement Lenses .....	..... \$25 per lens
Disposable Lenses (6 packages – 1- week or 2-week wear) .....	...\$19 per package
Frequent Replacement Lenses (6 packages – 1- week or 2-week wear) .....	...\$29 per package
Daily Disposable Lenses (30 packages – 1-day wear)	\$23.50 per package

Items not listed above may be available from the participating provider at other copayments or discounts. Copayments above may not apply to non-standard or special orders.

All the terms, conditions, limitations and exclusions of your Certificate of Coverage apply to the benefits provided by this Rider.

Vista Healthplan™, Inc.



Richard Weiss
Chief Financial Officer

Vista Healthplan™, Inc.
SCHEDULE OF BENEFITS – 2010
BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
Open Access CDH Low Option (\$2,100 Deductible)

Referrals are not required for Covered Services*

This Schedule of Benefits is not a complete summary or explanation of the Covered Services. Please review the Certificate of Coverage for an exact description of the Covered Services, limitations and exclusions and other terms and conditions of coverage.

Annual Deductible (per calendar year)

Individual	\$2,100
Family	\$4,200

Coinsurance Maximum (per calendar year)

Individual	\$1,500
Family	\$3,000

Lifetime Maximum Benefit \$2 million

BENEFITS

MEMBER RESPONSIBILITY

Outpatient Physician Services

Primary Care Physician (PCP) Office Visits \$20 copay

Specialist Physician Office Visits \$35 copay

Office visit includes routine lab tests, diagnostic procedures and radiology, hearing and vision screening and outpatient surgery in the physician's office.

Wellness Care No copay
(Wellness/Preventive care includes physical exams, eye exams, health education and counseling, immunizations; well-woman care, including Pap smears.)

Well-child care to age 16 including immunizations No copay

Annual well-woman care, including Pap smears No copay

Allergy injections at a PCP or Specialist's office \$20 copay
Limitation: copay applies for injections received in physician's office when no other health service is received.

Routine Mammography (based on established guidelines) No copay

Maternity Prenatal/ Postnatal Care

- in a Physician's office One-time \$25 copay
- in a Sub-Specialty office \$25 copay

Non-Surgical Spine and Back Services \$25 copay
Limitation: 1 visit & treatment per day; 24 visits per calendar year

Second Medical & Surgical Opinion

- by Participating Physician \$25 copay
- by Non-Participating Physician 40% of Allowed Amount

Inpatient Hospital/Physician Services

Inpatient Hospital Facility Services (Facility Services include semi-private room & board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms and prescription medications dispensed while confined.)	20% after annual deductible
Inpatient Rehabilitative Services	20% after annual deductible
In-Hospital Maternity Care	20% after annual deductible
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	20% after annual deductible
Inpatient Physician Services (Physician Services include surgeon and assistant surgeon, anesthesiologist, specialists' consultations and other physician visits while confined.)	20% after annual deductible
Human Organ Transplants	\$5,000 copay per Inpatient stay, NO deductible

Outpatient Services

Outpatient Surgery	
<ul style="list-style-type: none"> at a Hospital at an Ambulatory Surgical Center in a Physician's office 	<ul style="list-style-type: none"> 20% after annual deductible \$25 copay No copay, included in office visit copay
Outpatient Physical, Speech, Occupational Therapy Limitation: 60 visits per calendar year, combined for all therapies	\$15 copay
Outpatient Respiratory Therapy Limitation: 20 visits per calendar year	\$25 copay
Outpatient Cardiac Therapy Limitation: 36 visits per calendar year	\$25 copay
Outpatient Radiation and Chemotherapy	
<ul style="list-style-type: none"> at a Hospital at a Freestanding Facility 	<ul style="list-style-type: none"> 20% after annual deductible No copay
Outpatient Diagnostic Services including tests, chest X-rays, EKG's, blood tests, urinalysis, radiology and X-rays	
<ul style="list-style-type: none"> at a Hospital at a Freestanding Facility in a Physician's office at a separate lab 	<ul style="list-style-type: none"> \$25 copay No copay No copay, included in office visit copay No copay
Outpatient Diagnostic/Therapeutic Services including CAT Scan, PET Scan, MRI and Nuclear Medicine	
<ul style="list-style-type: none"> at a Hospital at a Freestanding Facility 	<ul style="list-style-type: none"> 20% after annual deductible No copay
Outpatient Endoscopic Procedures (Colonoscopy, Endoscopy, Sigmoidoscopy)	
<ul style="list-style-type: none"> at a Hospital at an Ambulatory Surgical Center at an Outpatient Diagnostic Center in a Physician's office 	<ul style="list-style-type: none"> 20% after annual deductible \$25 copay \$25 copay No additional copay
Outpatient Dialysis	20% after annual deductible

Skilled Nursing, Home Health and Hospice Care Services

Skilled Nursing Facility Care / Rehabilitation Center Limitation: 60 days per calendar year	20% after annual deductible
Home Health Care Limitation: 60 visits per calendar year	\$25 copay
Hospice Care Limitation: 180 days per lifetime	20% after annual deductible

Emergency and Urgent Care Services

Emergency Care at Hospital Emergency Room	\$150 copay (waived if admitted)
Emergency Care at Urgent Care Facility	\$35 copay
Emergency Care at Physician's Office	See office visit copay
Ambulance service to hospital (emergency only)	\$150 copay per transport

Mental Health, Alcohol & Substance Abuse Services

Mental Health Care

Inpatient Treatment	No copay
Outpatient Treatment	No copay

Alcohol and Substance Abuse Care

Inpatient Detoxification & Rehabilitation	No copay
Outpatient Rehabilitation Treatment	No copay

Family Planning Services

Voluntary Counseling	\$35 copay
Infertility Services	Not covered
Medically Necessary/Elective Abortion <ul style="list-style-type: none"> • in a Physician's office or Freestanding Facility • at a Hospital 	\$25 copay 20% after annual deductible
Elective Sterilization <ul style="list-style-type: none"> • in a Physician's office or Freestanding Facility • at a Hospital 	\$35 copay 20% after annual deductible
Intrauterine Devices (IUD) (device, insertion, removal)	\$35

Vista Healthplan™, Inc.
Summary of Benefits – 2010
Broward County Board of County Commissioners
Open Access CDH Low Option
\$2,100 Deductible

Referrals are not required for Covered Services

Annual Deductibles (Individual / Family)	\$2,100 / \$4,200
Coinsurance Maximums	\$1,500 / \$3,000
Lifetime Maximum Benefit	\$2,000,000
Major Provisions	Member Responsibility
Primary Care Physician (PCP) office visits	\$20 copay
Preventive care, including physical exams, eye exams, health education and counseling and immunizations	No copay
Well-child care to age 16 including immunizations	No copay
Annual well-woman care, including pap smears	No copay
Routine mammography (based on established guidelines)	No copay
Specialist office visits	\$35 copay
Hospital admission	20% after annual deductible
Emergency room (waived if admitted)	\$150 copay
Inpatient Hospital/Physician Services	Member Responsibility
Inpatient hospital facility services (includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, rehabilitation service, surgeon services, anesthesiologist services, specialist consultation, physician visits, maternity care, neonatal intensive care unit)	20% after annual deductible
Human Organ Transplants	\$5,000 copay per inpatient stay NO deductible
Outpatient Medical Services	Member Responsibility
Allergy injections (Benefits are available for injections received in a Physician's office when no other health service is received)	\$20 copay
Diagnostic procedures, tests, chest x-rays, blood tests, urinalysis, EKG's in physician's office	No copay; included in OV copay
Outpatient diagnostic services, lab, radiology and x-ray	
<ul style="list-style-type: none"> • at a Hospital • at a Freestanding Facility 	<p>\$25 copay</p> <p>No copay</p>
Outpatient diagnostic/Therapeutic Services, CT Scans, PET Scans, MRI and Nuclear Medicine	
<ul style="list-style-type: none"> • at Hospital • at a Freestanding Facility 	<p>20% after annual deductible</p> <p>No copay</p>
Outpatient surgery services (including physician and facility services)	
<ul style="list-style-type: none"> • at a Hospital • at an Ambulatory Surgical Center 	<p>20% after annual deductible</p> <p>\$25 copay</p>
Maternity Prenatal/Postnatal Care	
<ul style="list-style-type: none"> • in a Physician's office • in a Sub-Specialty office 	<p>One time \$25 copay</p> <p>\$25 copay</p>
Radiation and chemotherapy	
<ul style="list-style-type: none"> • at a Hospital • at an Outpatient Diagnostic Center 	<p>20% after annual deductible</p> <p>No copay</p>
Non-Surgical Spine and Back Services Limitation: 1 visit and treatment per day; 24 visits per calendar year	\$25 copay
Second medical and surgical opinion	
<ul style="list-style-type: none"> • Participating Provider • Non-Participating Provider 	<p>\$25 copay</p> <p>40% of Allowed Amount</p>

Mental Health, Alcohol & Substance Abuse Services	Member Responsibility
Mental health care	
• Inpatient	No copay
• Outpatient	No copay
Alcohol and substance abuse care	
• Inpatient detoxification and rehabilitation	No copay
• Outpatient rehabilitation treatment	No copay
Special Kinds of Care	Member Responsibility
Emergency and urgent care	
• in hospital emergency room (waived if admitted)	\$150 copay
• in urgent care facility	\$35 copay
• in physician's office	See office visit copay
• Ambulance service to hospital Emergency Only	\$150 per transport
Home health care	\$25 copay
Limitation: 60 visits per calendar year	
Hospice care	20% after annual deductible
Limitation: 180 days maximum lifetime benefit	
Skilled nursing facility care/Rehabilitation Center	20% after annual deductible
Limitation: 60 days per calendar year	
Dialysis treatment	20% after annual deductible
Insulin/Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	\$50 copay per month, Combined copay
Outpatient physical, speech, and occupational therapy	\$15 copay
Limitation: 60 visits per calendar year, combined for all therapies	
Outpatient cardiac therapy	\$25 copay
Outpatient respiratory therapy	\$25 copay
Durable medical equipment; other external orthotics and prosthetics	No copay
Limitation: \$2,500 per calendar year	
Enteral Formulas up to age 24	20% after annual deductible
Limitation: \$2,500 per calendar year	
Hearing Aids	Not covered
Family Planning	
• Voluntary Counseling	\$35 copay
• Intrauterine Device (IUD) (device, insertion, removal)	\$35 copay
• Infertility Services	Not covered
Elective Sterilization	
• Office visit or Freestanding Facility	\$35 copay
• Outpatient hospital	20% after annual deductible
Abortions, Medically Necessary	
• Office visit or Freestanding Facility	\$25 copay
• Outpatient hospital	20% after annual deductible
Abortions, Elective	
• Office visit or Freestanding Facility	\$35 copay
• Outpatient hospital	20% after annual deductible
Dental care	
• Preventive dental care	Cleaning, fluoride treatment & bitewing x-rays every 6 months, \$5 per service, maximum \$10 copay per visit
• General dental care	Discounted fee schedule of 25%
Vision care - at a participating Optometrist	
• Basic eye exam	No copay
• Eyeglasses (1 pair/year, single vision, bifocal, VISTA Standard Collection)	\$29/\$49
• Basic examination for Contact Lenses	\$69
• Daily Wear Contact Lenses	\$35 per pair
• Replacement Lenses	\$20 per lens
• Extended wear Contact Lenses	\$39 per pair
• Replacement lenses	\$25 per lens
• All other services available from participating provider	25% discount

Deductible and copayments do not apply toward the Coinsurance Maximum. Coinsurance amounts only apply toward the Coinsurance Maximum. PCP referrals are not required to obtain Covered Services; however **certain Covered Services require Prior Authorization**. Please refer to the Certificate of Coverage for further detail on Prior Authorization requirements. Services must be rendered within the VISTA network. VISTA participating physicians and providers have contracted with VISTA to provide care to our members. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.

This plan has exclusions, limitations and terms which may be continued in force or discontinued.

Coventry Health and Life Insurance Company

Amendment to Certificate of Insurance

Autism Spectrum Disorder

The Agreement between Coventry Health and Life Insurance Company and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

Effective date: April 1, 2009

The Certificate of Insurance is revised as follows:

The Certificate of Insurance has been revised to include Autism Spectrum Disorder and other Developmental Disability Therapies.

Eligibility

In order to be eligible to receive benefits, a Member is under eighteen (18) years of age or a Member is eighteen (18) years of age or older and in high school who has been diagnosed as having a developmental disability at eight (8) years of age or younger.

Definitions

Applied Behavior Analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

1. Autistic disorder.
2. Asperger's syndrome.
3. Pervasive developmental disorder not otherwise specified.

Covered Services

Autism Spectrum Disorder

Benefits are provided for the recognized services listed below when prescribed by the Member's treating physician in accordance with a treatment plan:

1. Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.
2. Speech therapy: treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, congenital anomaly or Autism Spectrum Disorder.
3. Occupational therapy.
4. Physical therapy.
5. Applied Behavior Analysis shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

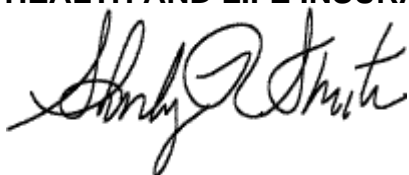
A treatment plan shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

Coverage may not be denied on the basis that provided services are habilitative in nature.

Exclusions and Limitations

Coverage is subject to a maximum benefit of \$36,000 per calendar year not to exceed \$200,000 in total individual lifetime benefits.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Shirley Smith". The signature is fluid and cursive, with the first name "Shirley" and last name "Smith" clearly distinguishable.

Shirley Smith
Senior Vice President, Legal (Corporate)

Coventry Health and Life Insurance Company. Amendment to Certificate of Insurance Dependent to Age 30

The Agreement between Coventry Health and Life Insurance Company ("Coventry") and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Insurance is revised as follows:

Dependent Eligibility

To be eligible to enroll a Dependent, the Named Insured's Dependent must meet all the requirements as the Covered Person as set forth in Subsection A and be the Named Insured's:

1. lawful spouse; or
2. a dependent child until the end of the Calendar Year in which the child turns twenty-five (25) years of age, if the child meets all of the following requirements:
 - a. the child is dependent on the Named Insured for support; and
 - b. the child is living in the Named Insured's household, or a Full Time or Part Time Student.
3. a dependent child until the end of the Calendar Year in which the child turns thirty (30) years of age, if the child meets all of the following requirements:
 - a. is unmarried and does not have a dependent of his or her own; and
 - b. is a resident of Florida or a Full Time or Part Time Student; and
 - c. is not provided coverage as a named subscriber, insured, enrollee, or a covered person under any other group or individual health benefit plan or is not entitled to benefits under Title XVIII of the Social Security Act.

If a Dependent child is provided coverage under the Named Insured's Certificate of Insurance after the child reaches age twenty-five (25) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Named Insured's Certificate of Insurance unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

The term child includes the Named Insured's natural born child, stepchild, or a foster or legally adopted child of the Named Insured upon placement in the residence, or at the birth of a newborn adopted child, where a written agreement to adopt such child had been entered into prior to the birth of the child, whether or not that agreement is enforceable. If the foster or adopted child is ultimately not placed in the residence of the Named Insured, no benefit will apply.

The term also includes any child for whom the Named Insured is the legal guardian or a child who is dependent on the Named Insured for health care coverage pursuant to a valid court order. Coventry has the right to request proof of any child's dependency status at any time.

Coventry Health and Life Insurance Company



**Shirley Smith
Senior Vice President, Legal (Corporate)**

Coventry Health and Life Insurance Company Amendment to Certificate of Insurance Qualifying Events

The Agreement between Coventry Health and Life Insurance Company ("Coventry") and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

Effective date: April 1, 2009

The Certificate of Insurance is revised as follows:

- 7. Special Enrollment Period.** *An Eligible Employee or Eligible Dependent requesting to enroll under this Group Agreement outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:*

The Eligible Employee or Eligible Dependent was covered under other health coverage (as defined by the Federal HIPAA Law) at the time coverage was previously offered to the employee or dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. Except as otherwise set forth herein, the Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage. Enrolling employee/dependent's whose Children's Health Insurance program (CHIP) or Medicaid coverage is terminated, please see below.

- a. *For an Eligible Employee, the previous coverage:*
 - (1) *Must have been under COBRA or State Continuation and the coverage was exhausted; or*
 - (2) *Other group health plan or insurance coverage was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.*
- b. *For an Eligible Dependent, the coverage:*
 - (1) *Is newly made available to dependents;*
 - (2) *Is for an individual who is a participant under the contract, or has met a waiting period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;*
 - (3) *Is for a person who becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption.*
- c. *New dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:*
 - (1) *The date coverage is made available; or*
 - (2) *The date of marriage, birth, adoption, or placement for adoption.*
- d. *In the case of a dependent's birth or adoption, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption. The employee and spouse coverage effective date is no later than the first day of the first month beginning after the date of eligibility if Coventry receives enrollment applications in the time frame specified herein. Other dependent coverage is effective:*
 - (1) *In the case of marriage, as of the date of the marriage, or*
 - (2) *In the case of a dependent's birth, as of the date of birth; or*

(3) *In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.*

e. *Enrollment Pursuant to Termination of Medicaid or CHIP coverage.*

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the dependents of such Eligible Employee, if eligible but not enrolled, may enroll in VISTA if either of the following two conditions are satisfied.

(1) **Termination of Medicaid or CHIP coverage.** *The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.*

(2) **Eligibility for Employment Assistance under Medicaid or SCHIP.** *The Eligible Employee or dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).*

Required Length of Special Enrollment Notification. *An Eligible Employee and/or his or her dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.*

Effective Date of Coverage. *Coverage shall become effective on the first (1st) day of the month following the month in which Coventry received the request for Special Enrollment.*

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

The Qualifying Events section is revised as follows:

Types of Qualifying Events

Documentation Required

<i>Marriage</i>	<i>Marriage Certificate</i>
<i>Adoption/Placement of Foster child</i>	<i>Legal Adoption Papers</i>
<i>Birth</i>	<i>Birth Certificate</i>
<i>Change in Legal Guardianship</i>	<i>Court ordered legal papers for Legal Guardianship</i>
<i>Employment Status change of employee or spouse</i>	<i>HIPAA Certificate or employer letter</i>
<i>Medicaid Termination*</i>	<i>Medicaid Termination or Premium Assistance Notification letter</i>

**An eligible, but not enrolled employee or dependent is permitted to enroll for coverage if either of the following conditions are met:*

- 1. the employee/dependent's Children's Health Insurance Program (CHIP) or Medicaid coverage is terminated due to loss of eligibility and the employee requests coverage with Coventry within sixty (60) days; or*
- 2. the employee/dependent becomes eligible for premium assistance subsidies and requests coverage with Coventry within sixty (60) days, if applicable.*

Coventry Health and Life Insurance Company



**Shirley Smith
Senior Vice President, Legal (Corporate)**

Coventry Health and Life Insurance Company Amendment to Certificate of Insurance Self-Inflicted/Suicide Exclusion

The Agreement between Coventry Health and Life Insurance Company ("Coventry") and the Group is hereby amended and supplemented by the terms and conditions of this Amendment.

Nothing contained in the Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

In the event of a conflict between the provisions of this Amendment and the Agreement, the provisions of this Amendment will prevail.

The Certificate of Insurance is revised as follows:

Exclusions and Limitations Section

This exclusion has been deleted:

Self-Inflicted/Suicide

Coventry Health and Life Insurance Company



**Shirley Smith
Senior Vice President, Legal (Corporate)**

Coventry Health and Life Insurance Company
1340 Concord Terrace
Sunrise, Florida 33323

Preferred Provider Organization (PPO)

**Certificate of Insurance
for
Broward County Board of County Commissioners**

This Certificate of Insurance is delivered in the State of Florida.

The Certificate of Insurance is a part of the Group Policy and is issued in consideration of the application of the Policyholder and payment of the premiums by the Policyholder as provided in the Group Policy.

The Company agrees to provide the Benefits shown in the Covered Services Section to the Named Insured and Eligible Dependents, if any, in accordance with the provisions and conditions of the Group Policy.

This Certificate of Insurance is subject to all the conditions and provisions set forth on this and the subsequent pages, which are made a part of the Group Policy.

**For inquiries or information about coverage or assistance in resolving problems call:
Telephone: 1-866-847-8235 TDD #: 1-888-444-7352**

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

IN WITNESS WHEREOF, Coventry Health and Life Insurance Company, (hereinafter referred to as "Coventry") has executed this Group Policy in Sunrise, Florida.



**Shirley Smith
Senior Vice President, Legal (Corporate)**

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INTRODUCTION

Coverage under this Contract is made as a result of the Named Insured's relationship to a Group such as an employer or union. The Named Insured must meet the eligibility rules of Coventry as well as eligibility rules established by the Group. The Group acts on behalf of the Named Insured by remitting premium for this coverage. Coventry will provide the benefits described in this Certificate of Insurance.

Please note that Coventry Plan, Inc. is a Preferred Provider Organization (PPO) that contracts with independently practicing physicians who render medical care and treatment to Coventry Covered Persons. At all times, these physicians are acting and performing as independent practicing physicians with respect to Coventry, and Coventry does not exercise any control or discretion over the method by which the providers render services to a Covered Person. No work, act, commission or omission of any provider, his agents, servants or employees shall be construed to make or render any provider, agent, servant or employee, an agent, servant, representative, or an employee of, or joint venturer with Coventry. Furthermore, the providers render medical care to Coventry Covered Persons in accordance with the traditional physician/patient relationship, which in no way is affected or interfered with by Coventry. All judgments and decisions of a medical nature remain within the province of the treating physician, and he/she remains solely responsible for all such medical judgments and related treatments.

Coventry shall not be liable for any negligent act or omission committed by any independent practicing physician or hospital, or any of their agents or employees who may, from time to time, provide medical services to a member of Coventry. Furthermore, Coventry shall not be vicariously liable for any negligent act or omission of any of these independent Healthcare Professionals who treat a member of Coventry.

SECTION 1 ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Subject to any Eligibility Exceptions noted in the Binder & Agreement, an employee becomes eligible for coverage on the date he or she completes any waiting period established by the Group, as shown in the Binder & Agreement, which is available from the Employer. The waiting period is the length of time an employee must wait before becoming eligible for coverage.

If an Eligible Employee is covered under any other Large Group Policy issued to the Group by Coventry, or any other health benefit plan established and maintained by the Group, he or she will not be considered eligible for coverage under this Group Policy.

All eligible employees within a designated "employee class" must be allowed to participate. An Employer has the option to cover part-time employees provided that a minimum employer contribution, as required by Coventry, is made and all part-time employees have the opportunity to participate.

A. Eligibility

1. Named Insured. To be eligible to enroll, You must:
 - a. For a full-time employee: work twenty-five (25) hours or more during a normal workweek and receive wages. Business owners must be noted on the Employer's federal income tax Schedule C. Officers and/or Board Members of a company are not eligible for coverage unless they meet the same eligibility requirements specified herein for a full-time employee.
 - b. Satisfy any probationary or waiting period requirements established by the Group;
 - c. Be eligible under the eligibility criteria established by the Group and agreed to by Coventry.
2. Dependents. To be eligible to enroll as a Dependent, You must:
 - a. Meet all Dependent eligibility requirements established by the Group, reside with the Named Insured; and
 - b. Be the lawful Spouse of the Named Insured; or
 - c. Be a child, which means the Named Insured's unmarried own child; adopted child or child placed in the Named Insured's home for the purpose of adoption in accordance with chapter 63, Florida Statutes; a stepchild whom the Named Insured claims as an exemption on his or her federal income tax return; a child for whom legal guardianship has been established pursuant to chapter 744, Florida Statutes; or any other unmarried child for whom the Named Insured has been granted temporary or other court-ordered custody. Children are covered:
 - (1) From the date of birth to the end of the month in which the dependent child's 19th birthday occurs; and
 - (2) From the dependent child's 19th birthday to the end of the calendar year in which the dependent child's 25th birthday occurs, if the child is dependent on the Named Insured for support and the child is either living in the Named Insured's household or is a full-time or part-time student at a secondary, college, university or trade school which is certified or licensed by a state.
3. A child who has attained the limiting age for a Covered Dependent and continues to be both:
 - a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
 - b. Chiefly dependent on the Named Insured for support and maintenance.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this Group Policy, the Named Insured has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

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 Coventry terminating such child's coverage for any other reason than the attainment of the limiting age. For newly enrolled handicapped children over the age of nineteen (19), the Named Insured must provide proof of prior coverage and proof of dependency.

4. A newborn child of You or Your Covered Dependent is covered from the moment of birth if the Named Insured has dependent coverage and if Coventry has been notified of the child's birth in writing through the completion and submission of an Enrollment Application, as specified herein.
 - a. If You enroll the child within thirty-one (31) days of birth, a premium will not be charged for the first thirty-one (31) days.
 - b. If You fail to enroll the child within thirty-one (31) days of birth, but enroll the child within sixty (60) days of birth, You will be required to pay the applicable premium for the child from the date of birth.
 - c. If the child is enrolled within sixty (60) days of birth, Coventry will not deny coverage.
 - d. Enrollment of the child more than sixty (60) days after birth but prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and the child will be subject to the delayed coverage rules specified in the Late Enrollee provision.
 - e. A newborn child of a covered dependent child is covered for a period of eighteen (18) months from birth if the newborn child is enrolled within sixty (60) days of birth. Enrollment of the child more than sixty (60) days after birth but prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and the child will be subject to the delayed coverage rules specified in the Late Enrollee provision.
5. All health coverage applicable for children under this Group Policy will be provided for the adopted child of the Named Insured if the Named Insured has dependent coverage. Coverage is provided to a child the Named Insured proposes to adopt who is placed in the Named Insured's residence in compliance with chapter 63, from the moment of placement. A newborn infant who is adopted by the Named Insured is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in Your residence in compliance with chapter 63. In the event the child(ren) is not placed, the Named Insured will be responsible for repayment of any claims paid.

The Named Insured's adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if Coventry is notified of the event in writing through the completion and submission of an Enrollment Application as specified herein:

- a. If the Named Insured enrolls the child within thirty-one (31) days of the moment of birth or placement, a Premium will not be charged for the first thirty-one (31) days.
- b. If the Named Insured fails to enroll the child within thirty-one (31) days of the event, but enrolls the child within sixty (60) days of the event, the Named Insured will be required to pay an additional Premium from the date of birth or placement.
- c. If notice is given within sixty (60) days of the event, Coventry will not deny coverage.

- d. Enrollment of the child more than sixty (60) days after the event or prior to the next Annual Open Enrollment Period will be considered a Late Enrollment and subject to the delayed coverage rules specified in the Late Enrollment provisions.
6. Coventry shall be responsible for requesting, verifying, and maintaining documentation for Eligible Dependents who reach the maximum age requirements to determine school enrollment or handicap status.
7. Military Personnel

Any health insurance policy, certificate, or evidence of health coverage, which was in effect on April 30, 1991, or which is issued or renewed after such date that provides coverage to a member of the Florida National Guard, or a member of any branch of the United States military reserves who is a resident of this state, called to active military duty, must comply with the following:

- a. Continue all coverage which was in effect for the person, or the person's dependents covered by the same policy, at the premium in effect for all insured under the same contract, unless the employee requests coverage changes which might alter the premium he or she was paying prior to such activation during the time he or she serves on active duty.
- b. Reinstatement of the coverage for any such person who elects not to continue it while on active duty, at the person's request upon return from active duty, without a waiting period or disqualification for any condition, which existed at the time he or she was called to active duty. Such reinstatement must be requested within thirty (30) days after returning to work with the same employer or within sixty (60) days if the policy is an individual policy.
- c. Any coverage available to the insured employee's dependent under the CHAMPUS program will be considered in the payment of any benefits.
- d. The employee must notify his or her employer of his or her reserve or National Guard status and the employee's intent to invoke the provisions of subsections (a) and (b) prior to leaving his or her employer to report for active military duty unless such notice is precluded by military necessity or is impossible or unreasonable.
- e. Nothing in this section is intended to require an employee group health insurance policy to provide coverage to a person serving on active military duty.

B. Enrollment

No person meeting eligibility requirements will be refused enrollment or re-enrollment by Coventry because of health conditions, age, need for health services or mental condition or pre-existing physical condition, including pregnancy.

1. **Initial Enrollment Period.** As an employee of the Group, You are entitled to apply for coverage for Yourself and Your Eligible Dependents during the initial Group Open Enrollment Period. Enrollment starts on the employee's initial date of eligibility and ends no less than thirty (30) days later. All persons included for coverage must be listed on the Enrollment Applications provided. No proof of insurability will be required.
2. **Annual Open Enrollment.** An Annual Open Enrollment Period shall be held at least once every twelve (12) months and no less than thirty (30) days prior to the Group's anniversary date during which an eligible Employee and any Eligible Dependents may enroll as a Covered Person if:
 - a. You did not enroll during the Initial Enrollment Period, or
 - b. You maintained coverage under another employer sponsored plan and You change coverage to this Group Policy, or
 - c. You are enrolling as a Late Enrollee.

No proof of insurability will be required.

3. **Newly Eligible Employees.** As a new employee of the Group who becomes eligible for coverage, You may enroll Yourself and Your Eligible Dependents within thirty-one (31) days of becoming eligible.
4. **Newly Eligible Dependents.** You may enroll a person who becomes newly eligible as a Dependent due to marriage, birth, adoption or legal guardianship by completing and submitting to Coventry signed Enrollment Applications along with supporting documentation within thirty-one (31) days of becoming eligible. If You have family coverage the addition of a Dependent will not change Your Policy type, although You must complete required forms within thirty-one (31) days of the event or be subject to the delayed coverage rules specified in the Late Enrollee provision. If You have single or two-person coverage, Your Policy type and associated premium will change. A newborn or adopted child as a Dependent added after the Employee's effective date, must be enrolled within the time frames specified in this Group Policy. If a newly Eligible Dependent is not enrolled as specified herein, the Dependent will be considered a Late Enrollee and subject to the Late Enrollee provision.
5. **Changes in Eligibility.** It is Your responsibility to notify the Group Employer and Coventry in writing of any changes, which will affect Your eligibility or the eligibility of Your Dependents within thirty-one (31) days of the event.
6. **General Limitation Period.** If an Eligible Employee and his or her Eligible Dependents enroll for coverage under this Group Plan during his or her Initial Enrollment Period, Annual Open Enrollment Period, or Special Enrollment Period, Pre-existing Conditions will be covered. If an Eligible Employee and his or her Dependents do not enroll for coverage during these Enrollment Periods, he or she will be considered a Late Enrollee and subject to the delayed coverage rules as specified in the Late Enrollee Provision.
7. **Special Enrollment Period.** An Eligible Employee or Eligible Dependent requesting to enroll under this Group Policy outside of the Initial Enrollment Period will **not** be considered a Late Enrollee under the following conditions:
 - a. The Eligible Employee or Eligible Dependent was covered under other health coverage at the time coverage was previously offered to the Employee or Dependent. The declination of coverage at the Initial Enrollment Period or subsequent Annual Open Enrollment Period must have been in writing. The Eligible Employee or Eligible Dependent must enroll within thirty-one (31) days after termination of the prior coverage.
 - (1) For an Eligible Employee, the previous coverage:
 - (a) must have been under COBRA or State Continuation and the coverage was exhausted; or
 - (b) was terminated as a result of loss of eligibility for coverage, including separation, divorce, death, termination of employment, reduction in the number of hours of employment, or coverage was terminated as a result of the termination of employer contributions.
 - (2) For an Eligible Dependent, the coverage:
 - (a) is newly made available to Dependents;
 - (b) is for an individual who is a participant under the contract, or has met a Waiting Period requirement and is eligible to be enrolled but for a failure to enroll during the previous enrollment period;
 - (c) Is for a person who becomes an Eligible Dependent through marriage, birth,

adoption, or placement for adoption.

- (3) New Dependents have a Special Enrollment Period of not less than thirty-one (31) days that must begin on the later of:
 - (a) The date coverage is made available; or
 - (b) The date of marriage, birth, adoption, or placement for adoption.
- (4) In the case of a Dependent's birth or adoption, or placement of a Dependent in foster care, an Eligible Employee and an Eligible Dependent spouse who did not previously enroll for coverage is eligible to enroll within thirty-one (31) days of the birth or adoption, or foster care placement. The employee and spouse coverage Effective Date is no later than the first day of the first month beginning after the date of eligibility if Coventry receives Enrollment Applications in the time frame specified herein. Other Dependent coverage is effective:
 - (a) In the case of marriage, as of the date of the marriage, or
 - (b) In the case of a Dependent's birth, as of the date of birth; or
 - (c) In the case of a Dependent's adoption or placement for adoption, or placement in foster care, the date of adoption, placement for adoption, or placement in foster care

If enrollment is not completed in accordance with the guidelines specified above, that person will be considered a Late Enrollee and subject to the Late Enrollee delayed coverage provisions.

8. **Late Enrollees.** Unless otherwise prohibited by law, an Eligible Employee or Eligible Dependent who tries to enroll outside the Initial Enrollment Period or Annual Enrollment Period will be considered a Late Enrollee, unless that person is considered a Special Enrollee as described above. A Late Enrollee who wants to enroll for coverage under this Group Policy must complete an Enrollment Application. Coverage will be for all conditions except for Pre-existing Conditions. The Pre-existing Condition exclusion relates to a physical or mental condition regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period prior to the enrollment date. Pre-existing Conditions will not be covered by this Group Policy until the Late Enrollee has been enrolled for eighteen (18) months from the date of enrollment. An Eligible Employee and his or her Eligible Dependents enrolling for coverage as a Late Enrollee may receive credit for the partial or full satisfaction of a Pre-existing Condition waiting period if the individual had Creditable Coverage as specified below.
 - a. **Creditable Coverage.** Creditable Coverage means benefits or coverage which is continuous to a date within sixty-three (63) days of enrollment under this Group Policy, exclusively of any waiting period, and which was provided under any health plan, public or private. Accident or disability income policies, policies for supplements to liability insurance, workers' compensation, auto medical payments, credit-only insurance, coverage provided by pre-paid health clinics, and others as defined by Florida Department of Financial Services rules are not considered Creditable Coverage.

If offered separately, the following are not considered Creditable Coverage:

- (1) Limited scope dental or vision benefits;
- (2) Long term care, nursing home care, home health care, community-based care; or any combination.
- (3) Coverage for Medicare Supplement insurance and other limited benefits as specified by department rules.

If offered independently and as non-coordinated benefits, the following are also not considered Creditable Coverage:

- (1) Coverage for specified disease or illness-only insurance; and

(2) Hospital indemnity or other fixed indemnity insurance.

- b. **Late Enrollees with Creditable Coverage.** A Late Enrollee who has Creditable Coverage continuous to a date sixty-three (63) days before the individual's enrollment date under this Group Policy, will be given credit for the partial or full satisfaction of a Pre-existing Condition limitation waiting period. An Eligible Employee or Dependent whose Creditable Coverage was in effect for twelve (12) months or longer, will not be subject to a Pre-existing Condition waiting period if he or she was covered under Creditable Coverage continuous to a date sixty-three (63) days before the enrollment date in this Group Policy. If an Eligible Employee's or Dependent's creditable coverage was in effect less than twelve (12) months, it will be applied to the eighteen (18) month pre-existing period and reduced accordingly.
- c. **Late Enrollees without Creditable Coverage.** A Late Enrollee will be subject to the full Late Enrollee Pre-existing Condition waiting period if he or she does not have Creditable Coverage.

C. Effective Date of Coverage

After Coventry receives completed Enrollment Applications and the appropriate Premium arrangements are made, coverage under this Group Policy shall begin on the earliest of the following dates:

1. Initial Enrollment and Annual Open Enrollment. Coverage shall begin on the date agreed upon by the Group and Coventry.
2. Newly Eligible Employees. Coverage will begin as of the first day of the calendar month following the date the employee becomes eligible, if written application is made on or before that date or within thirty-one (31) days after the date he or she becomes eligible.
3. Newly Eligible Dependents and Special Enrollees. Coverage will begin as of the first day of the calendar month following the date he or she becomes eligible (e.g. date of event such as guardianship, etc.), if written application is made on or before that date or within thirty-one (31) days after the date he or she becomes eligible. Newborn and adopted children are covered as specified in this Group Policy.
4. Late Enrollee. Coverage will begin as of the first day of the calendar month following the date application is received.
5. The Effective Date of Coverage as noted in 1 through 4 above may be changed by agreement of the Group and Coventry and only in accordance with applicable state and federal laws.

D. Enrollment Application

Newly Eligible Employees must complete Enrollment Applications available from the Employer within thirty-one (31) days of the date of his/her eligibility to assure timely coverage. Eligible Employees who choose not to elect group coverage for themselves or any Eligible Dependents must complete and sign a Waiver of Coverage within thirty-one (31) days of initial eligibility. A newly eligible employee who does not complete an Enrollment Application (or waive coverage) within thirty-one (31) days of initial eligibility, and requests coverage at a later date, may be considered a Late Enrollee and subject to the delayed coverage rules specified in the Late Enrollee provision.

To assure timely issuance of initial coverage, Coventry should receive an Enrollment Application from all Eligible Employees by the tenth (10th) day of the month prior to the Group Effective Date.

Enrollment Applications and Premiums received by Coventry after the tenth (10th) day of the month, but before the Group's Effective Date may result in delayed coverage and/or an inaccurate invoice for the following month. Inaccurate invoices will be appropriately adjusted by Coventry during the next billing cycle.

For an Eligible Employee and his/her Eligible Dependent(s) enrolling during an Initial, Annual, or if applicable, Special Enrollment Period, Coventry should receive his/her Enrollment Application by the

tenth (10th) day of the month prior to the individual's Effective Date (or for Group renewal, the Anniversary Date), to assure timely coverage.

The following documentation will be required to be submitted with the Enrollment Application when enrolling a newly Eligible Dependent:

Type of Qualifying Events

Marriage
Birth
Adoption/Placement of foster Child
Employment Status Change of Employee/Spouse
Change in Legal Guardianship

Documentation Required

Marriage Certificate
Birth Certificate
Legal Adoption/Foster Child Papers
HIPAA Certificate/Employer Letter
Court Ordered Legal Papers for Legal Guardianship

E. Member Status Change Form

For any change in coverage for existing Covered Persons, the Employer must submit a completed Member Status Change Form. The Member Status Change Form must be completed and sent by the Employer, under separate cover to Coventry Enrollment Department:

Coventry Health Care
Attention: Enrollment Department
1340 Concord Terrace
Sunrise, Florida 33323

1. Terminations

The Member Status Change Form must be used when terminating a Covered Person's coverage and the form must be signed by the Employer.

2. Proof of Dependent Status

If a dependent has a different last name than that of the employee, You must attach copies of supporting documents showing evidence of his/her dependent status (e.g. Birth Certificate, Court Order for Guardianship, Marriage Certificate).

If adding a dependent who is unmarried and age 19 or older, You must attach the following documents to show proof of dependent status:

- a. a copy of Your last IRS 1040 form; and
- b. if a student, a letter from registrar's office certifying current hours enrolled; or
- c. if not a student but living in the household, provide proof that dependent maintains his/her primary residence with the Named Insured (e.g. driver's license, etc.); or
- d. if disabled, a Healthcare Professional's certification stating date and degree of disability.

After enrollment, Coventry may from time to time require proof of dependent eligibility.

F. Notification of Ineligibility

A condition of membership in Coventry is the Named Insured's agreement to notify Coventry of any changes in status that affects the Named Insured or his or her Eligible Dependent's ability to meet the eligibility criteria set forth in this Group Policy within thirty-one (31) days of such change.

G. Restrictions upon Expulsion or Refusal to Issue or Renew Contract

Coventry shall not expel or refuse to renew the coverage nor refuse to enroll any eligible individual of a Group on the basis of the race, color, creed, marital status, sex or national origin of the individual. Coventry shall not expel or refuse to renew the coverage of any eligible individual Covered Person of a group on the basis of the age, health status, health care needs, or prospective costs of health care services of the individual. Nothing in this Section shall prohibit Coventry from requiring that, as a condition of continued eligibility for coverage, dependents of a Named Insured, upon reaching a specified age, convert to COBRA or a conversion contract. Coventry may also require that individuals entitled to have payments for health costs made under Title XVIII of the United States Social Security Act, as amended, be offered a Coventry contract for Medicare beneficiaries so long as Coventry is authorized to issue contracts for Medicare beneficiaries.

SECTION 2 MEDICARE ELIGIBLES

Medicare Part A: the Social Security Program that provides hospital health benefits.

Medicare Part B: the Social Security Program that provides Healthcare Professional services and outpatient health benefits.

A. 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 Policy, the benefits of the Group Policy shall be primary and the Medicare benefits shall be secondary as set forth below, but only to the extent required by law. In all other instances, the benefits under this Group Policy shall be secondary to any Medicare benefits. To the extent Coventry is primary payer, claims for Covered Services should be filed with Coventry first.

In order to ensure compliance with the Medicare federal regulations, the Employer shall advise Coventry, without delay, of any Covered Person who is covered under Medicare prior to or immediately following the date such Covered Person becomes so covered (e.g., prior to the Covered Person's 65th birthday). Additionally, the Employer shall advise Coventry, without delay, of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date. The Employer shall indemnify and hold Coventry harmless to the extent of any liability, including attorney fees and costs that results directly or indirectly from the Employer's failure to so advise Coventry.

In any circumstances under which the Medicare secondary payer requires that the benefits under this Group Policy be primary for any Covered Person, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individual. Also, the Employer may not induce such Covered Person to decline or terminate his or her group health coverage and elect Medicare as primary payer.

B. Working Elderly

1. If the Employer employs:
 - a. 20 or more persons for 20 or more weeks of the current or preceding Calendar Year, or
 - b. is a member of a multi-employer group health plan that includes at least one (1) employer with 20 or more employees,

the Group Policy provides primary coverage for employees and/or their spouses, age 65 or older. These names, along with any other identifying information requested by Coventry shall be provided to Coventry on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls under the Group Policy pursuant to the following terms:

- (1) The Employer shall provide Coventry without delay, the names of Named Insureds, age 65 or older:
 - (a) Who are covered under this Group Policy;
 - (b) Who are employed (not retired);
 - (c) Who are not eligible for Medicare due to end stage renal disease (ERSD).
- (2) The Employer shall provide Coventry, without delay, the names of spouses, age 65 or older, of current employees of any age:
 - (a) Who are covered under the Group Policy;
 - (b) Who are not eligible for Medicare due to ESRD.

- (3) For Covered Person who meets one of the descriptions set out above, Coventry will provide group health coverage, as set forth in the Group Policy, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is age 65 or over at the time of enrollment.
 - (4) Individual entitlement to primary coverage under this Section will terminate automatically:
2. Under the Medicare federal regulations, the Employer may not offer, subsidize, procure, or provide a Medicare supplement insurance policy to such individual. Also, the Employer may not induce such individual to decline or terminate his or her group health coverage and select Medicare as primary payer.
 - a. Entitlement of the employee and/or spouse to primary coverage under this Section will terminate automatically when:
 - (1) The employee retires; or
 - (2) The employee no longer meets the employer eligibility requirements.
 - b. The primary coverage described in this Section will not be provided in the case of a member of a multi-employer group health plan where that Employer has fewer than 20 employees and the plan has elected treatment of that member's employees under the exception for Employers described in 42 U.S.C. 1395y(b)(1)(A)(iii).
 - c. A person becomes entitled to Medicare on the basis of disability after the individual has been entitled to Social Security disability for twenty-four (24) months. There is a five (5)-month waiting period. Once a disabled individual turns age 65, he or she may be entitled to benefits on the basis of age. This does not apply to an individual who is covered under Medicare due to ESRD.

NOTE: Changes in the number of employees to fewer than 20 employees or from fewer than 20 employees to 20 or more employees, including pertinent changes in multi-employer group health plans, must be immediately reported by the Employer to Coventry.

C. Individuals with End Stage Renal Disease (ESRD)

1. Primary coverage under this Group Policy is provided for the Covered Persons who are entitled to Medicare coverage because of ESRD, pursuant to the following terms:
 - a. The Employer shall provide Coventry, without delay, the names of any individuals covered under the Group Policy who are or will be undergoing a regular course of renal dialysis, or who will receive or already have received a kidney transplant, including the beginning date of such dialysis or the date of such transplant, and any other identifying information requested.
 - b. For Covered Person who is entitled to Medicare coverage because of ESRD, Coventry will provide group health insurance coverage, as set forth in this Group Policy, on a primary basis for thirty (30) months beginning with the earlier of:
 - (1) The month in which the individual becomes entitled to Medicare Part A ESRD benefits; or
 - (2) The first month in which the individual would have become entitled to Medicare Part A ESRD benefits if a timely application had been made.
2. If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For Covered Persons eligible for Medicare due to ESRD on or after March 1, 1996,

Coventry will provide group health coverage, as set forth in the Group Policy, on a primary basis for eighteen (18) months, on or after March 1, 1996, for thirty (30) months.

3. Under the Medicare federal regulations, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individuals. Also, the Employer may not induce such individuals to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

D. Miscellaneous

1. This Medicare Secondary Payer Section shall be subject to, modified 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 the Group Policy.
2. Coventry shall not be liable to the Employer or to any Covered Person on account of any non-payment of primary benefits resulting from any failure of performance of the Employer's obligations as set forth in this Section.
3. If Coventry should elect to make primary payments covering services rendered to an employee or dependent described in this Section in a period prior to receipt of the information required by the terms of this Section, Coventry may require the Employer to reimburse Coventry for such payments. Alternatively, Coventry may require the Employer to pay the rate differential that resulted from the Employer's failure to provide the required information in a timely manner.
4. The Employer shall indemnify and hold Coventry harmless to the extent of any liability that the Employer may be charged as a result of any failure of performance of the Employer's obligations as set forth in this Section.

NOTE: The federal laws described in this Section are directed at the Employer. Individuals with questions regarding their rights under those laws should direct their questions to the Employer.

SECTION 3 COVERAGE PROVISIONS

A. How the Plan Works

Coventry agrees to arrange for Covered Services as listed in the Schedule of Benefits in accordance with the procedures and subject to the limitations and exclusions specified in this Group Policy. Covered Services can be rendered by Participating or Non-Participating Providers. However, benefits are paid at a higher amount for services received from Participating Providers than from Non-Participating Providers.

B. Payment to Providers (Participating and Non-Participating)

1. Payment to Participating Providers

Payment of benefits for Covered Services will be made by Us directly to the Participating Provider. You are responsible for unauthorized or non-Covered Services.

The examples below illustrate how services rendered by Participating Providers will be paid at the In-Network level of benefits after the applicable Deductible has been satisfied:

- a. Assume Your In-Network Hospital Coinsurance is 20%. The Hospital bill is \$5,000 (actual charges), and Our contracted rate for the Hospital is \$3,000. In this example, the amount in excess of the \$3,000 contracted rate is not Your responsibility. We would pay 80% of the \$3,000 contracted rate, which is \$2,400. You would pay 20% of the \$3,000 contracted rate, which is \$600.
- b. Assume Your Specialist visit Copayment is \$50. The Specialist's bill is \$140 (actual charges) and Our contracted rate for the Specialist is \$80. In this example, the amount in excess of the \$80 contracted rate is not Your responsibility. We would pay \$30 (the contracted rate minus Your Copayment amount). You would pay the \$50 Copayment.

2. Payment to Non-Participating Providers

You may receive Covered Services from Non-Participating Providers. Services rendered by Non-Participating Providers will be paid at the Out-of-Network level of benefits pursuant to the terms and conditions stated herein and on the Schedule of Benefits.

Except for Emergency Services and Care, coverage for Covered Services provided by Non-Participating Providers is limited to the Out-of-Network Rate less applicable Copayments, Coinsurance and Deductibles. The Out-of-Network Rate shall be the lesser of the Non-Participating Provider's billed charges or an amount based upon the Florida Medicare fee schedule. Covered Individuals may contact Customer Service to inquire about specific services and the applicable Out-of-Network rates.

If the amount You are charged for a service is equal to or less than the Out-of-Network Rate, then the charges should be completely covered by Us, except for any Prior Authorization penalties that may apply, or any Copayment, Deductible and/or Coinsurance payments that may apply as Your responsibility. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular service, then You must pay the excess.

The examples below illustrate how services rendered by Non-Participating Providers will be paid at the Out-of-Network level of benefits after the applicable Deductible has been satisfied:

- a. Assume Your Out-of-Network Hospital Coinsurance is 40% of the Out-of-Network Rate. The Hospital bill is \$20,000 (actual charges), and the Out-of-Network Rate for the Hospital is \$12,000. We would pay 60% of the \$12,000 Out-of-Network Rate, which is \$7,200. You would pay 40% of the \$12,000 Out-of-Network Rate, which is \$4,800. In this example, You are also responsible for the amount in excess of the Out-of-Network Rate. Therefore, You

would also pay the Hospital for the \$8,000 of actual charges that exceed the \$12,000 Out-of-Network Rate, for a total cost to You of \$12,800. Please note that any payments You make in excess of the Out-of-Network Rate do not count towards Your Out-of-Pocket Maximum.

- b. Assume Your Out-of-Network Specialist visit Copayment is \$50. The Specialist's bill is \$140 (actual charges) and the Out-of-Network Rate for the Specialist is \$80. We would pay \$30 (the Out-of-Network Rate minus Your Copayment amount). In this example, You are also responsible for the amount in excess of the Out-of-Network Rate. Therefore, You would also pay the Specialist for the \$60 of actual charges that exceed the \$80 Out-of-Network Rate, for a total cost to You of \$110. Please note that any payments You make in excess of the Out-of-Network Rate do not count towards Your Out-of-Pocket Maximum.

3. Payment, Generally

- a. Coventry will pay for Covered Services on a Benefit Year basis, after satisfaction of the applicable Deductible, Coinsurance and Copayments (as stated in the Schedule of Benefits), and provided:
 - (1) The Expense is incurred while covered under this Group Policy;
 - (2) The Expense is incurred for Covered Services specified in the Covered Services Section;
 - (3) The Expense is not paid or payable under another benefit of this Group Policy; and
 - (4) Such payment:
 - (a) Will not exceed the Lifetime Maximum Individual Benefit set forth in the Schedule of Benefits of this Group Policy; and
 - (b) Will be subject to the Covered Services Section, Exclusions and Limitations Section and Schedule of Benefits of this Group Policy.
- b. In addition to applicable Deductibles, Copayments and Coinsurance, Covered Persons who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.
- c. If Prior Authorization is not obtained for certain services provided by Non-Participating Providers, a penalty, as stated in the Schedule of Benefits will be applied.

C. Benefit Levels

The benefit level this Group Policy will pay depends on the Provider the Covered Person uses to receive Covered Services:

1. If the Provider used is part of the Coventry Participating Provider Network, benefits are payable at the Participating Provider benefit level shown in the Schedule of Benefits. You may see any Participating or Non-Participating Providers. A Provider's network status can be determined by reviewing the Provider Directory provided by Coventry, but is subject to change. To verify participation, please call Customer Service at 1-866-847-8235.
2. If the Healthcare Professional used is not part of Coventry's Participating Provider Network, benefits are payable at the Non-Participating benefit level shown in the Schedule of Benefits.
3. There are three (3) important exceptions:
 - a. If a Covered Person is admitted to a Participating Hospital and services are rendered by a Non-Participating Provider, the Non-Participating Healthcare Provider will be paid at the Participating Provider benefit level.
 - b. If a Covered Service is not available through a Participating Provider in the Coventry network, and Coventry authorizes services from a Non-Participating Provider, those services rendered by a Non-Participating Provider will be payable at the Participating Provider benefit level. The Covered Person may be responsible for any charges that exceed the Allowed Amount.

- c. If the Covered Person requires Emergency services while in the Service Area or while traveling outside the Service Area, and travel to a Participating Healthcare Professional location would jeopardize the Covered Person's health, those Emergency services rendered by a Non-Participating Healthcare Professional will be payable at the Participating Healthcare Professional benefit level. If a Hospital admission occurs as a result of an Emergency Room visit, You must notify Coventry within forty-eight (48) hours of the admission or as soon as reasonably possible. If you fail to provide proper notification, benefits otherwise payable may be reduced as set forth in the Schedule of Benefits.

D. Your Responsibilities when using Participating Providers

When services are provided by a Participating Provider, all paper work is handled by the Participating Provider, so there are no bills for You to submit to Coventry. However, it is your responsibility to:

1. Verify the participation status of the:
 - a. Healthcare Professional who prescribes the treatment, and
 - b. Healthcare Provider who provides the covered service.
2. Know which Covered Services require Prior Authorization. Verify that Your Healthcare Professional has received authorization from Coventry to perform the service.
3. Pay all expenses incurred for Covered Services until the Deductible is satisfied. The Deductible must be satisfied before benefits begin.
4. Pay the applicable Coinsurance or Copayment amount required at the time of service.
5. Pay any charges for services and supplies not covered by this Group Policy.
6. Pay any increase in Coinsurance, if Prior Authorization requirements are not followed as specified in this Section.

E. Your Responsibilities when using Non-Participating Providers

1. Verify the participation status of the:
 - a. Healthcare Professional who prescribes the treatment, and
 - b. Healthcare Provider who provides the Covered Services.
2. Know which services require Prior Authorization. Verify that your Healthcare Professional has received authorization from Coventry to perform the service.
3. Pay all expenses incurred for Covered Services until the Deductible is satisfied. The Deductible must be satisfied before benefits begin.
4. Pay the Coinsurance amount required.
5. Pay any expenses for Covered Services which exceed the Allowed Amount.
6. Pay any increase in Coinsurance if Prior Authorization requirements are not followed.
7. Pay any charges for services and supplies not covered under this Group Policy.
8. You must complete and submit claim forms and provider bills to Coventry.

F. Deductible

Before Coventry will begin paying for Covered Services, a Covered Person must satisfy the annual Deductible which is a flat dollar amount as specified in the Schedule of Benefits. Only those charges indicated on claims received by Coventry for Covered Services that are subject to the Deductible and Coinsurance will be credited towards the Deductible. The Individual Deductible or Family Deductible must be satisfied each Calendar Year before any payment will be made by Coventry for any claim. Expenses used to satisfy the coinsurance percentage will count toward satisfying the Deductible specified in the Schedule of Benefits.

G. Coinsurance

Once the Calendar Year Deductible has been met, a Covered Person is responsible for paying a percentage of Covered Services. The coverage percentage, called "Coinsurance," is specified in the Schedule of Benefits.

H. Copayment

Some services may be subject to a nominal Copayment that must be paid to the health care provider at the time a service is rendered. Copayment amounts are specified in the Schedule of Benefits.

I. Coinsurance Maximum

Coinsurance Maximum limits the amount of Coinsurance a Covered Person will pay each Calendar Year before benefits are payable at 100% of the Allowed Amount under this Group Policy. Expenses used to satisfy the coinsurance percentage will count toward satisfying the Coinsurance Maximum specified in the Schedule of Benefits.

Expenses that **will not** count towards satisfying the Coinsurance Maximum are expenses related to charges for:

1. Copayments.
2. Services that are not specified as covered under this Group Policy or are specifically excluded;
3. Expenses used to satisfy the Calendar Year Deductible;
4. Charges that are not considered a covered Expense;
5. Charges in excess of the Allowed Amount;
6. Expenses related to services that exceed specific treatment limitations explained in the Exclusions and Limitations Section and in the Covered Services Section; and
7. Amounts for any reduction of benefits due to failure to obtain Prior Authorization for a service or supply, or obtain a second opinion when required or failure to notify in a timely manner.

The application of any specific service limits or specific benefit maximums noted in the Exclusions and Limitations Section, the Covered Services Section and Schedule of Benefits is not affected by the satisfaction of the Coinsurance Maximum. These specific service provisions will still apply after the Coinsurance Maximum is satisfied.

J. Effect of Prior Coverage

The following provisions apply to Covered Persons who, on the day before this Group Policy Effective Date was covered under Prior Coverage:

1. Prior Coverage means the Policyholder's group medical plan that this Group Policy replaced.

2. Prior Coverage credit does not apply if this Group Policy is replacing a Health Maintenance Organization (HMO) plan.

Coventry will automatically insure any such person under this Group Policy on its Effective Date, subject to the following provisions.

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

1. Annual Deductible Carry-over

Any charges credited by Coventry towards the Calendar Year Deductible requirements during the last three months of the prior Calendar Year will be carried over to reduce the Calendar Year Deductible requirement for the next Calendar Year if that deductible has not been satisfied for the previous year.

2. Deductible Carry-over

Any expenses incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of the Deductible for the first year under this Group Policy if:

- a. The expenses were incurred during the ninety (90) days before the Effective Date of this Group Policy;
- b. The expenses were applied toward satisfaction of the Deductible under the Prior Coverage during the ninety (90) days before the Effective Date of this Group Policy; and
- c. The expenses would be considered Covered Services under this Group Policy and such deductible provisions were the same or similar to those contained in this Group Policy.

However, the Covered Person must supply evidence of satisfaction of the deductible under the Prior Coverage by providing Coventry with an Explanation of Benefits (EOB) showing what has been paid under Prior Coverage in order to receive a deductible carry-over credit. This credit will not apply if this Group Policy is replacing a Health Maintenance Plan.

3. Coinsurance Maximum Carry-over

Any expenses incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of the Coinsurance Maximum for the first year under this Group Policy if:

- a. The expenses were incurred during the ninety (90) days before the effective date of this Group Policy;
- b. The expenses were applied toward satisfaction of the Coinsurance Maximum under the Prior Coverage during the ninety (90) days before the Effective Date of this Group Policy; and
- c. The expenses would be considered Covered Services under this Group Policy.

However, the Covered Person must supply evidence of satisfaction of the Coinsurance Maximum under the Prior Coverage by providing Coventry with an Explanation of Benefits (EOB) showing what has been paid under Prior Coverage in order to receive the Coinsurance Maximum credit. This credit will not apply if this Group Policy is replacing a Health Maintenance Plan.

K. Individual Lifetime Maximum Benefit

Coventry will pay benefits limited to the Lifetime Maximum Individual Benefit shown in the Schedule of Benefits. This applies individually to each Covered Person. When the Lifetime Maximum Individual Benefit amount has been paid for the Named Insured or Insured Dependent, all insurance for that person under this Policy will terminate.

L. Prior Authorization

In order to be eligible to receive maximum benefits available under this Group Policy, Coventry requires Prior Authorization for certain services. If you fail to obtain Prior Authorization for these services, benefits otherwise payable may be reduced as set forth in the Schedule of Benefits. The following treatment or services, including but not limited to, must be authorized by Us as explained below:

1. Hospital confinements and Skilled Nursing Facility confinements;
2. Non-emergent transportation;
3. Outpatient surgical, laboratory, diagnostic, and non-emergent wound care procedures;
4. Inpatient and outpatient rehabilitative services;
5. Home Health Care Services, DME, Prosthetics, Braces, Hospice;
6. Pain Management

For a current list of those services requiring Prior Authorization, You may call Customer Service at 1-866-847-8235, TDD #: 1-888-444-7352.

If the treatment or service is not authorized in advance, benefits will be reduced as described in the Schedule of Benefits.

Prior Authorization Procedures:

The penalty for not obtaining authorization of a planned admission is to reduce benefits. The Covered Person or his or her attending Healthcare Professional must notify Us as follows:

1. At least ten (10) days prior to the start of any treatment requiring Prior Authorization.
2. Within forty-eight (48) hours or as soon as reasonably possible after the start of emergency treatment or an emergency Hospital confinement.
3. Within ten (10) days for a planned inpatient Hospital admission
4. In the case of pregnancy, within twenty-four (24) hours or as soon as reasonably possible after the date of a maternity delivery or maternity-related admission.

In response to the request for Prior Authorization We will:

1. Advise that the treatment or service is authorized; or
2. Deny Prior Authorization and advise as to the alternative treatment or service that will be authorized; or
3. Deny Prior Authorization entirely. If We deny an authorization, We will send the denial in writing to the Covered Person, the attending Healthcare Professional, and if applicable, the Hospital.

The Covered Person or his or her attending Healthcare Professional may at any time ask Us to reevaluate its decision on Prior Authorization or extend the number of days of Hospital confinement deemed to be appropriate for the treatment of the Covered Person's Condition.

Prior Authorization is not a guarantee of payment and will not result in payment of benefits that would not otherwise be payable.

M. Semi-Private Room Rate

In the case of a Hospital which does not have semiprivate accommodations; the standard daily semiprivate room rate will, for purposes of this benefit, be 80% of the daily charges for regular Hospital services at its lowest rate for private accommodations. If the Hospital charges for a private room, We will not pay more than for a semi-private room.

N. Second Medical or Surgical Opinion

You must inform your Physician of your intent to seek a second opinion. You have the right to a second opinion based on meeting at least one of the following conditions. If you seek a second opinion, You will be responsible for satisfying the Deductible, paying the applicable Coinsurance amount required, and any charges for services not covered under this Policy.

1. A diagnosis has not been determined after a diagnostic work-up has been completed;
2. You have an unsatisfactory response to a treatment plan of sufficient duration;
3. You disagree with your Physician's proposed treatment plan;
4. You disagree with Your Physician's or Coventry's opinion of the necessity for a medical or surgical procedure; or
5. You are subject to a serious illness or injury.

The Second Opinion must be given:

1. by a state board certified specialist whose specialty is appropriate to the surgical procedure being evaluated, who has personally examined the Covered Person and who does not perform the surgery;
2. no later than six (6) months after the Initial Surgical Opinion indicating the need for the same surgery; and
3. in writing.

Coventry may also request that the Covered Person obtain a second opinion or surgical opinion during the Prior Approval review process when Medical Necessity, efficiency or appropriateness of the proposed covered Service is in question. If Coventry requires a second opinion, We will assist You in finding an appropriate board-certified Physician. We will pay 100% of the Allowed Amount related to a second opinion requested by Us.

SECTION 4 COVERED SERVICES

Covered Persons are entitled to receive the services and benefits set out in this section, subject to the limitations, Exclusions, Deductibles, Coinsurance and Copayments specified. Some services, as specified herein, are subject to a maximum benefit amount per Calendar Year.

Covered Persons are free to obtain services from Participating Healthcare Professionals or Healthcare Professionals of their choice (Non-Participating Healthcare Professionals). However, benefits are paid at a higher percentage rate for services received from Participating Healthcare Professionals than from Non-Participating Healthcare Professionals. Please refer to the Schedule of Benefits for percentages paid.

A Covered Person is entitled to receive Covered Services when provided, prescribed or directed by a Healthcare Professional.

Coventry shall make all determinations that are required for the administration of this Group Policy, including determinations regarding Medical Necessity and Covered Services, at its discretion. Coventry shall interpret this Certificate of Insurance, including any terms and conditions which may otherwise be or appear to be ambiguous, whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions, and interpretations made by Coventry and in accordance with applicable law, shall be binding upon the Covered Person. In accordance with this Group Policy, the Covered Person has the right to file a Grievance regarding decisions made by Coventry. In all cases, Medical Necessity is to be determined in accordance with generally accepted standards of medical care as determined by Coventry.

A. Hospital Inpatient Services

Coventry covers the services of Hospitals when the Healthcare Professional receives authorization from Coventry in advance of the inpatient hospitalization or in the case of an Emergency Medical Condition, notification to Us within forty-eight (48) hours or as soon as reasonably possible after the start of Emergency Services and Care treatment or an Emergency Hospital confinement. Hospital services include, but are not limited to:

1. Semi-private room and board including special diets, use of operating room, anesthesia, intensive care or other special care units, oxygen, and general or private duty nursing when prescribed. If a Covered Person signs a waiver assuming private room charges, the Covered Person will be responsible for the cost.
2. Healthcare Professional services including surgery, delivery and administration of anesthesia.
3. Laboratory, X-Ray, and diagnostic services.
4. Acute dialysis.
5. Blood, blood plasma, blood derivatives and blood factors.
6. Drugs, medications and biologicals, dressings and casts.
7. Reconstructive Surgery:

Benefits are available for reconstructive surgery if it is incidental to or follows surgery from trauma, infection or other diseases of the part of the body involved. With respect to a child covered under this Contract, benefits are available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.

8. Rehabilitative Services (speech, occupational, physical, respiratory):

Rehabilitative services provided while the Covered Person is confined in a Hospital will be covered for the duration of the Hospital confinement, subject to the conditions listed herein.

Speech, occupational, physical and respiratory therapy services received during an admission to a Hospital do not reduce the number of outpatient rehabilitative therapy visits as indicated on the attached Schedule of Benefits.

9. Inpatient Neonatal Intensive Care Unit (NICU) admission and subsequent inpatient care.

B. Outpatient Services

Office visits and consultations to include:

1. Routine adult check-up and physical examination. See Schedule of Benefits for limitations.
2. Pediatric examinations and well-child care. Visits include hearing and vision screening and preventive care services when ordered and performed by a Healthcare Professional for health maintenance and preventive care. Services include Healthcare Professional - delivered or Healthcare Professional - supervised visits from birth to sixteen (16) years which includes a history, a physical examination, developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Services and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Benefits are limited to one visit payable to one provider for all of the services provided at each visit.
3. Diagnosis and treatment of illness or Injury.
4. Annual OB/GYN visit (breast exam, pelvic exam and Pap smear) with a Healthcare Professional, Gynecologist or Obstetrician/Gynecologist. See Schedule of Benefits for limitations.
5. Immunizations required because of an injury or immediate risk of infection.
6. Immunizations for routine preventive care as recommended by the Centers for Disease Control Advisory Committee on Immunization Practices (CDCACIP) and subsequently published in the CDC Morbidity and Mortality Report and approved by Coventry.
7. Allergy testing, diagnosis, and treatment; allergy serum, and the administration of injections.
8. Newborn hearing screening at birth and any follow-up re-evaluations leading to diagnosis is covered through age twelve (12) months. Treatment and services covered under this Group Policy and delivered or authorized by the child's Healthcare Professional will be provided to any Covered dependent child diagnosed as having a permanent hearing impairment.
9. Non-surgical Spine and Back Disorder Treatment: Manual manipulation of the spine to correct subluxation. See Schedule of Benefits for limitations.
10. Rehabilitative Services: ordered by a treating physician and approved by Coventry are limited to the therapy categories listed below. Coventry must specifically pre-approve a written plan of treatment submitted by the Covered Person's Physician and agree that the Covered Person's Condition will improve significantly within sixty (60) days of the date therapy begins.

Rehabilitative Therapy Services are limited to four (4) modalities per day not to exceed the benefit maximum set forth in the Schedule of Benefits. They include:

- a. Services of a licensed speech-language pathologist to aid in the restoration of speech loss or swallowing disorders or an impairment resulting from injury, stroke or a surgical procedure while this coverage was in force.

- b. Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to injury, stroke or a surgical procedure while this coverage was in force.

Outpatient therapies listed below may be Covered Services when ordered by a Healthcare Professional licensed to perform such services. The outpatient therapies listed below are in addition to the Cardiac Rehabilitation, Occupational Therapy, Physical Therapy and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

- a. Cardiac Rehabilitation – Services provided under the supervision of a Healthcare Professional, or a Healthcare Professional trained for Cardiac Rehabilitation, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.
- b. Occupational Therapy – Services provided by a Healthcare Professional or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Covered Condition are covered.
- c. Speech Therapy – Services of a Healthcare Professional, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Covered Condition are covered.
- d. Physical Therapy – Services provided by a Healthcare Professional or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.
- e. Respiratory or Inhalation Therapy – Services provided for the purpose of aiding in the restoration of normal physical function of the lungs, due to injury, stroke or a surgical procedure while this coverage was in force.

C. Additional Services

Ambulance Services

Ground ambulance services for an Emergency Medical Condition are covered. Please call Customer Service regarding benefit requirements applicable to air ambulance and non-emergency transportation services. Non-emergency transportation between healthcare facilities for receipt of Covered Services must receive Prior Authorization.

Breast Cancer Treatment

Coverage for breast cancer treatment includes inpatient Hospital care and outpatient post-surgical follow-up care for mastectomies 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 Healthcare Professional'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 attending Physician.

The Federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- a. reconstruction of a surgically removed breast;

- b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under Your health plan, including Copayments, Deductible and Coinsurance provisions.

Chemotherapy & Cancer Drugs

Standard chemotherapy for the treatment of cancer; drugs prescribed for the treatment of cancer, including those that are not approved by the FDA for a particular indication but the drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature. Coverage includes medically appropriate services associated with the administration of the chemotherapy agent.

Cleft Palate and Cleft Lip

Treatment is provided for a dependent under age eighteen (18). Benefits are available for medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the Healthcare Professional. Coverage is subject to benefit and benefit limitations listed in the Covered Services and Exclusions and Limitations Sections of this Group Policy.

Dental Services

Benefits are available for the treatment of an Accidental Dental Injury to sound natural teeth if the services are rendered, and the treatment is received within six (6) months of the accident. This benefit does not include coverage for expenses for services related to an injury occurring while, and as a result of, biting or chewing. Bite splints are covered.

Dental Treatment in a Hospital or Ambulatory Surgical Center

Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or surgery subject to Prior Authorization by Us for:

- a. A dependent child under age eight (8) whose treating Healthcare Professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
- b. A Covered Person who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any 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. Use of general anesthesia in a hospital or ambulatory surgical center is subject to Prior Authorization by Us.

Diabetes Treatment

Benefits are available for services including all medical equipment, supplies and diabetes outpatient self-management training and educational services used to treat diabetes when the Covered Person's Healthcare Professional or a Healthcare Professional that specializes in the treatment of diabetes certifies that such services are necessary and Prior Authorization is received from Coventry. We may require that diabetes outpatient self-management

training and educational services be provided under the direct supervision of a certified diabetes instructor or a board-certified endocrinologist. We may require that a licensed dietitian provide nutrition counseling. Supplies will be obtained from a vendor designated by Coventry.

Durable Medical Equipment (DME) for Outpatient Use

Benefits are available for DME as prescribed by a Healthcare Professional and subject to Prior Authorization by Us, up to the maximum benefit allowed. DME must meet Medicare Guidelines as defined in the Medicare DME manual. See Schedule of Benefits for limitations.

1. Repair, replacement and maintenance of authorized durable medical equipment. Coverage is limited to normal wear and use and body growth or change.
2. Equipment for the treatment of diabetes.
3. Drug infusion pumps and release devices.
4. DME will be limited to the most cost effective equipment available and capable of performing the needed medical purpose.

Enteral Formulas

Benefits are available for enteral formulas for home use which are physician prescribed as appropriate for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited disease of amino acid and organize acids include food products modified to be low protein, in an amount not exceeding \$2,500 per Calendar year for any Covered Person through the age of twenty-four (24).

Eye Care

Benefits are available for initial prescription lenses (eye glasses or contact lenses) following an operation for cataract or other diseases of the eye. See Schedule of Benefits for limitations.

Family Planning

Benefits are available for voluntary counseling for problems of fertility and infertility subject to Prior Authorization by Coventry.

1. Voluntary sterilizations, tubal ligations and vasectomies,
2. Intrauterine Devices (IUD), insertion and removal.
3. Measurement and fitting for contraceptive diaphragms.

Foot Care

Benefits are available for the treatment of a disease or injury of the foot, including infection, bony malformation, tendonitis, hammertoes and treatment of bunions.

Foot Care (routine) for Diabetics only

Benefits are available for removal of warts, corns or calluses or trimming of toenails

Gene Testing

Subject to Prior Authorization, coverage is limited to chromosome analysis when there is a risk of a genetic defect.

Genetic Counseling

Subject to Prior Authorization, services are provided for counseling with trained Healthcare Professionals before testing begins and when Covered Persons receive the test results, as well as appropriate post testing follow-up, if the medical indication of significant potential for occurrence of genetic defects exists.

Government Hospital

Benefits are available for Covered Services in a Government Hospital if, because of serious injury or sudden illness, the Covered Person is taken to one of these Hospitals for an Emergency Medical Condition. In this instance, We will continue to cover services only for as long as Emergency Services and Care is appropriate and it is not possible for the Covered Person to be transferred to a Participating Hospital.

Hearing

Benefits are available for hearing screening in a licensed Healthcare Professional's office.

1. Services of a licensed audiologist to determine and measure the hearing function loss and aid in the restoration of hearing function loss, if such loss has occurred while this coverage was in force.
2. Cochlear implants are covered subject to Prior Authorization by Us.

Home Health Care Services

Benefits are available if the Covered Person is confined at home and requires home health care services in lieu of hospitalization, subject to Prior Authorization by Us.

Services must be provided:

- a. by a licensed home health agency or
- b. through a licensed nurse registry or
- c. by an independent nurse licensed under Section 464 of the Florida Statutes.

Covered Home Health Care Services include:

- a. Part-time or intermittent nursing care by a registered nurse or licensed practical nurse which shall consist of a visit not to exceed four (4) hours in duration.
- b. Physical therapy by a licensed physical therapist; occupational therapy by a licensed occupational therapist; and speech therapy by a licensed speech-language pathologist.
- c. Medical appliances, equipment, laboratory services, supplies, drugs and medicines prescribed by the Covered Person's Healthcare Professional and other services provided by the home Healthcare Professional.

Home Peritoneal Dialysis

Benefits are available for home peritoneal dialysis.

Hospice Care

Benefits are available for terminally ill Covered Persons. Hospice services must be pre-authorized and provided by a licensed Hospice organization

- a. A Covered Person is considered terminally ill if the Healthcare Professional has certified the Covered Person as having a life expectancy of one (1) year or less, should the illness run its normal course.
- b. Care relating to the terminal condition may be provided on an inpatient basis (in either a Hospice or a Hospital as directed by Hospice) or an outpatient basis.
- c. Coverage includes drugs and medical supplies, bereavement counseling and respite care provided by Hospice.

Laboratory Testing.

Mammography Screening

Benefits include for males and females:

- a. one (1) or more mammograms a year at any age for men or women who are at risk for having breast cancer, based upon the recommendation of the treating Healthcare Professional; and
- b. a single baseline mammogram for women age thirty-five (35) through thirty-nine (39), inclusive; and
- c. mammograms shall be covered every two (2) years, or more frequently upon the recommendation of a Healthcare Professional, for ages forty (40) through forty-nine (49), inclusive; and
- d. an annual mammogram at age fifty (50) and older. Except with respect to mammograms performed more frequently than one (1) every two (2) years from ages forty (40) through forty-nine (49)
 - (1) a Healthcare Professional's involvement will not be required if the mammogram is performed with radiological equipment registered with the State Department of Health and Rehabilitative Services for breast cancer screening; and
 - (2) benefits will be payable the same as for any outpatient visit.

Mammograms performed pursuant to the above are covered in full and not subject to a Deductible, Copayment or Coinsurance.

Maternity Services

Benefits are available for:

- a. maternity care received on an inpatient or outpatient basis including pre-natal and post-natal care of the mother and child;
- b. the performance of any clinical tests and immunizations in keeping with prevailing medical standards;
- c. the use of Hospital delivery rooms and related facilities or affiliated birthing centers;

- d. the use of newborn nursery and related facilities;
- e. special procedures performed by a Healthcare Professional; and
- f. complications of pregnancy; and
- g. Specialist and Sub-Specialty Obstetrics and Gynecology.

Post-delivery care may be provided:

- a. at the Hospital,
- b. at the attending Healthcare Professional's office,
- c. at an outpatient maternity center, or
- d. in the home by a qualified licensed Healthcare Professional trained in mother and baby care.

Services provided by affiliated licensed birthing centers, certified nurse-midwives and licensed midwives working within the scope of his or her license are covered.

The Newborns' & Mothers' Health Protection Act of 1996 (the Newborns' Act) provides that health plans that offer maternity coverage, may not restrict a mother's or newborn's benefits for a Hospital length of stay that is connected to childbirth to less than forty-eight (48) hours of inpatient care following a vaginal delivery or ninety-six (96) hours of inpatient care following a cesarean delivery.

Covered Persons have the option, with the Provider's authorization, to leave the Hospital earlier than stated above and receive a home health visit within seventy-two (72) hours of leaving the Hospital. If You choose to leave the Hospital early and receive a home health visit, the postpartum home health visit shall not be subject to Copayments or Coinsurance, if any.

Neuropsychological Testing

Benefits are available subject to Prior Authorization by Us.

Newborns

The coverage, benefits, or services for newborns shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or pre-maturity, and up to \$1,000 transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the treating Healthcare Professional as necessary to protect the health and safety of the newborn child.

If a newborn is admitted to a Neonatal Intensive Care Unit (NICU) there is a separate Hospital admission with applicable Copayment or Coinsurance.

Benefits are available for a circumcision performed within the first month in either a hospital setting or in a physician's office.

Oral Surgery

Benefits are available for diagnostic and surgical procedures involving bones or joints of the jaw and facial region, 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, for intra-oral prosthetic devices, or for surgical procedures for cosmetic purposes.

Orthognathic Surgery

Benefits are available for the surgical procedures involving bones or joints of the jaw and facial region, to treat conditions caused by congenital or developmental deformity. This coverage does not include coverage for care or treatment of the teeth or gums, intra-oral prosthetic devices, or surgical procedures for cosmetic purposes.

Orthotic Devices (as authorized by Coventry)

Benefits are available for

1. customized devices, such as braces and trusses
2. other supports for the feet are not a Covered Benefit unless they are an integral part of the leg brace or a Healthcare Professional prescribes therapeutic shoes for a Covered Person with diabetes.

The appliance must be an orthotic device as defined by the Medicare DME Manual and subject to Prior Authorization by Us.

Benefits are also available for dynamic orthotic cranioplasty (DOC) – bands or similar devices and helmets or any other type of devices to treat plagiocephaly.

Osteoporosis Screening

Benefits are available for the diagnosis and treatment of osteoporosis subject to Prior Authorization by Us for estrogen-deficient Covered Persons who:

- a. are at clinical risk for osteoporosis,
- b. have vertebral abnormalities,
- c. are receiving long-term glucocorticoid (steroid) therapy,
- d. have primary hyperparathyroidism, or
- e. have a family history of osteoporosis.

Outpatient Surgery

Benefits are available in a Hospital, Hospital outpatient unit, or licensed Ambulatory Surgical Center.

Prosthetic Devices

Benefits are available for the most cost effective Prosthetic Device available and capable of performing the needed medical purpose:

1. Special features prescribed by the Healthcare Professional are subject to Prior Authorization by Us. See the Schedule of Benefits for limitations.
2. Devices are limited to standard/evaluated internal and external devices such as artificial limbs, organic lenses, pacemakers, heart-valve replacements, artificial joints, and external breast prostheses.

3. Repair, replacement and maintenance of authorized prosthetic devices. Coverage is limited to normal wear, and use and body growth or change.
4. Special appliances and surgical implants required by a Covered Person for an illness or injury when they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue of the human body.

The appliance must be a prosthetic device as defined by the Medicare DME Manual and is subject to Prior Authorization by Us.

Radiology and Diagnostic Testing

For a current list of radiology and diagnostic tests that require Prior Authorization, contact Customer Service at 1-866-847-8235.

Skilled Nursing Facility Care

Benefits are available for Skilled Nursing Facility Services subject to Prior Authorization by Us (excluding nervous and mental conditions and alcohol/substance abuse) and when rendered in a licensed Hospital or Skilled Nursing Facility.

- a. Services must be provided in lieu of hospitalization or continued hospitalization.
- b. Covered Services 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), and chemotherapy treatment for proven malignant disease.
- c. A Covered Person is entitled to a limited number of days, as indicated on the attached Schedule of Benefits, for short-term speech therapy, occupational therapy, physical therapy and respiratory therapy upon admission to a Skilled Nursing Facility. Such coverage is available only for rehabilitation following injuries, surgery or other medical conditions and is intended to improve or restore bodily functions within a reasonable and generally predictable period of time. Coverage is not provided to maintain the Covered Person at his or her present level or to prevent further deterioration.
- d. Services must be skilled level services and must be ordered by and provided under the direction of a Healthcare Professional.
- e. Services are limited as specified in the Schedule of Benefits.

Surgical Procedures in a Healthcare Professional's Office.

Temporomandibular Joint (TMJ)

Coverage is provided for the diagnosis and standard treatment of jaw joint disorders, including TMJ and craniomandibular joint disorder (CMD). Coverage does not include coverage for care or treatment of the teeth or gums, for intra-oral prosthetic devices or for surgical procedures for cosmetic purposes.

Transplantation

Transplantation of tissue or organ, as defined below, is covered subject to Prior Authorization by Us and applicable conditions and limitations.

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications related to transplantation. Coventry will cover services received in connection with the transplantation of the following human tissue or organs:

- a. Cornea
- b. Heart
- c. Lung
- d. Liver
- e. Kidney
- f. Pancreas
- g. Bone Marrow Transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental in accordance with applicable Florida law. As used in this section, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, 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 chemotherapy.
- h. Other transplants as approved by Coventry in its sole discretion consistent with nationally established guidelines.

Coventry will cover organ acquisition and donor costs. Testing to find a suitable donor is limited to the reasonable costs of searching for the donor and is limited to the immediate family members and the national donor programs.

The Covered Person or the Covered Person's Healthcare Professional must notify Us in advance of the Covered Person's initial evaluation for the transplant procedure. Prior Authorization is required for a transplant procedure.

Hospital services and medical services will be paid under provisions set forth in this Plan, in accordance with the same terms and conditions as Coventry will cover benefits for care and treatment of any other covered condition.

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 one-hundred (100) miles from the Covered Person's home.

Direct, non-medical costs for one (1) member of the Covered Person's immediate family, two (2) members if the patient is under age eighteen (18), for:

- a. transportation to and from the approved facility where the transplant is performed, but no more than one (1) 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. Costs listed above are only payable if the Covered Person lives more than one-hundred (100) miles from the approved transplant facility. The maximum benefit for these expenses is \$5,000 per transplant.

Wigs and Cranial Prosthesis

Benefits are available when related to restoration after cancer or brain tumor treatment with a \$250 limit per Benefit Year.

D. Emergency Services and Care

Emergency Services and Care for Emergency Medical Conditions are covered. When time and circumstances permit, a Covered Person must notify Coventry within forty-eight (48) hours or as soon as reasonably possible after the start of emergency treatment or an emergency Hospital confinement. Whenever possible, consult Your treating Physician if You believe You are experiencing an Emergency Medical Condition. Your treating Physician or an on-call Physician should be available twenty-four (24) hours a day.

Coventry will pay for the screening, evaluation, examination and treatment that are reasonably calculated to assist the Provider in arriving at the determination as to whether the Covered Person's condition is an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination may be denied.

1. In-Network

Coventry will pay for the costs incurred for Covered Services subject to the payment provisions set forth in this Certificate of Insurance.

2. Out-of-Network

- a. Emergency Medical Conditions which require Emergency Services and Care before the Covered Person can reasonably return to Coventry's Service Area are covered on the same basis as in-area Emergency Medical Conditions. The Covered Person should notify Coventry as soon as reasonably possible.
- b. Coverage or treatment out of Coventry's Service Area is limited to Emergency Services and Care for an Emergency Medical Condition.
- c. Benefits are payable for Emergency Medical Conditions for which Emergency Services and Care is provided. Elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from Coventry's Service Area may not be covered.

3. Emergency Room follow-up Care

A Covered Person is covered for any follow-up care necessary after receiving Emergency Services and Care for an Emergency Medical Condition. If the Covered Person receives follow-up care in the Emergency Room Department, the Covered Person may be responsible for payment for such services. To be eligible for coverage of follow-up care from a Non-Participating Provider at the In-Network level of benefits, follow-up care resulting from an Emergency must be provided by a Participating Provider, or Pre-Authorized by Us.

SECTION 5 EXCLUSIONS and LIMITATIONS

All services not specifically listed as a Covered Service in this Certificate of Insurance or in any rider, unless such services are required by applicable state or federal law, are excluded. In addition to certain exclusions and limitations already described in this Certificate of Insurance benefits will not be provided under this Certificate of Insurance when any of the following apply unless provided for by a separate rider or amendment.

The fact that a Healthcare Professional may prescribe, recommend, approve or furnish a service or supply does not, of itself, make it appropriate or a Covered Service, nor does it make the charge an Allowed Amount under this Group Policy, even though the service or supply is not specifically listed as an exclusion.

Acupuncture services.

Alcoholism or substance abuse: Benefits are not available for treatment services and supplies except as specifically provided for by Rider, if elected by the Group.

Alternative Medicine: Benefits are not available for services, testing, equipment, and supplies associated with alternative modalities of care including, but not limited to acupuncture, hypnosis, hypnotic anesthesia, naturopathy, homeopathy, massage therapy, and aromatherapy.

Ambulance Services: Benefits are not available for Ambulance services obtained for a non-emergency, or if the service is determined by Coventry to be for the convenience of the Covered Person, except those services specifically provided for in the Covered Services Section.

Arch Supports: Benefits are not available for orthopedic shoes, sneakers, support hose, or similar type therapeutic devices/appliances regardless of intended use.

Athletic Event-Related: Benefits are not available for care and treatment for injuries sustained by a Covered Person in the course of any athletic event, or while training for such athletic event, for which the Covered Person is to receive remuneration in cash or in kind.

Autopsy or Post Mortem Examination Services.

Biofeedback: Benefits are not available for services and other forms of self-care or self-help training or educational programs and any related diagnostic testing, meditation, pain control, pain management therapies (except for medically-related conditions that receive Prior Authorization).

Blood: Benefits are not available for whole blood, blood plasma, blood components, and blood derivatives which are replaced.

Childbirth and Surrogate Parenting Classes.

Complications: Benefits are not available for medical or surgical complications, such as wound infections, during or as a result of a non-covered surgical procedure or service including, but not limited to services rendered for cosmetic purposes including any body piercing and tattooing, gastric bypasses, gastric stapling, breast reductions, breast implants, hypertrophic scars, breast asymmetry.

Contraceptives: Benefits are not available for over-the-counter contraceptives.

Cosmetic Surgery: Benefits are not available for:

1. Any service and supply to improve the Covered Person's appearance or self-perception, including but not limited to, electrolysis, procedures or supplies to correct baldness or the appearance of skin, face lifts, scar reduction (except as related to surgery that has received Prior Authorization), or ear lobe repair.

2. Any professional services and/or hospitalization in connection with elective cosmetic surgery, including but not limited to, body piercing and tattooing, tattoo removal, rhinoplasty, liposuction, abdominoplasty, breast reduction mammoplasty, blepharoplasty, varicose vein injections, removal or injection of skin tags, of cherry angiomas, telangiectasias, spider angiomas.
3. Diagnosis and treatment of any medical complications as a result of previous elective cosmetic surgery, regardless of how long ago such services were performed.
4. Removal of breast implants related to Cosmetic Surgery.
5. Excess skin surgery and treatment of complications arising from this procedure.

Costs incurred for Sickness Injury: Benefits are not available for:

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.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Counseling: Benefits are not available for marriage or relationship counseling, services or adoption agencies, pastoral counseling, family counseling, social, occupational, religious, or other social maladjustment's; chronic behavior disorders; codependency; impulse control disorders; organic disorders; learning disabilities; hyperkinetic syndromes. This exclusion includes any prescription medications prescribed for treatment associated with any of the above conditions.

Court-Ordered Services: Benefits are not available for Court ordered care or treatment, unless otherwise listed as Covered Services.

Criminal Activities: Benefits are not available for:

1. Care and treatment incurred in connection with injuries which occurred during a crime committed by a Covered Person or which the Covered Person tries to commit including, without limitation, treatment and care for any injuries sustained when the Covered Person's blood alcohol content is in excess of the legal limit whether or not the Covered Person is charged with or convicted of any criminal offenses.
2. Care and treatment for injuries sustained while the Covered Person is under the influence of any illegal or illicit drug, or any controlled or legend drug or substance if the drug or substance is not then subject to a valid prescription issued in the name of the Covered Person by a Healthcare Professional and being administered to treat a current episode of illness.

Custodial Care (Residential Care): Benefits are not available for 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 mothers, domestic maid services, and health resorts and spas and respite care. This includes services provided by a non-eligible institution and which is primarily a place of rest or for the aged or similar institution.

Dental Care: Benefits are not available for routine dental procedures including, but not limited to:

1. extraction of teeth,
2. restoration of teeth with fillings,
3. crowns or other materials,
4. bridges,
5. cleaning of teeth,
6. dental implants,
7. dentures,
8. periodontal or endodontic procedures,

9. orthodontic treatment including palatal expansion devices,
10. bruxism appliances,
11. dental x-rays,
12. routine intra-oral surgical procedures,
13. orthodontics and fixed and removable prosthetics, and
14. services related to an injury occurring while, and as a result of biting or chewing

except as otherwise specifically referenced in the Group Policy as covered.

All procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as temporomandibular joint (TMJ) syndrome or craniomandibular joint disorders (CMJ).

Coverage does not include diagnosis or treatment of dental disease, or the services of the dentist or oral surgeon, nor are the services set forth in this provision covered if provided in a dental office.

Diagnostic Admissions: Benefits are not available for diagnostic services that could have been provided in a Healthcare Professional's office, an outpatient department of a Hospital, or some other setting without adversely affecting the Covered Person's condition.

Dietary Regimens: Benefits are not available for dietary regimens, treatments, food, food substitutes or vitamins.

Disposable Medical Supplies and Personal Convenience: Benefits are not available for supplies, equipment, or personal convenience items such as, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags or the use of telephones or television while an inpatient.

Durable Medical Equipment: Benefits are not available for the following:

1. Devices and equipment used for environmental control, convenience functions or physical fitness.
2. Lost, abused or improperly cared for equipment.
3. Customized equipment.
4. Deluxe or motorized equipment.
5. Wheelchair lifts or ramps.

Educational Materials and Supplies: Benefits are not available for educational materials and supplies commonly available for purchase, except in the treatment of diabetes.

Experimental and/or Investigational Treatments and Procedures.

Eye Care: Benefits are not available for:

1. Eyeglasses and/or contact lenses unless indicated on the attached Schedule of Benefits.
2. Training or orthoptics, including eye exercises.
3. Prescription inserts for diving masks or other protective eyewear.
4. Nonstandard items for lenses including tinting and blending.
5. Refractive eye surgery to correct visual acuity problems.

Family Planning Services: Benefits are not available for any service other than those specified in the Covered Services Section of this Group Policy.

Foot Care (routine): Benefits are not available for any service or supply in connection with foot care in the absence of disease, injury, or accident. This exclusion includes, but is not limited to, clipping of nails, soaking the feet, removing calluses, treatment of flat feet, fallen arches, chronic foot strain and weak feet.

Gastric Bypass, Gastric Stapling, Gastric Balloon and Cylastic Bands: Benefits are not available regardless of medical or psychological condition.

Gene Therapy.

Government Hospital: Benefits are not available for care in any Hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless for an Emergency Medical Condition.

Government Programs: Benefits are not available for any service that is received and payment made on behalf of the Covered Person, under any federal, state or local government program.

Health Care Services: Benefits are not available for consultations, treatment or services or supplies received at a penal facility or outside a penal facility while a Covered Person is incarcerated.

Hearing Aids: Benefits are not available for hearing aids (external and implantable), and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Home Hemodialysis: Benefits are not available for any furniture, plumbing, electrical or other fixtures needed to perform dialysis treatments at home.

Home Oxygen Equipment: Benefits are not available for certain home oxygen equipment items including, but not limited to, emergency oxygen inhalators, portable preset oxygen units, and oxygen administration equipment.

Hypnotism or Hypnotic Anesthesia.

Illegal Actions: Benefits are not available for treatment of a condition resulting from participating in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony; includes care and treatment incurred in connection with injuries suffered in a fight in which the Covered Person is the aggressor or while the Covered Person is under the use of an illegal substance.

Immediate Relatives and Self Imposed Treatment: Benefits are not available for charges for physicians' services provided by an immediate relative, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation. This exclusion also precludes a Covered Person that is also a physician from treating himself or herself and submitting claims to Coventry for such coverage. For the purpose of this exclusion, "Immediate Relative" means any of the following:

1. Husband or wife;
2. Natural or adoptive parent, child or sibling;
3. Stepparent, stepchild, stepbrother or stepsister;
4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;
5. Grandparent or grandchild;
6. Spouse of grandparent or grandchild.

Immunizations: Benefits are not available for immunizations and autogenous vaccines related to foreign travel.

Impotence Treatment: Benefits are not available for penile prosthesis, medications such as Viagra, and other devices.

Infertility Treatment.

Learning Disorders: Benefits are not available for non-medical conditions related to hyperkinetic syndromes and learning disabilities (including ADD and ADHD disorders), mental retardation, developmental delay, and adult onset of attention deficit disorder.

Medical Care or Surgery not prescribed.

Mental Health Treatment: Benefits are not available for treatment, services and supplies, except as specifically provided for by Rider, if elected by the Group.

Military-Related: Benefits are not available for Military service-related medical care, for which the Covered Person is legally entitled to service from military or government facilities and for which facilities are reasonably accessible.

Non-Prescription Drugs: Benefits are not available for any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin or mineral supplements, appetite suppressants, fluoride products, or health foods.

Orthognathic Surgery: Benefits are not available for:

1. care of treatment of the teeth or gums, for intra-oral prosthetic devices; or
2. treatment for the consequences of bone loss in the jaw related to dental problems; or
3. treatment related to orthodontic procedures, braces, insertion of dentures, external fixation devices, splints and any other dental procedure;
4. surgical procedures for cosmetic purposes.

Orthomolecular Therapy: Benefits are not available for therapy including nutrients, vitamins, and food supplements.

Personal Comfort, Hygiene or Convenience Items: Benefits are not available for services and supplies 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, allergenic pillows or mattresses or waterbeds, physical fitness equipment, travel expenses other than authorized ambulance services that are specifically provided for under the Covered Services section.

Physical Examinations: Benefits are not available specifically for obtaining or continuing employment or required for education, insurance, government licensing or premarital purposes.

Prescription Drugs.

Prosthetic Devices: Benefits are not available for:

1. Deluxe equipment.
2. Devices related to erectile dysfunction except if due to an organic cause. This includes, but is not limited to penile implants.

Rehabilitation: Benefits are not available for:

1. Inpatient rehabilitation services if outpatient services are appropriate.

2. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Covered Person's Condition within a sixty (60) day period.
3. Long-term therapy.

Self-Inflicted/Suicide: Benefits are not available for treatment for a condition resulting from intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Covered Person.

Services or Supplies: Benefits are not available for services or supplies received prior to a Covered Person's effective date or received on or after the date a Covered Person's coverage terminates under this Group Policy, unless coverage is extended in accordance with the Extension of Benefits provision.

Sexual Dysfunction: Benefits are not available for sex therapy and drug therapies except certain injectable drugs approved by Us and only to treat erectile dysfunction due to an organic cause.

Sexual Reassignment (gender transformation) or Modification Services: Benefits are not available for any services or supplies related to such treatment including psychiatric services.

Sleep Disorders: Benefits are not available for sleep apnea (except for premature infants born on the Plan), insomnia, and/or narcolepsy, treatment, services and supplies for the purpose of treating or diagnosing sleep disorders or any related condition thereof.

Smoking Cessation: Benefits are not available for smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco; including, but not limited to, nicotine withdrawal programs and treatments such as Nicorette gum or patch.

Specific Therapies and Treatments as follows: Benefits are not available for hypnotherapy, biofeedback, acupuncture, sleep therapy, behavioral training, and hair analysis, unless used as a diagnostic tool for heavy metal poisoning.

Sterilization Reversals: Benefits are not available for reversal of voluntary, surgically induced sterility, including the reversal of tubal ligations and vasectomies and complications thereof.

Transplantation: Benefits are not available for:

1. The services related to the transplantation of any nonhuman organ or tissue;
2. The service related to the donation or acquisition of an organ for a recipient who is not covered by Coventry;
3. Services, follow-up care and immunosuppressive drugs, for non-covered transplants and complications from such transplants;
4. Artificial heart devices.

Transportation Services: Benefits are not available for non-emergency transportation between institutional care facilities, and/or to and from the Covered Person's residence unless Prior Authorized by the Plan. Air ambulance is not an exclusion.

Treatment of Obesity: Benefits are not available for weight control and weight loss programs; including, but not limited to dietary supplements, appetite suppressants, dietary regimens or treatments, exercise programs or equipment, laboratory testing, examinations and prescription drugs. Gastric stapling, gastric balloon, gastric bypass, liposuction and related procedures, or reversal there of, including treatment of the complications resulting from surgical treatment; regardless of associated medical or psychological conditions.

Vocational Rehabilitation: Benefits are not available for training and educational programs.

War-Related Treatment: Benefits are not available for treatment of a condition resulting, from war or an act of war, whether declared or not.

Wigs or cranial prosthesis: Benefits are not available except when related to restoration after cancer or brain tumor treatment.

Workers' Compensation: Benefits are not available for care and treatment of any injury, illness, or condition which arises out of, or in the course of, any occupation for wage or for-profit, any injury, illness, or condition for which the Covered Person is paid or receives benefits under any Workers' Compensation policy law, employer's liability policy, or any similar policy.

SECTION 6 CLAIMS

A. Assignment

The Covered Person may authorize Us to pay benefits under the Group Policy directly to the provider on whose charges a claim is based.

B. Discharge

Any payment by Us in accordance with these provisions will discharge Us from all further liability to the extent of the payment made.

C. Facility of Payment

If Covered Person dies while benefits under the Group Policy remain unpaid, We may, at Our option, make payments directly to the provider on whose charges the claim is based; or to the surviving spouse of the Covered Person; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Covered Person's estate.

D. Notice of Claim

Notice of a claim for benefits must be given to Coventry. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by Us within twenty (20) days after the start of the loss on which the claim is based. If notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the twenty (20) day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

E. Notice

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

Coventry Health Care
1340 Concord Terrace
Sunrise, FL 33323

F. Proof of Loss

For services rendered by Participating Providers, no written proof of loss is needed from the Covered Person. Participating Providers are responsible for submitting claims for Covered Services directly to Coventry on the Covered Person's behalf. For services rendered by Non-Participating Providers, written proof of loss must be given to Coventry within ninety (90) days after the date of injury or sickness for which claim is made. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

G. Time Payment of Claims

After receiving written proof of loss, Coventry will reimburse all claims or any portion of any claim from a Covered Person or a Covered Person's assignees, within forty (40) days from Our receipt of the claim. If a claim or portion of a claim is contested by Coventry, the Covered Person or the Covered Person's assignees will be notified in writing that the claim is contested within forty (40) days after Our receipt of the claim. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim.

Upon Coventry's receipt of the additional information requested from a Covered Person or his or her assignees, We will pay or deny the contested claim or portion of the contested claim within sixty (60) days.

Coventry will pay or deny any claim no later than one-hundred-twenty (120) days after receiving the claim. Payment will be treated as being made on the date a draft or valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed post-paid envelope or, if not so posted, on the date of delivery. All overdue payments will bear simple interest at the rate of twelve percent (12%) per year.

Upon written notification by a Covered Person, Coventry will investigate any claim or improper billing by a physician, hospital, or other Healthcare Professional. We will determine if the Covered Person was properly billed for only those procedures and services the Covered Person actually received. If Coventry determines the Covered Person has been improperly billed, We will notify the Covered Person and the provider of Our findings and will reduce the amount of the payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the Covered Person, We will pay to the Covered Person twenty percent (20%) of the amount of the reduction, up to \$500.

H. Legal Actions

No legal action may be brought to recover under this Group Policy until at least sixty (60) days after written proof of claim has been filed with Coventry. If such action is taken after the sixty (60) day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

I. Clerical Error

Clerical error, whether of the Group or Coventry in keeping any record pertaining to the coverage under this Policy, will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

J. Examination

Coventry, at its own expense, shall have the right to examine the person whose Sickness or Injury is the basis of a claim when and as often as it may be reasonably required during the pended status of the claim.

K. Complaints and Problems

If for any reason You are dissatisfied with the services You receive under this Group Policy or if You believe that We incorrectly denied a claim, paid an incorrect amount, or incorrectly determined that a service is not a Covered Service, contact Customer Service and explain Your concern. We will investigate and attempt to respond to Your concern fairly and promptly. Please refer to the Grievance Procedure Section of this Certificate of Insurance for Your Grievance and Appeal rights and responsibilities.

L. Dental Claim Review Procedure

If a covered dental service claim:

1. is denied as not medically or dentally necessary, or
2. the Covered Person has had a claim paid based on an alternate dental service in accordance with accepted dental standards for adequate and appropriate care, then

the Covered Person or a dentist acting on behalf of the Covered Person, may appeal to Coventry's licensed dentist. The appeal may be by telephone or in writing. Coventry will respond to the claim appeal within fifteen (15) business days from receipt of the appeal.

M. Subrogation and Right of Recovery

Immediately upon paying or providing any benefit hereunder, Coventry shall be subrogated to all rights of recovery a Covered Person has against any third party, to the full extent of benefits provided by Coventry. In addition, if a Covered Person receives any payment from any third party as a result of an injury, Coventry has the right to recover from, and be reimbursed by the Covered Person for all amounts paid hereunder and will pay as a result of that injury, up to the amount the covered person has received from all third parties.

As used throughout this provision, the term "third party" means any party possibly responsible for making any payment to the Covered Person for any injuries or any insurance coverage, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers compensation coverage or no-fault automobile insurance coverage. As used throughout this provision, the term "Covered Person" means the injured person or persons or any of their agent, representatives, assignees, guardians, heirs, or beneficiaries.

The Covered Person shall do nothing to prejudice Coventry's subrogation and reimbursement rights and shall, when requested, cooperate with Our efforts to recover its benefits paid. It is the duty of the Covered Person to notify Coventry within forty-five (45) days of the date when any notice is given to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person.

The Covered Person acknowledges that Coventry's subrogation and reimbursement rights are a first priority claim against all potential third parties and are to be paid to Coventry before any other claim for the Covered Person's damages. Coventry shall be entitled to full reimbursement first from any third party payments, even if the remainder is insufficient to make the Covered Person whole or compensate the Covered Person in part or in whole for the damages sustained. Coventry is limited to the actual amount of damages recovered by the claimant minus its pro rata share of costs and attorney's fees incurred by the claimant in recovering such damages. In determining Coventry's pro rata share of the costs and attorney's fees Coventry shall have deducted from its recovery a percentage amount equal to the percentage of the judgment or settlement which is for costs and attorney's fees.

This entire subrogation and reimbursement provision will apply regardless of whether liability for payment is admitted by the third party and regardless of whether the settlement or judgment received by the covered person identifies the medical benefits the plan provided. In the event any claim is made that any part of this subrogation and reimbursement clause is ambiguous or questions arise concerning the meaning or intent of any of its terms, the covered person and this plan agree that Coventry shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

SECTION 7 GRIEVANCE PROCEDURE

A. Introduction

We are committed to your satisfaction. We will try to resolve any problems You may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, We have a Grievance Procedure available that provides channels for You, or an Authorized Representative acting on Your behalf (including Your treating Provider) to voice Your concerns and have them reviewed and addressed by Coventry.

Coventry's Grievance Procedure is designed to provide prompt, meaningful and confidential resolution of Covered Person concerns regarding quality of care, physician behavior, office waiting times, claims payment, coverage of services, and other similar matters. The Grievance Procedure includes informal and formal steps. You have one (1) year from the date of the occurrence of the action that initiated the Grievance (which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date you receive initial notice of the Adverse Benefit Determination) to submit a Grievance to Us in writing, or verbally if you are unable to submit one in writing.

B. Complaints

To advise Coventry of a Complaint, the Covered Person (or an Authorized Representative of the Covered Person) should first contact Customer Service, either by telephone or in person. The Customer Service telephone number is listed on the Covered Person's identification card. The Covered Person must provide to the Customer Service Representative all of the facts relevant to the Complaint. The Covered Person's failure to provide any requested or relevant information may delay Coventry's review of the Complaint. Consequently, the Covered Person is obliged to cooperate with Coventry in its review of the matter.

The Customer Service Representative, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to the Covered Person's satisfaction. If the Complaint cannot be resolved to the Covered Person's satisfaction, and the Covered Person remains dissatisfied, the Covered Person may submit a Grievance for formal review.

C. Grievances

The Covered Person, or an Authorized Representative of the Covered Person, may submit a Grievance. Coventry will provide the Covered Person the forms necessary to initiate a Grievance. The Covered Person may request these forms by contacting the Customer Service telephone number listed on their ID card. While the Covered Person is not required to use Coventry's pre-printed form, Coventry strongly encourages that Grievances be submitted on such a form to facilitate logging, identification, processing, and tracking of the Grievance through the review process.

If the Covered Person needs assistance in preparing the Grievance, or in submitting a Grievance verbally, the Covered Person may contact Coventry for such assistance. Hearing impaired Covered Persons may also contact Coventry via TDD at 1-888-444-7352.

Covered Persons (or their Authorized Representatives) must file a first level Grievance within one (1) **year** from occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Covered Person's receipt of the initial notice of such Adverse Benefit Determination. If the decision of the first level Grievance is still unfavorable to the Covered Person, the Covered Person may, in the case of an Adverse Benefit Determination, request a second level Grievance within thirty-one (31) days of the date on Coventry's first level Grievance decision letter.

Within five (5) business days of receiving a first or second level Grievance, Coventry will send the Covered Person (or Authorized Representative) a letter acknowledging receipt of the Grievance. Except as stated below regarding Grievances related to non-Adverse Benefit Determinations, Coventry will respond to all first and second level Pre-Service Grievances within fifteen (15) calendar days, and all first and second level Post-Service Grievances within thirty (30) calendar days.

The timeframes in which Coventry must review Grievances may be extended if Coventry needs to collect information from outside the Service Area in order to properly review the Grievance. If this extension is necessary, Coventry will notify the Covered Person in writing. The extension will not be longer than 30 days. Once the information is collected, Coventry will resume review of the Grievance according to the applicable timeframes.

If the first or second level Grievance is resolved in the Covered Person's favor, the notice to the Covered Person ("Grievance Decision Letter") will advise of the favorable determination and further instructions on Authorization of services and/or claims payment. If the first or second level Grievance is not resolved in the Covered Person's favor, the Grievance Decision Letter will be drafted clearly and include the following information:

- The specific reason(s) for the Grievance decision;
 - Reference to the specific plan provision on which the Grievance decision is based;
 - A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the Covered Person's Grievance;
 - A statement describing any further procedures for review rights offered by Coventry, if any, and the Covered Person's right to obtain information about the procedures and a statement of the Covered Person's right to bring action under the Employee Retirement Income Security Act of 1974, if applicable;
 - If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Grievance decision, a statement that such rule, guideline, protocol or other criterion was relied upon in making the Grievance decision and that a copy of such rule, guideline, protocol or other criterion will be provided upon request and free of charge;
 - If the Grievance decision is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the specific clinical judgment for the decision, applying the terms of the benefit plan to the Covered Person's medical circumstances, or notice that a written explanation of the clinical rationale is available upon request and free of charge; and
 - The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. DOL office and your State insurance regulatory agency.
- **Grievances Regarding Non-Adverse Benefit Determinations:** Grievances regarding such issues as: (1) quality of service; (2) allegations of Coventry agent misrepresentation or provider discrimination; or (3) non-clinical potential provider issues will be researched by Coventry and Coventry will send the Covered Person written notice of investigation results and actions taken by Coventry within an appropriate amount of time, not to exceed thirty **(30) calendar days** from the date the Grievance was received by Coventry.
- **Grievances Regarding Adverse Benefit Determinations:** Grievances involving Adverse Benefits Determinations based, in whole or in part, on medical judgment will be reviewed by a Clinical Peer, or by a committee that is appropriately comprised of Clinical Peers.
- **Expedited Review of Urgent Grievances:**
1. Covered Persons may request expedited review of an Urgent Grievance if the application of the standard Grievance review timeframes would seriously jeopardize the Covered Person's life or health (or in the case of a pregnant woman, the life/health of the unborn child), or the Covered Person's ability to regain maximum function. Expedited review may also be applied where application of the standard Grievance review timeframes would, in the opinion of a physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is being requested.

2. The Covered Person, or an Authorized Representative acting on the Covered Person's behalf, must specifically request the expedited review. For example, the request may be made by stating, "I want an expedited review" or "Please review this request in an expedited manner." Only services subject to Pre-Authorization, or requests for extension of concurrent care services made within twenty-four (24) hours prior to the termination of Authorization for such on-going services, may be subject to expedited review.
3. A Covered Person may request an Urgent Grievance for the first time (similar to a first level Grievance). However, if a Covered Person initially requested a first level Grievance (non-Urgent) related to an Adverse Benefit Determination and Coventry upheld its initial Adverse Benefit Determination, the Insured will not be precluded from requesting second level Grievance as an Urgent Grievance, if relevant.
4. Generally, in determining whether a Grievance will be subject to the expedited timeframes applicable to Urgent Grievances, Coventry must apply the judgment of a Prudent Layperson that possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Covered Person's medical condition requests an Urgent Grievance, the Grievance shall be deemed as such.
5. Within twenty-four (**24**) hours after receiving an Urgent Grievance, Coventry's Grievance and Appeal Administrator will collect and forward all relevant information to an appropriate Clinical Peer(s) who shall perform the expedited review. The Clinical Peer will not have been involved in making the initial Adverse Benefit Determination, or if applicable, the first level Grievance decision, nor be a subordinate to someone who was.
6. Coventry will notify the Covered Person (or their Authorized Representative) of Coventry's benefit determination on review as expeditiously as the Covered Person's medical condition requires, but no more than seventy-two (**72**) hours after Coventry's receipt of the request for review of the Urgent Grievance. If the expedited review is a Concurrent Review determination, the service will be continued without liability to the Covered Person until the Covered Person is notified of the determination. Written notice of the final decision concerning expedited review of an Urgent Grievance will be provided to the Covered Person or their Authorized Representative within two (**2**) working days, if the initial notification was not already provided in writing.
7. If the Covered Person's request for expedited review arises out of an Adverse Benefit Determination that a continued hospitalization or continuation of a course of treatment is not Medically Necessary, coverage for the course of treatment or hospitalization shall continue until the Covered Person is notified of the Grievance decision.
8. Coventry will not honor a request for expedited review that relates to services that have already been performed, rendered, or provided to the Covered Person, or a request that is not eligible for expedited review (Urgent Grievance). Coventry will process any such Grievances in accordance with its standard Grievance time frame.

D. General Rules and Information

General rules regarding Coventry's Complaint and Grievance Process include the following:

1. The Covered Person must cooperate fully with Coventry in Our effort to promptly review and resolve a Complaint or Grievance. In the event the Covered Person does not fully cooperate with Coventry, the Covered Person will be deemed to have waived the Covered Person's right to have the Complaint or Grievance processed within the time frames set forth above.
2. Coventry will not honor a request for expedited review that relates to Services that have already been performed, rendered, or provided to the Covered Person or a request that is not eligible for expedited review of an Urgent Grievance. Coventry will process any such Grievance, however, in accordance with the standard Grievance procedure.

3. Coventry must receive all Grievances within one (1) year after the date of the occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Covered Person's receipt of the initial notice of such Adverse Benefit Determination.
4. If the Grievance involves a determination that the Services did not meet Coventry's guidelines for coverage of a Service or that the Service is excluded because it meets the definition of an Experimental or Investigational Service or a similar exclusion or limitation, then the Covered Person may request an explanation of the scientific or clinical judgment relied upon, if any, for determination, that applies the terms of the Group Policy to the Covered Person's medical circumstances.
5. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
6. The Covered Person may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

E. Telephone Numbers and Addresses

The Covered Person may contact a Coventry Grievance Coordinator at the number listed on the acknowledgement letter or Grievance Decision Letter. If a Grievance is unresolved, or at any time, the Covered Person may contact an agency at the telephone numbers and addresses listed below.

Department of Financial Services

Division of Consumer Services
200 E. Gaines St.
Tallahassee, FL 32399-0322
1-800-693-5236

Coventry

In person or in writing:
Attention: Grievance Department
1340 Concord Terrace
Sunrise, FL 33323
Customer Service: 1-866-847-8235
Hours: Monday through Friday, 8 a.m. – 6 p.m.
TDD: 1-888-444-7352

SECTION 8 COORDINATION OF BENEFITS

A. Avoidance of Duplicate Payment

The Coordination of Benefits provision is intended to assure that a Covered Person covered under any other Health Plan receives as much of his/her medical expense as possible, while avoiding duplicate payment of covered services. Health Plans include:

1. Coverage under government programs (excluding Workers' Compensation and Medicaid) required or provided by a statute unless law forbids coordination of benefits with any such program.
2. Group coverage (other than group automobile insurance) or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including any prepayment coverage, group practice or individual practice coverage and any coverage for students which is sponsored by, or provided through, a school or other educational institution above the high school level.

B. Definition of Health Plan

The term "Health Plan" shall be construed separately with respect to:

1. Each policy, contract or other arrangement for benefit or services.
2. The portion of any such policy, contract or other arrangement which reserves the right to take the benefits of other Health Plans into consideration in determining its benefits and that portion which does not.

C. Rules

Should a Covered Person be covered by or under any other health plan, in addition to coverage under this Group Policy, the following provisions and rules shall determine whether Coventry or the other Health Plan is primarily responsible for paying the costs of benefits and services.

1. Benefits Subject to This Provision

All of the benefits and services, which Coventry is obligated to provide under this Group Policy, are subject to the provisions of this Section. Copayments are required, even if a Covered Person is covered under other health insurance.

2. Determination of Benefits

a. Wherever the sum of all benefits available under this Group Policy determined without regard to this provision and all benefits available under all other Health Plans determined without regard to provisions similar to this exceed the Allowed Amount incurred by a Covered Person during the Claim Determination Period, the benefits that would otherwise be payable by Coventry in the absence of this provision shall be reduced by such excess. Benefits payable under other health insurance include the benefits that would have been payable had claim been duly made therefore.

b. The following rules apply to determination of benefits:

- (1) The benefits of a policy or plan which covers the person as an employee, Covered Person, or Covered Person and not as a dependent are determined before those of the policy or plan which covers the person as a dependent.
- (2) Except as stated below, when two (2) or more policies or plans cover the same child as a dependent of different parents:

- (a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time. However, if a policy or plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan shall determine the order of benefits.
- (3) If two (2) or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- (a) First, the policy or plan of the parent with custody of the child;
 - (b) Second, the policy or plan of the spouse of the parent with custody of the child; and
 - (c) Third, the policy or plan of the parent not having custody of the child.

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

- (4) The benefits of a policy or plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph shall not apply.
- (5) If none of the rules set forth in this Group Policy determine the order of benefits, the benefits of the policy or plan which covered a Covered Person for a longer period of time are determined before those of the policy or plan which covered that person for the shorter period of time.
 - (a) None of the above coordination of benefits rules shall serve as a barrier to the Covered Person first receiving direct health care services under Coventry where such services are covered under this Group Policy.
 - (b) Whenever an Coventry Covered Person is also a Medicaid recipient, Coventry's coverage shall be primary to the recipient's Medicaid benefits and Coventry shall be a third party subject to the provisions of Florida Statute 409.266(3)(c).

D. The Effect of COBRA

The Plan which covers the person as an employee (or as that employee's dependent) is the primary Plan; the Plan which covers the person pursuant to COBRA is the secondary Plan.

E. The Effect of Medicare

This Plan will be primary to Medicare as required by the Tax Equity and Fiscal Responsibility Act (TEFRA/DEFRA), the Omnibus Budget Reconciliation Act (OBRA), and other laws and regulations applicable to GROUP.

F. The Effect of No-Fault Auto Coverage

This Group Policy is not in lieu of and does not affect any requirement for, or coverage by, or benefits paid by automobile insurance. Coventry will not pay for benefits that are covered under the automobile insurance. The rules of this Group Policy should be followed in the event automobile insurance is exhausted or does not pay for the injury.

G. Right to Receive and Release Necessary Information

Coventry may release any information considered to be necessary for Coventry coordination of benefits with respect to any person claiming benefits under this Group Policy without consent of, or notice to, the Covered Person or any other person or organization. However, Coventry shall not be required to determine the existence of any other Group Policy or insurer or the benefits payable under such plan or insurer when computing services or benefits due a Covered Person covered under this Group Policy.

H. Facility of Payment

Whenever payments which should have been made under Coventry coverage in accordance with this provision have been made under any other health plan or insurer, Coventry will have the right to pay over to such health plan or insurer any amount Coventry will determine to be warranted in order to satisfy the intent of this provision. Any amounts so paid shall be deemed to be benefits under this Group Policy, and to the extent of such payments, Coventry will be fully discharged from liability under this Group Policy.

I. Right of Recovery

Whenever Coventry payment for Covered Services exceeds the maximum amount of payment necessary to satisfy the intent of this provision, Coventry shall have the right to recover such payment to the extent of such excess, from any insurer, any organization, or any person(s) to whom such payments were made.

J. Disclosure

Each Covered Person agrees to disclose to Coventry at the time of enrollment, at the time of receipt of services and benefits, and from time to time as requested by Coventry the existence of other health insurance coverage, the identity of the carrier, and the group through whom provided.

SECTION 9 TERMINATION OF COVERAGE

A. Upon Notification

This Group Policy may be terminated by either Coventry in accordance with the terms of this Group Policy or by the Group upon written notice to Coventry at least sixty (60) days prior to the termination date. Such termination by Coventry or the Group shall occur at midnight of the day preceding the termination date. In the event either party gives no such notice, this Group Policy shall continue in effect for another Contract Year unless terminated pursuant to other provisions of this Group Policy.

B. Termination of Named Insured's Coverage

Unless otherwise prohibited by law, the Named Insured's coverage may be terminated by Coventry for any of the following reasons:

1. On the date the Group Policy terminates;
2. On the last day of the first month that the Eligible Employee fails to continue to meet any of the applicable eligibility requirements;
3. On the date the Eligible Employee's coverage is terminated for cause (see the Termination of an Individual's Coverage for Cause subsection); or
4. On the date specified by the Large Employer that the Eligible Employee's coverage terminates.

C. Termination of a Dependent's Coverage

Unless otherwise prohibited by law, a Covered Dependent's coverage may be terminated by Coventry for any of the following reasons:

1. On the date the Group Policy terminates;
2. On the date the Eligible Employee's coverage terminates for any reason;
3. On the last day of the first month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g. a child reaches the limiting age, court order no longer in effect, spousal divorce);
4. On the date Coventry specifies that the Covered Dependent's coverage is terminated by Us for cause (see the Termination of an Individual's Coverage for Cause subsection); or
5. On the date specified by the Large Employer that the Covered Dependent's coverage terminates.

D. Termination of a Covered Person's Coverage for Cause

If, in Our opinion, any of the following events occur, We may terminate a Covered Person's coverage for cause:

1. Fraud, material misrepresentation or omission in applying for coverage or benefits;
2. The knowing misrepresentation, omission or the giving of false information on enrollment forms or other forms completed for Us, by or on Your behalf. False, material information includes, but is not limited to information relating to residence and/or employment, information relating to another person's eligibility for coverage or status as a Dependent; or
3. Fraudulent misuse of the Identification Card.

Upon termination of a Covered Person's coverage for any reason, Coventry shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Group Policy.

NOTE: Coventry has the right to terminate coverage back to the effective date, in accordance with s. 627.607, Florida Statutes, "Time Limit on Certain Defenses," which states, "Relative to a misstatement in the applications, after two (2) years from the issue date, only fraudulent misstatements in the applications may be used to void the coverage or deny any claim for loss incurred or disability starting after the two (2) year period."

SECTION 10 CONTINUATION OF COVERAGE

If coverage for a Covered Person ends, the Covered Person may, depending on his or her situation, have the right to have coverage extended under the extension of benefits provision. Also, the Covered Person may be eligible for coverage under the federal coverage provisions or a health benefit plan under the conversion privilege provision.

A. Extension of Benefits (Post Termination Disability Coverage)

If Coventry's Group Policy with the Group terminates for any reason and the Covered Person is Totally Disabled on the effective date of termination, he or she will be entitled to continue to receive the benefits under this Group Policy for the treatment of the condition or illness or injury resulting in the Total Disability until the earlier of:

1. Twelve (12) months from the effective date of the termination of coverage;
2. The Covered Person receives the maximum benefit payable under the Policy; or
3. The Covered Person is no longer Totally Disabled as a result of the condition or illness that existed and manifested itself as of the effective date of the termination of coverage.
4. In the case of maternity coverage, an extension of benefits is provided for a pregnancy that commenced while the policy was in effect. The extension is for the period of the pregnancy and is not based on Total Disability.
5. If coverage terminates before the Covered Person completes a course of dental treatment incurred for treatment of an injury or sickness covered by the Group Policy, benefits will be extended until the earliest date of the following events:
 - a. the end of ninety (90) consecutive days beginning the date following the coverage termination date; or
 - b. the date insurance begins under another policy or contract which provides benefits for the treatment in progress.

This extension will not be based on Total Disability.

6. For the purposes of this Section, "continuous total disability" and "Totally Disabled":
 - a. For the Named Insured, the inability to perform any work or occupation for which the Named Insured is reasonably qualified or trained; or
 - b. For any other Covered Person, the inability to engage in most normal activities of a person in good health of like age and sex.

B. COBRA

Federal law (the Consolidated Omnibus Budget Reconciliation or "COBRA"), as amended, permits Covered Persons to continue coverage under an employer- established health benefit plan under certain circumstances. This provision does not apply to employers with fewer than twenty (20) employees. Covered Employees should consult with the Employer regarding the availability of this option. It is the Employer's responsibility to make employees aware of any COBRA rights they may have.

A qualified beneficiary must make timely election of COBRA coverage. An election is considered timely if it is made during the election period. The COBRA election period begins on or before the date that the qualified beneficiary would lose coverage due to a qualifying event. The election period ends sixty (60) days from the later of:

1. The date coverage is lost due to the qualifying event; or
2. The date the qualifying beneficiary is given notice of the right to elect COBRA coverage.

Covered Person responsibilities include:

1. A Covered Person must contact the Group to determine if he/she is entitled to COBRA continuation coverage.
2. If a Covered Person is eligible for COBRA, he/she may elect to continue group health benefits if he/she qualifies under one (1) of the circumstances specified in COBRA and satisfies all of the requirements for such coverage, including payment of required Premiums.
3. The Covered Person must provide the Group with all required notices, in the form and within the time period required by COBRA and the Group, including but not limited to, notice of:
 - a. Medicare entitlement, divorce or legal separation, or the failure of a Covered Dependent child to meet eligibility requirements of the Group Policy.
 - b. Coverage under another group Health Plan.
 - c. With respect to the Covered Person's ability to receive additional periods of coverage under COBRA in the event that the Covered Person is disabled, a determination by the Social Security Administration that the Covered Person is disabled, or a determination by the Social Security Administration that the Covered Person has ceased to be disabled.

A Covered Person must apply for continuation coverage under COBRA. Upon exhaustion of coverage, or if the Covered Person is not eligible for COBRA, he or she may be eligible to apply for coverage under the Conversion privilege. A request for conversion coverage must be made no later than sixty-three (63) days from termination of coverage under this health benefit plan.

C. Conversion Plans

In the event a Covered Person's Group coverage terminates for any reason other than those set forth in this Group Policy, the Covered Person may elect to apply immediately for conversion. Neither Coventry nor the Group has any obligation to notify any such individual of the conversion privilege. Such individual has the sole responsibility to exercise this conversion privilege.

The Covered Person should contact Coventry at 1-866-847-8235 immediately following termination and give Us notification of interest in conversion. Coventry will mail to the eligible individual within fourteen (14) days, an Election and Premium Notice Form including Outlines of Coverage for the conversion plans available. The individual must return the completed application and the first monthly premium to Coventry no later than sixty-three (63) days after termination of Group coverage.

Covered Persons' eligibility for conversion coverage shall be strictly subject to the following requirements and conditions:

1. Covered Person must have been a Covered Person (or have been covered under any group contract providing similar benefits hereto) for at least three (3) months immediately prior to termination of Covered Person's coverage hereunder;
2. Covered Person must not be covered or be eligible for coverage under Medicare;
3. Covered Person must not be 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 any other plan;

4. Covered Person must not be eligible for similar benefits, whether or not covered thereby, under any arrangement of coverage for individuals in a group, whether on an insured basis or uninsured basis;
5. Covered Person must not be entitled to receive similar benefits pursuant to or in accordance with the requirements of any state or federal law.
6. To be eligible for conversion, the Covered Person must not have lost his or her eligibility for coverage hereunder for any of the following reasons:
 - a. failure to pay any require premium or contribution unless such nonpayment of premium was due to acts of an employer or person other than the individual;
 - b. replacement of any discontinued group coverage by similar group coverage within thirty-one (31) days;
 - c. fraud or intentional misrepresentation in applying for any benefits under this Group Policy; or

D. Scope of Conversion Coverage

At the time of application, the individual will be offered a choice of at least two (2) conversion plans; the Standard conversion plan and at least one other plan which provides benefits substantially similar to the level of benefits of this Group Policy. The conversion plan shall cover only the Named Insured and those dependents covered by this Group Policy on the date of termination of Covered Person's coverage hereunder. Such conversion coverage may continue in effect, provided that each individual who has converted to the conversion contract continues to meet all applicable eligibility requirements, pay all premiums, and otherwise complies with all requirements set forth in the conversion contract.

Coventry's conversion plans are monthly policies whereby a Covered Person is required to pay monthly for coverage. Pro-rated refunds are not available under these policies. Conversion plan Covered Persons contract directly with Coventry and have no further interaction with their former employer. The premium for conversion coverage shall be determined in accordance with premium rates applicable to the age and class and risk of each person to be covered and shall be paid in advance on a quarterly basis to Coventry.

Upon receipt of an application not later than sixty-three (63) days after termination of Group coverage and payment of the first monthly premium, the effective date of the conversion contract shall be the day following termination of coverage hereunder.

Issuance of conversion coverage shall not be subject to evidence of health qualification of the Covered Person. Furthermore, conversion coverage shall not exclude a Pre-existing Condition not excluded by the Group Policy. The conversion contract will provide that any benefits thereunder shall be reduced by the amount of any coverage or benefits afforded under this Group Policy after the Covered Person's termination of coverage. During the first coverage year, the coverage or benefits under the converted contract shall not exceed those that would have been provided had the individual's coverage or benefits under the Group Policy remained in force.

Please note that if the employee qualifies for COBRA or State of Florida Continuation Coverage, conversion benefits take place at the end of the federal or state continuation period, if written application is made and the first monthly payment is made within sixty-three (63) days of the date coverage under the continuation plan ends.

SECTION 11 MISCELLANEOUS

A. Records and Information

1. It is the Covered Person's responsibility to insure that any Healthcare Professional, Hospital, insurance company, employee benefit association, governmental body or program, or any other person or entity with knowledge of or records relating to:
 - a. any illness or injury for which benefits are claimed under this Group Policy,
 - b. any medical history which might be pertinent to such illness or injury or claim or
 - c. any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such claim,furnish Coventry, at any time upon its request, any and all information and records (or copies of records) relating to such illness, injury or claim.
2. Coventry may furnish similar information and records (or copies of records) to any insurance company, governmental body or program or other entity providing insurance type benefits requesting the same.

B. Notices

1. Any notice under this Group Policy, required of the Named Insured or the Group may be mailed to the following address:

Coventry Health Care
1340 Concord Terrace
Sunrise, Florida 33323
2. Any notice required of Coventry shall be sufficient if mailed to the holder of this Group Policy, at the address appearing on the records of Coventry.

C. Civil Remedy

In any civil action brought to enforce the terms and conditions of a Coventry contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. This Section shall not be construed to authorize a civil action against the Department of Financial Services.

D. Entire Group Policy

This Group Policy and any attached riders and the Binder and Agreement constitute the entire contract between the Group and Coventry. To be valid, any change in the form must be approved by an officer of Coventry and attached to the affected form and no agent has the authority to change the form or waive any of the provisions.

E. Policyholder's Copy

A copy of this Group Policy, all Attachments, Applications, and forms hereto will be provided to the Policyholder.

F. Workers' Compensation

This Group Policy is not in lieu of and does not affect any requirement for, or coverage by, or benefits paid by Workers' Compensation Insurance. Coventry will not pay for benefits that are covered under Workers' Compensation. The rules of this Group Policy should be followed in the event Workers' Compensation and/or Automobile Insurance does not pay for the injury.

G. Refusal to Accept Treatment from Participating Healthcare Professionals

You may, for personal reasons, refuse to accept procedures or treatment from a Participating Healthcare Professional. The Healthcare Professional may regard such refusal to accept his or her recommendation as incompatible with continuance of the physician-patient relationship and if no acceptable alternative exists for what the physician believes to be proper medical care, You will be so advised in writing. If You still refuse to accept the recommended treatment, neither Coventry nor the Participating Healthcare Professional will be responsible for treatment of the condition.

H. Relationship of Parties

Healthcare Providers, including Participating Providers under an independent contract, are not agents or employees of Coventry, nor is Coventry or any of its employees, an employee or agent of Healthcare Providers. Coventry shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You in connection with the furnishing of, or failure to furnish services by any Healthcare Providers.

I. General Limitation

In the event that, due to circumstances not within the control of Coventry, including but not limited to: a major disaster; epidemic; the complete or partial destruction of facilities; riot; civil insurrection; disability of a significant part of Coventry's Participating Provider's personnel or similar causes, the rendering of Professional Services or Hospital Services provided under this Contract is delayed or rendered impractical, Coventry shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Coventry and Participating Providers shall render the Hospital and Professional Services provided under this Contract insofar as practical, and according to their best judgment. Coventry and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

J. Termination

This Group Policy shall remain in effect for the first Contract Year and thereafter for successive Contract Years unless terminated earlier as provided herein. The effective time for any dates used is 12:01 A.M. at the address of the Policyholder.

K. Amendment

This Group Policy may be amended at any time, without the consent of the Covered Persons, or any other person having a beneficial interest in it, upon written request made by the Group and agreed to by Coventry. Any such amendment shall be without prejudice to any claim arising prior to the date of such amendment.

L. Force Majeure

No party to this Agreement shall be liable for any default or delay in the performance of its obligations hereunder if and to the extent the default or delay is caused, directly or indirectly, by strikes, picketing, insurrection, acts of God, military actions, terrorist attacks, war, emergencies, shortages or unavailability of materials or other causes beyond a party's reasonable control (a "Force Majeure Event"), and such party shall be excused from performance and shall not be considered to be in default hereunder in respect to the affected obligation. The suspension of performance due to a Force Majeure Event shall be of no greater scope and no longer duration than that which is reasonably necessary. The excused party shall use its reasonable best efforts to remedy its inability to perform as soon as possible.

M. Performance Outcomes and Financial Data

You may obtain information regarding performance outcomes and financial data for Coventry published by the State of Florida Agency for Health Care Administration by accessing the web site

www.vistahealthplan.com. This website includes the link to FloridaHealthStat where this information is published, or You can go directly to www.floridahealthstat.com.

N. Third Party Beneficiary

This Group Policy is entered into exclusively between Coventry and Group. This Group Policy is intended only to benefit Covered Persons covered under this Group Policy and does not confer any rights to any third parties. These are no intentional or incidental third-party beneficiaries to this agreement.

O. Construction

Coventry shall interpret this Group Policy including any terms or provisions which may otherwise be or appear to be ambiguous, whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions, and interpretations made by Coventry, and in accordance with applicable law, shall be binding upon the Covered Person.

SECTION 12 DEFINITIONS

DEFINITIONS

As used in this Certificate of Insurance, the following words and phrases shall apply:

Accredited Institution: a secondary, college, university or trade school which is certified or licensed by a state.

Acute: sudden onset, acting keenly on the senses; sharp, brief and severe.

Administrator: Coventry and/or its designated agents who perform a number of administrative duties, including processing all claims occurring under the Policy.

Allowed Amount: the amount that a Participating Provider has agreed to accept as payment in full for Covered Services; or with respect to a Non-Participating Provider, the amount that Coventry will consider for the Out-of-Network Rate.

Ambulatory Surgical Center: a facility duly licensed pursuant to applicable state law, the primary purpose of which is to provide 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.

Anniversary Date: the yearly return of the Effective Date.

Annual Open Enrollment Period: an annual thirty (30) day period, beginning no less than thirty (30) days prior to the Anniversary Date of the Group's health benefits program, during which:

1. If the Group has established and maintained more than one health coverage plan for their Eligible Employees, an Eligible Employee who had elected another plan, and maintained coverage under that plan up to the beginning of the Annual Open Enrollment Period, can change to this Group Policy.
2. Employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under this Group Policy during the Initial or Special Enrollment Periods can enroll.

Authorized Representative: means an individual authorized in writing or verbally by the Covered Person or state law to act on the Covered Person's behalf in requesting a health care service, obtaining claim payment, or during the Grievance process. A provider may act on behalf of a Covered Person without the Covered Person's express consent when it involves an Urgent Grievance.

Birth Center: an outpatient facility which:

1. complies with licensing and other legal requirements in the jurisdiction where it is located;
2. is engaged mainly in providing a comprehensive birth services program to pregnant individuals who are considered normal low risk patients;
3. has organized facilities for birth services on its premises;
4. has birth services performed by a Healthcare Professional specializing in obstetrics and gynecology, or at his or her direction, by a midwife or nurse midwife; and
5. has a twenty-four (24)-hour-a-day Registered Nurse service.

Calendar Year: a period of one (1) year that starts January 1 and ends December 31.

Chronic: lasting a long time, lingering, long duration involving very slow changes.

Coinsurance: the sharing of covered health care expenses between Coventry and the Covered Person, as specifically set forth in the Schedule of Benefits. The coinsurance is expressed as a percentage rather than as a dollar amount.

Coinsurance Maximum: the amount of Coinsurance a Covered Person will pay each Calendar Year before this Group Policy pays the Allowed Amount at 100%. The Individual and Family Coinsurance Maximums are specified in the Schedule of Benefits.

Complaint: means any oral expression or dissatisfaction including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a provider pursuant to Coventry's contract and which is submitted to Coventry or to a State agency. A Complaint is part of the informal steps of a Grievance procedure and is not part of the formal steps of a Grievance procedure, unless it is a Grievance as defined below.

Complications of Pregnancy: is a Condition diagnosed as separate from a pregnancy. Complications means a condition, requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, therapeutic abortion, non-elective Caesarean section, tubal pregnancy which is terminated; miscarriages; or medical and surgical conditions of similar severity. Complications of pregnancy do not include false labor, occasional spotting, Healthcare Professional prescribed bed rest during the period of pregnancy, morning sickness, uncontrolled vomiting; convulsions and high blood pressure; or similar conditions associated with a difficult pregnancy.

Condition: the state in which a person has any sickness, illness, injury, bodily dysfunction or pregnancy.

Copayment: those amounts payable by the Covered Person at the time of service, from a Participating Healthcare Professional, as a supplement to the monthly Premium payments, as specifically set forth in the Schedule of Benefits and any rider or endorsement attached to this Group Policy. The Copayment is normally expressed as a dollar amount rather than as a percentage. Healthcare Professionals have the obligation to collect these Copayments.

Cosmetic Surgery: plastic surgery for improving the outer appearance of parts of the body that does not improve bodily function and its purpose is to improve appearance and/or self esteem.

Cost Effective: an intervention is considered cost effective if there is no other available intervention that offers a clinically appropriate benefit at a lower cost.

Coventry: Coventry Health and Life Insurance Company, a Florida corporation licensed by the State of Florida Department of Financial Services.

Covered Dependent: an Eligible Dependent who receives health care benefits through Coventry and meets the dependent criteria specified in the Eligibility Section of this Group Policy.

Covered Person: the Named Insured or an Eligible Dependent who is covered under this Group Plan and for whom premium has been received.

Covered Services: those professional services of Healthcare Professionals or other Providers, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services and supplies specified in the Covered Services Section of this Group Policy, listed on the Schedule of Benefits or any rider, amendment or endorsement attached.

Custodial Care: care primarily provided to assist a patient in meeting the activities of daily living such as help in walking; getting out of bed; bathing; dressing; feeding and preparation of special diets; and supervision of medications which are ordinarily self-administered.

Deductible: the amount a Covered Person must pay each year before Coventry will make payment toward any covered services.

Disease: a condition of an organism that impairs normal physiological functioning.

Disposable Medical Supplies: those supplies that are not meant to be re-used by another individual and include, but are not limited to, gauze, tape, syringes, needles, I.V., plastic tubing, canvas/Velcro splints, and blood pressure cuffs.

Durable Medical Equipment (DME): medical equipment furnished by a supplier or a Home Health Agency that:

1. can stand repeated use;
2. is primarily and usually used to serve a medical purpose;
3. is not for comfort or convenience;
4. is appropriate for use in the home; and
5. is generally not useful to You in the absence of a Condition.

Effective Date: the date on which coverage begins for this Group Policy.

Eligible Dependent: the Named Insured's spouse, natural child, adopted child, stepchild, or child for whom legal guardianship has been established where such child is primarily dependent on the Named Insured for support and lives with the Named Insured in a permanent parent-child relationship.

Eligible Employee: an employee of the Group who works for the Group on a full-time basis, with a normal work week of twenty-five (25) hours or more and is eligible based on the criteria established by the Group.

Eligible Retiree: a retiree of the Group who is eligible for retiree health coverage from the Group based on criteria established by the Group.

Emergency Medical Condition: 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:

1. Serious jeopardy to the health of the patient, including a pregnant woman or fetus;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care: medical screening, examination, and evaluation by a Healthcare Professional to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Healthcare Professional, to determine if any emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a Healthcare Professional necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Enrollment Applications: the forms prescribed by Coventry which the Named Insured shall be required to complete and submit to the Employer for the purpose of enrolling him or herself and any Eligible Dependents for coverage hereunder.

Expenses: the cost incurred for healthcare services and supplies.

Experimental and Investigational Treatment: 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:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration (USFDA) or the Florida Department of Health and Rehabilitative Services (HRS), and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Person; or
2. Reliable evidence shows 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; or
3. Reliable evidence 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; or
4. Reliable evidence shows that such 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 peer reviewed medical literature, using generally accepted scientific, medical, or public health methodologies or statistical practices.

Reliable evidence means:

1. Reports, articles, or written assessments in peer reviewed medical and scientific literature;
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 Healthcare Professional or institution or the protocols of another Healthcare Professional or institution studying substantially the same evaluation, treatment, therapy, or device; or
4. The written informed consent used by the treating Healthcare Professional or institution or by another Healthcare Professional 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 which has reviewed the evaluation, treatment, therapy or device for the condition in question.

Extended Care or Skilled Nursing Facility: an institution or a distinct part thereof, including an intermediate nursing facility, which:

1. is licensed pursuant to state and local laws;
2. is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness;
3. is approved by and is a participating facility with Medicare;

4. has organized facilities for medical treatment;
5. provides twenty-four (24)-hours-a-day nursing service under the full-time supervision of a Healthcare Professional or Registered Nurse;
6. maintains daily clinical records on each patient;
7. has available the services of a Healthcare Professional under an established Policy;
8. provides appropriate methods for dispensing and administering drugs and medicines;
9. has transfer arrangements with one (1) or more Hospitals; a utilization review plan in effect; and operational policies developed with advice of and reviewed by a professional group including at least one (1) Healthcare Professional; and
10. is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

Full Time Student: a Covered Person who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Full Time Student status. A student is considered full time during normally scheduled school vacations if he or she is registered to return to that or a similar institution at the end of the vacation. A Covered Person is considered enrolled during summer or holiday vacations when school is not in session.

Gene Testing: examining a sample of blood or other body fluid or tissue for biochemical, chromosomal, or genetic markers that indicate the presence or absence of a genetic abnormality.

Gene Therapy: treatment of disease, condition or genetic abnormality by replacing, altering, or supplementing a gene that is absent or abnormal and is responsible for the disease, condition or predisposition to disease.

Genetic Counseling: meeting with trained Healthcare Professionals before testing begins, when Covered Persons receive the test results, and for appropriate post-testing follow-up.

Grievance: means a written (or verbal as may be specified herein) Complaint submitted by or on behalf of a Covered Person to Coventry or a State agency regarding the: (a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an Adverse Benefit Determination made pursuant to utilization review; (b) Claims payment, handling, or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between a Covered Person and Coventry. A Grievance includes both Pre-Service Grievances and Post-Service Grievances (as defined below). A Grievance does not include a written complaint submitted by or on behalf of a Covered Person eligible for a grievance and appeals procedure provided by Coventry pursuant to contract with the Federal Government under Title XVIII of the Social Security Act or other government programs.

Grievance and Appeals Committee (Committee): means a panel, comprised of a person or persons who previously were not involved in the initial Adverse Determination, established to review second level Grievances related to Adverse Benefit Determinations made by the Plan. In cases involving Adverse Benefit Determinations that were based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental/investigational or not medically necessary or appropriate, Clinical Peer(s) should be appropriately included in the committee. In cases in which there was a denial of coverage, person(s) previously involved with the Adverse Benefit Determination will not be a member of the Committee but may appear before the Committee to present information or answer questions. The Committee has the authority to bind the Plan to its decisions.

Group, Group Policyholder: an employer or other party that has entered into an agreement with Coventry, and through which an employee, retiree and/or his or her Eligible Dependents, if any, may enroll in this Group Policy.

Group Policy: the Certificate of Insurance, Binder and Agreement, and all applicable attachments and riders thereto, as duly executed by and between Coventry and the Group.

Health Intervention: an activity taken for the primary purpose of preventing, improving, or stabilizing a Medical Condition. Activities that are primarily Custodial Care, part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered Health Interventions.

Health Outcomes: outcomes of medical conditions that directly affect the length or quality of a person's life.

Healthcare Professionals: Physicians, dentists, nurses, midwives, nurse midwives, certified registered nurse anesthetists, advanced registered nurse practitioners, audiologists, podiatrists, osteopaths, chiropractors, ophthalmologists, Physician assistants, clinical psychologists, social workers, mental health counselors, pharmacists, nutritionists, physical therapists, speech therapists and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, are certified, or practice under the authority of a Physician or legally constituted professional association, or other authority consistent with the laws of the State of Florida.

Home Health Agency: an organization licensed by the State and certified by Medicare to render home health services.

Hospice: an organization that meets the standards outlined by the National Hospice Association and is licensed, certified and registered as required by Florida law. A Hospice primarily provides services for pain relief, symptom management, and supportive services to terminally ill persons and their families. A Covered Person is considered terminally ill if the Healthcare Professional has certified the Covered Person as having a life expectancy of twelve (12) months or less.

Hospice Care Program: a coordinated, interdisciplinary program:

1. to meet the physical, psychological, spiritual and social needs of terminally ill persons and their families;
2. that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
3. for persons who have a terminal illness and for the families of those persons.

Hospital: an institution which is operated pursuant to law, is accredited by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, and is primarily engaged in providing, on an inpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which services must be provided on its premises under the supervision of a staff of Healthcare Professionals and with twenty-four (24)-hour-a-day nursing service.

Hospital Services: (except as limited or excluded herein) those services furnished and billed by a Hospital or skilled nursing facility.

Identification Card: the card that Coventry issues to a Covered Person upon enrollment. When a Covered Person arrives at a Participating Healthcare Professional to receive Covered Services, the Covered Person must show the Healthcare Professional his or her Identification Card to verify coverage by Coventry.

Infertility: the inability to achieve fertilization of an ovum and/or carry a fetus to term.

Infertility Treatment: all services, supplies and drugs related to the diagnosis and treatment of infertility, including but not limited to counseling, testing, semen analysis, ferning, spinbarkeit and Huhner's test, sperm agglutination or penetration studies, hysterosalpingography, endometrial biopsy, laparoscopy,

laparotomy, myomectomy, dilation and curettage, tuboplasty, microsurgical procedures of the female pelvis or male genital tract, ovulation induction and artificial intercervical or intrauterine insemination.

Injury: an accidental bodily condition that:

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

Initial Enrollment Period: the period of time during which an employee or dependent is first eligible to enroll. It starts on the employee's and/or dependents' initial date of eligibility and ends no less than thirty (30) days later.

Large Group Employer: an organization that is actively engaged in business and employs more than fifty (50) Eligible Employees as of the Effective Date and subsequent Policy Anniversary Dates.

Late Enrollee: any Covered Person who applies for coverage under this Group Policy other than during the first period in which the Covered Person is eligible to enroll or during a Special or Annual Open Enrollment Period.

Late Enrollment: that enrollment period that is provided for employees and/or their dependents who do not enroll in a timely manner as specified in this Group Policy and does not meet the requirements of special enrollment.

Medical Condition: a disease, an illness, or an injury. A biological or psychological condition which lies in the range of normal human variation is not considered a disease, illness, or injury.

Medical Services: (except as limited or excluded under this Group Policy) those professional services of Healthcare Professionals or other Participating Providers, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services.

Medically Necessary: those services and supplies that are not expressly excluded under this Agreement and that are determined by Coventry to be:

1. Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;
2. Necessary to meet the basic health needs of the Covered person as a minimum requirement;
3. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
4. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by Coventry;
5. Consistent with the diagnosis of the condition;
6. Required for reasons other than the comfort or convenience of the Covered Person or his/her physician; and
7. Of demonstrated value based on clinical evidence reported by Peer Reviewed Medical Literature and by generally recognized academic medical experts; that is, it is not experimental (investigational, unproven).

Medicare: Title XVIII of the Social Security Act and regulations there under.

Mental Health and Nervous Disorders: disorder that impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin.

Modalities: a form, method, or apparatus of therapy, especially physiotherapy or electrotherapy.

Named Insured: the Eligible Employee of the Employer whose Enrollment Applications have been accepted by Coventry in accordance with the enrollment requirements of this Group Policy, and for whom the premium charges required under this Group Policy have been received by Coventry.

Non-Participating Provider: Healthcare Professional, organization, supplier of healthcare items, or a healthcare facility who does not have a written contract at the time services are rendered with Coventry to provide Covered Services to Coventry Covered Persons.

Orthognathic Surgery: the surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw) or the maxilla (upper jaw). These malformations may be present at birth, or they may become evident as the patient grows and develops.

Orthotic Devices: rigid or semi-rigid appliances to support or restrict the motions of a part of the body.

Out-of-Network: pertaining to the payment level for Covered Services received from a Non-Participating Provider.

Out-of-Network Rate: the amount Coventry pays for Covered Services furnished by Out-of-Network Providers, unless such services are Pre-Authorized at the In-Network level of benefits.

Out-of-Pocket Maximum: the maximum amount of Coinsurance and Deductibles a Covered Person will pay each Benefit Year. Once the Covered Person reaches the Out-of-Pocket Maximum, benefits for those Covered Services that apply to the Out-of-Pocket Maximum are payable at 100% of eligible Expenses during the rest of the Benefit Year. The individual and family maximums are specified in the Schedule of Benefits.

Outpatient: a person who receives care at a Hospital or other facility that does not last longer than twenty-three (23) hours.

Part Time Student: a Covered Person who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Part Time Student status. A student is considered part time during normally scheduled school vacations if he or she is registered to return to that or a similar institution at the end of the vacation. A Covered Person is considered enrolled during summer or holiday vacations when school is not in session.

Participating Provider: any physician or Healthcare Professional, organization, supplier of healthcare items, or a healthcare facility having a written contract at the time services were rendered with Coventry to provide Covered Services to a Coventry Covered Person.

Physician: an individual who is (a) licensed to practice medicine and/or surgery; or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose services are required to be covered under this Contract by the laws of the jurisdiction where treatment is given; or is a partnership or professional association or corporation of such individuals in (a) or (b) above.

Post-Service Grievance: a Grievance for which an Adverse Benefit Determination was rendered for a service that was already provided, and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Covered Person's receipt of the initial notice of such Adverse Benefit Determination.

Pre-Admission Tests: laboratory tests or x-ray examinations done on an outpatient basis in a Hospital or other facility no more than seven (7) days before a Covered Person is scheduled to be admitted to the Hospital or receives outpatient surgery.

Pre-existing Condition: is any Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) month period immediately preceding the earlier of:

- a. The first day of the Covered Person's Waiting Period, typically the date full-time employment begins, for individuals enrolling during their Initial Enrollment Period; or
- b. The Effective date of the Covered Person's coverage for individuals enrolling during a Special Enrollment or Annual Enrollment Period

A pre-existing Condition does not include:

- a. Pregnancy;
- b. Genetic information in the absence of a diagnosis of the Condition;
- c. Routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or
- d. Conditions arising from domestic violence.

Pre-Service Grievance: means any Grievance for which a requested service requires prior authorization, an Adverse Benefit Determination was rendered and the requested service was not provided and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Covered Person's receipt of the initial notice of such Adverse Benefit Determination.

Prior Authorization: an advance approval that a Covered Person must receive from Coventry, before the Covered Person receives certain Covered Services under this Group Policy.

Prosthetic Devices: devices which aid body functioning or replace a limb or body part after accidental or surgical loss to correct a defect of body form or function.

Psychiatric Treatment Program: services offered by programs licensed for the treatment of mental and nervous disorders, or substance abuse rehabilitation.

Rehabilitative Outpatient Therapy long-term (except as limited or excluded under this Contract): treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy, respiratory therapy and occupational therapy that would take longer than sixty (60) days.

Rehabilitative Outpatient Therapy short-term (except as limited or excluded under this Contract): treatment modalities that are part of a rehabilitation program which will not exceed sixty (60) days from date therapy begins and includes physical therapy, speech therapy, respiratory therapy and occupational therapy.

Room and Board: services provided by a Hospital that include room, meals and all general services and activities needed for the care of regular bed patients.

Service Area: the geographic area within the State of Florida where Coventry has Participating Healthcare Professionals under contract.

Sickness: a physical illness or disease, including a pregnancy and any resulting complications of such pregnancy. The term "sickness" does not include mental illness or substance abuse.

Special Enrollment Period: an enrollment period that is provided for employees and/or their dependents due to special circumstances as described in the Special Enrollment provision.

Sufficient Evidence: evidence is considered to be sufficient to draw conclusions if it is peer reviewed, is well controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Total Disability (Totally Disabled):

1. for the Named Insured and covered spouse, the person's inability to perform any work or occupation for which the person is reasonably qualified or trained; and
2. for a covered Dependent child, the inability to engage in the normal activities of a person of like age or sex in good health.

Urgent Care Facility: a licensed, non-hospital facility that has a written contract with Us as an independent contractor to provide services for treatment of conditions which, although not life threatening, could result in serious injury or disability if left untreated.

Urgent Grievance: means a Grievance for which a requested service requires prior authorization, or an extension of concurrent care is being requested; an Adverse Benefit Determination was rendered; the requested service has not been provided; and the application of non-urgent care Grievance time frames could seriously jeopardize: (a) the life or health of the Covered Person or the Covered Person's unborn child; or (b) the Covered Person's ability to regain maximum function. An Urgent Grievance is also a Grievance where application of the non-Urgent timeframes would, in the opinion of a physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is being requested.

Waiting Period: the period, if any that must pass with respect to an individual before the individual is eligible to be covered under this Group Policy.

We, Us, Our, Company: Coventry Health Care.

Website: www.vistahealthplan.com

You, Yours: refers to You (Named Insured) and Your eligible enrolled Dependents.



BENEFITS SCHEDULE

These co-payments are the maximum fees that will be charged by participating GENERAL DENTIST for the specified covered services.

DIAGNOSTIC & PREVENTIVE

Member Pays

0120▲	Periodic oral evaluation	5
0140▲	Limited oral evaluation—problem focused	5
0150▲	Comprehensive oral evaluation	5
0160▲	Detailed and extensive oral evaluation— problem focused	5
0210	Intraoral—complete series (1 per 24 months)	53
0220	Intraoral—periapical single film	10
0230	Intraoral—periapical each additional film	10
0240	Intraoral—occlusal film	15
0250	Extraoral—first film	20
0260	Extraoral—each additional film	18
0270▲	Bitewing single film (1 per 6 months)	5
0272▲	Bitewings 2 films (1 per 6 months)	5
0274▲	Bitewings 4 films (1 per 6 months)	5
0330	Panoramic film (1 per 24 months)	48
0340	Cephalometric film	56
0460	Pulp vitality tests	23
0470	Diagnostic casts	40
0471	Diagnostic photographs	24
1110▲	Complete prophylaxis—adult (1 per 6 months)	5
1120▲	Complete prophylaxis—child (1 per 6 months)	5
1201▲	Fluoride treatment—child (prophylaxis included) (1 per 6 mos)	10
1203▲	Fluoride treatment—child (prophylaxis not included) (1 per 6 months)	5
1204▲	Fluoride treatment—adult (prophylaxis not included) (1 per 6 months)	5
1205▲	Fluoride treatment—adult (prophylaxis included) (1 per 6 months)	10
1330	Oral hygiene instructions	No charge
1351	Sealants—per tooth	20
1510	Space maintainer (fixed unilateral)	134
1515	Space maintainer (fixed bilateral)	175
1520	Space maintainer (removable unilateral)	163
1525	Space maintainer (removable bilateral)	208
1550	Recementation of space maintainer	30

▲ The combined charge for these dental procedures shall not exceed \$10 per visit.

RESTORATIVE (Fillings)

2140	Amalgam—one surface (primary or permanent)	44
2150	Amalgam—two surfaces (primary or permanent)	56
2160	Amalgam—three surfaces (primary or permanent)	70
2161	Amalgam—four+ surfaces (primary or permanent)	86
2330	Resin—one surface, anterior	55
2331	Resin—two surfaces, anterior	68
2332	Resin—three surfaces, anterior	85
2335	Resin—four or more surfaces or involving incisal angle (tooth reconstruction including incisal edge), anterior ..	100
2391	Resin—one surface, posterior	60
2392	Resin—two surfaces, posterior	82
2393	Resin—three surfaces, posterior	102
2394	Resin—four or more surface, posterior	102
2940	Sedative filling	40
2950	Core buildup including any pins	105
2951	Pin retention (per tooth, in addition to restoration)	22
2952	Cast post and core in addition to crown	165

Member Pays

2954	Prefabricated post and core in addition to crown	130
2955	Post removal not in conj. with endodontic therapy ..	116
2960	Labial veneer (laminate) (chairside)	219

FIXED CROWN AND BRIDGE

2510	Inlay—metallic, one surface	315
2520	Inlay—metallic, two surfaces	376
2530	Inlay—metallic, three or more surfaces	414
2543	Onlay—metallic, three surfaces	445
2544	Onlay—metallic, four or more surfaces	453
2610	Inlay—porcelain/ceramic, one surface	356
2620	Inlay—porcelain/ceramic, two surfaces	397
2630	Inlay—porcelain/ceramic, three or more surfaces ..	440
2642	Onlay—porcelain/ceramic, two surfaces	430
2643	Onlay—porcelain/ceramic, three surfaces	450
2644	Onlay—porcelain/ceramic, four or more surfaces ...	470
2650	Inlay—composite/resin, one surf. lab processed	310
2651	Inlay—composite/resin, two surf. lab processed	363
2652	Inlay—composite/resin, three surf. lab processed ..	400
2710	Crown—resin laboratory	285
2720	Crown—resin with high noble metal	480
2721	Crown—resin with predominantly base metal	428
2722	Crown—resin with noble metal	460
2740	Crown—porcelain/ceramic substrate	496
2750	Crown—porcelain fused to high noble metal	478
2751	Crown—porcelain fused to base metal	445
2752	Crown—porcelain fused to noble metal	466
2790	Crown—full cast high noble metal	475
2791	Crown—full cast base metal	420
2792	Crown—full cast noble metal	460
2810	Crown—¾ cast metallic	460
2910	Recement inlay (per unit)	37
2920	Recement crown (per unit)	39
2930	Prefabricated stainless steel crown (primary—child) ..	108
2931	Prefabricated stainless steel crown (permanent)	125
2932	Prefabricated resin crown	132
2933	Prefabricated stain. steel crown w/resin window	152
6210†	Bridge pontic—cast high noble metal (per unit)	470
6211†	Bridge pontic—cast base metal (per unit)	420
6212†	Bridge pontic—cast noble metal (per unit)	430
6240†	Bridge pontic—porc. to high noble metal (per unit) ..	470
6241†	Bridge pontic—porcelain to base metal (per unit)	431
6242†	Bridge pontic—porcelain to noble metal (per unit) ..	445
6250†	Bridge pontic—resin with high noble metal	460
6251†	Bridge pontic—resin with predom. base metal	431
6252†	Bridge pontic—resin with noble metal	454
6545	Retainer—cast metal for resin bonded fixed pros. ..	265
6720†	Crown—bridge retainer, resin w/high noble metal ..	475
6721†	Crown—bridge retainer, resin predom. base metal ..	437
6722†	Crown (resin with noble metal)	454
6750†	Bridge abutment—porcelain to high noble metal (per unit)	490
6751†	Bridge abutment—porcelain to base metal (per unit) ..	448
6752†	Bridge abutment—porcelain to noble metal (per unit)	464
6780†	Crown—retainer ¾ cast high noble metal	460
6790†	Bridge abutment—full cast high noble metal (per unit) ...	467
6791†	Bridge abutment—full cast base metal (per unit)	426
6792†	Bridge abutment—full cast noble metal (per unit)	460
6930	Recement fixed partial denture	57



BENEFITS SCHEDULE

These co-payments are the maximum fees that will be charged by participating GENERAL DENTIST for the specified covered services.

	Member Pays		Member Pays
6970 Cast post and core (in add'n to fixed partial denture retainer) .	161	5820 Interim partial upper denture	280
6971 Cast post as part of fixed partial denture retainer	160	5821 Interim partial lower denture	280
6972 Prefabricated post and core in addition to fixed partial denture retainer	131	5850 Tissue conditioning, upper	50
6973 Core buildup for retainer including any pins	109	5851 Tissue conditioning, lower	50
6975 Coping—metal	280		
† Per unit, up to six (6) units. Seven (7) or more units, add an additional \$40 per unit. Laboratory processed temporary splint, add an additional \$25 per unit for seven (7) or more units.			
*ENDODONTICS (Root Canal Therapy)			
3110 Pulp cap—direct (excluding final restoration)	28	REPAIRS TO PROSTHETICS (Full & Partial Dentures)	
3120 Pulp cap—indirect (excluding final restoration)	31	5510 Repair broken complete denture base	69
3220 Therapeutic pulpotomy (excluding final restoration)	70	5520 Replace missing or broken teeth, comp. dent/ (each tooth) .	50
3230 Pulpal therapy—resorbable fill, ant. primary tooth	90	5610 Repair resin denture base	65
3240 Pulpal therapy—resorbable fill, post. primary tooth ...	80	5620 Repair cast framework	117
3310 Anterior root canal (excluding final restoration)	270	5630 Repair or replace broken clasp	87
3320 Bicuspid root canal (excluding final restoration)	335	5640 Replace broken teeth—per tooth	55
3330 Molar root canal (excluding final restoration)	428	5650 Add tooth to existing partial denture	75
		5660 Add clasp to existing partial denture	100
*PERIODONTICS (Gum Treatment)			
4341 Scaling and root planing (per quadrant) (limit 4 per year) ...	104	*ORAL SURGERY	
4355 Full mouth debridement to enable comprehensive periodontal evaluation & diagnosis	67	7111 Extraction, coronal remnants - deciduous tooth	56
4910 Periodontal maintenance (following active therapy)	59	7140 Extraction, erupted tooth or exposed root	52
4920 Unscheduled dressing change (not by treating dentist) ..	38	7210 Surgical extraction of erupted tooth	111
9941 Fabrication of athletic mouthguard	90	*ORTHODONTICS (ADULTS OR CHILDREN)	
9950 Occlusion analysis—mounted case	120	8070 Comprehensive orthodontic treatment of the Transitional Dentition	UCR less 20%
9951 Occlusal adjustment (limited)	67	8080 Comprehensive orthodontic treatment of the Adolescent Dentition	UCR less 20%
9952 Occlusal adjustment (complete)	270	8090 Comprehensive orthodontic treatment of the Adult Dentition	UCR less 20%
9970 Enamel Microabrasion	76	8210 Removable appliance therapy	UCR less 20%
		8660 Pre-orthodontic treatment visit	UCR less 20%
PROSTHETICS (Full & Partial Dentures)			
5110 Complete upper denture	600	MISCELLANEOUS	
5120 Complete lower denture	600	9110 Emergency treatment (palliative treatment for dental pain) -minor procedure ..	40
5130 Immediate upper denture	650	9210 Local anesthesia, not in conjunction with operative or surgical procedures	20
5140 Immediate lower denture	650	9211 Regional block anesthesia	22
5211 Partial upper—resin base	460	9215 Local anesthesia	18
5212 Partial lower—resin base	464	9230 Analgesia	22
5213 Partial upper—cast metal frmwrk w/resin dent. base ...	680	9310 Consultation—second opinion (arranged by CompBenefits and provided by a Participating Dentist)	47
5214 Partial lower—chrome cast frmwrk w/resin denture base ..	680	9430 Office visit for observation (during regularly scheduled hours)—No other services performed ..	29
5281 Remove unilateral partial dent., 1pc. metal (w/teeth)	360	9440 Office visit—after regularly scheduled hours	55
5410 Adjustments—complete upper	30	9910 Application of desensitizing medicament	25
5411 Adjustments—complete lower	30		
5421 Adjustments—partial upper	30	*SPECIALIST CARE: All dental procedures will be provided to the member in accordance with the Plan Benefits Schedule as long as that procedure is within the scope and competence of general dental practice. For those cases in which the procedure is beyond the scope and competence of the participating general dentist (i.e., certain oral surgery, endodontics, periodontics, pedodontics), the member will be referred to a participating specialist (where participating specialists are available), and receive a 20% discount from the usual, customary and reasonable (UCR) fees of the specialist.	
5422 Adjustments—partial lower	30	NOTE: Procedures not listed on the Benefits Schedule will be provided at the participating dentist's usual, customary and reasonable (UCR) fees less 20%.	
5710 Rebase complete upper denture (laboratory)	220	<i>The plan does not cover all procedures which might be provided by general dentist.</i>	
5711 Rebase complete lower denture (laboratory)	220	<i>Not all participating dentists perform all listed procedures. Please consult your dentist prior to treatment.</i>	
5720 Rebase partial upper denture (laboratory)	210		
5721 Rebase partial lower denture (laboratory)	210		
5730 Reline complete upper denture (office)	145		
5731 Reline complete lower denture (office)	145		
5740 Reline partial upper denture (office)	138		
5741 Reline partial lower denture (office)	138		
5750 Reline complete upper denture (laboratory)	190		
5751 Reline complete lower denture (laboratory)	190		
5760 Reline partial upper denture (laboratory)	190		
5761 Reline partial lower denture (laboratory)	190		
5810 Interim complete upper denture	320		

CERTIFICATE OF COVERAGE

CHOICE OF DENTIST

CompBenefits contracts with established dentists in the community to provide quality care to our members. To receive benefits, you and your dependents must select a dental facility from the CompBenefits list of participating dental offices. Dentists undergo a thorough review process prior to acceptance to our network. Each privately owned office is operated by a licensed general dentist and a staff of professional auxiliaries.

MAKING AN APPOINTMENT WITH YOUR DENTIST

You may schedule an appointment by calling the dental office you selected on or after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the CompBenefits/Vista Healthplan, Inc. dental plan. You will receive a VISTA identification card, but this card is not necessary to receive dental services.

CHANGING YOUR SELECTION OF DENTIST

A situation may occur in which you need to change your dental office selection. Provider transfer requests may be made by calling our Member Support Department. Requests received prior to the 20th of the month will be effective the first of the following month. Transfers can only be processed if you have no balance due or pending appointments at your dental office.

SPECIALIST CARE REFERRALS

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, your general dentist will refer you to a participating specialist (where participating specialists are available). You will be provided a referral form to present to the participating specialist to ensure proper coverage.

WHAT ARE CO-PAYMENT FEES?

Co-payments are reduced fees charged by the participating dental offices for some covered dental procedures as specified in the Benefits Schedule. The reduced fees are 30-50% less than the usual, customary and reasonable fees charged in a dental office. Members are financially responsible for co-payment fees, payable to the dental office.

CANCELLING APPOINTMENTS

The time set aside for a patient is very valuable to the dentist. Therefore, if you cannot keep an appointment, notify the dental office a minimum of 24 hours in advance. If you do not notify the office, charges will be made for broken appointments.

EMERGENCY CARE WITHIN THE SERVICE AREA

In the event of an emergency, contact the participating CompBenefits dental office you selected. If you are unable to reach your dentist, call the CompBenefits 24-Hour Hotline and you will be instructed on how to receive necessary emergency dental care. CompBenefits 24-Hour Emergency Hotline Toll-Free: 800-848-3480

REIMBURSEMENT PROVISION FOR OUT-OF-AREA EMERGENCY CARE

Members and dependents are covered for emergency dental treatment while temporarily more than fifty (50) miles from their participating dental office. In the event of an emergency, obtain treatment to relieve your pain/discomfort only. Pay for the services rendered and submit the receipt to CompBenefits with your name, social security number, address, and phone number. CompBenefits will reimburse no less than 75% of the reasonable charges for covered services and supplies, subject to applicable co-payments, and shall not exceed \$100.00 per claim.

SECOND OPINIONS

CompBenefits can arrange for second opinions to the member. To coordinate second opinions, members should call the CompBenefits Member Support Department. Second opinions not arranged by CompBenefits or rendered by a non-participating dentist will not be covered.

MEMBER SUPPORT

CompBenefits is responsible for all administrative functions of the program. If you have an inquiry or grievance, CompBenefits encourages you to submit it in writing to:

CompBenefits
Grievance & Appeals Dept.
5775 Blue Lagoon Drive #400
Miami, Florida 33126

Or call the Member Support Department, Monday through Friday, 8:00 AM to 6:00 PM at:

Toll-Free: **800-848-3480**

EXCLUSIONS AND LIMITATIONS

The following dental benefits are not covered or offered under the plan:

- Oral surgery requiring the setting of fractures or dislocations.
- Treatment of congenital malformations.
- Treatment of malignancies.
- Dispensing of drugs.
- Any treatment requiring hospitalization.
- Any work which is not able to be performed because of the general health and physical limits of the eligible member, as indicated by said member's personal physician or the CompBenefits dentist.
- Precision attachments or stress breakers.
- Replacement of partial or full dentures within two (2) years after installation unless resulting from the acts or omissions of CompBenefits.
- Any treatment paid by Workers' Compensation or employer's liability laws, by a federal or state government agency, or provided without cost by any municipality, county or other political subdivision.
- Any procedure, implantation and/or any dental procedure considered to be experimental by the providing dentist.
- General anesthesia.
- Surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Replacement of lost or stolen prosthetic devices.
- Any dental care provided by a non-participating general dentist or specialist, except when authorized by CompBenefits.
- Services resulting from any act of war, declared or not, or resulting from military service.
- Charges for broken appointments are not covered.

The following limitations apply:

- The Participating Dentist shall have the right to refuse treatment to a member who fails to follow a prescribed course of treatment.
- Published member co-payments apply only when treatment is performed at a Participating Dental Office.
- If a member obtains dental services from other than a Participating Dentist/Specialist, the member shall be responsible for all costs.

Coventry Health and Life Insurance Company
Rider to Certificate of Insurance
Broward County Board of County Commissioners
Domestic Partner

In consideration of the payment of all applicable premiums, the Coventry Health and Life Insurance Company Group Binder & Agreement and Certificate of Insurance are hereby amended, as follows:

A Named Insured may add a domestic partner and his/her dependent children, if any, if the Named Insured enrolls in the applicable tier of coverage. A domestic partner of the Named Insured is an eligible dependent if:

1. each party is at least 18 years of age and competent to contract;
2. neither person is married, nor a partner to another domestic partnership relationship;
3. consent of either person to the domestic partner relationship has not been obtained by force, duress or fraud;
4. each person agrees to be jointly responsible for each other's basic food and shelter; and
5. both parties must be domiciled in Broward County OR one of the parties must be employed by the Broward County Board of County Commissioners.

The domestic partner may be the same or opposite sex as the Named Insured.

To add a domestic partner, the Named Insured and domestic partner must register their domestic partnership with the Broward County Records Division and the Named Insured must enroll the domestic partner as his/her dependent within 31 days of such registration. The effective date of coverage is the 1st of the month following the date of submission of the Domestic Partner Registration. A Named Insured may not elect coverage for more than 2 registered domestic partners in each calendar year.

A dependent of the registered domestic partner is also eligible for coverage if:

1. the dependent meets eligibility criteria for dependent children as defined in the Certificate of Insurance;
2. a copy of the child's birth certificate showing the partner is the parent of the child is provided;
3. if the domestic partner is the legal guardian of the child, a copy of the court order is provided;

Coverage for the domestic partner and dependents, if any, terminates 30 days following the date a certificate of termination of domestic partnership is issued by the Broward County Records Office. Upon such termination, the domestic partner and dependents may continue the coverage they were receiving immediately prior to the termination of the domestic partnership for up to 18 months upon timely election and payment of the premium.

All of the other terms, conditions, limitations and exclusions of the Group Binder & Agreement and Certificate of Insurance apply.

This Rider is effective as of the effective date of the Certificate to which it is attached.

Coventry Health and Life Insurance Company



Shirley Smith
Senior Vice President, Legal (Corporate)

Coventry Health and Life Insurance Company
Rider to PPO Certificate of Insurance
Mental Health Treatment
Broward County Board of County Commissioners

	In-Network	Out-of-Network
Annual Deductible (per calendar year) Individual/Family <i>(deductible credit is applied towards satisfaction of both in-network and out-of-network deductible)</i>	\$1,100 / \$2,200	\$1,500 / \$3,000
Coinsurance Maximum (per calendar year) Individual/Family	\$1,500 / \$3,000	
Mental Health Treatment	Member Responsibility	
Inpatient Services	Refer to Schedule of Benefits	Refer to Schedule of Benefits
Outpatient Services	Refer to Schedule of Benefits	Refer to Schedule of Benefits

This Rider is attached to and made a part of the Coventry Health and Life Insurance Company (“Coventry”) PPO Policy. The benefits provided by this Rider apply to the extent they are greater than those shown in the PPO Policy. This Rider is subject to all the provisions, of the PPO Policy, including the Exclusions and Limitations, contained in the Policy to the extent they are not in direct conflict with the following:

A. Definitions

All terms used in this Rider shall have the respective meanings specified in the PPO Policy unless the context otherwise requires:

1. "Mental Health and Nervous Disorders": disorder that impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. Mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.
2. "Partial Hospitalization": outpatient treatment, services, or supplies provided by a duly licensed program which is accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) or in compliance with equivalent standards.

B. Conditions

1. The benefits and services covered by this Rider are limited to the benefits and services set forth herein which are provided, prescribed, directed, or approved by Coventry in accordance with the terms and conditions of the Agreement.
2. The Premium for this Rider is set forth in the Binder and Agreement comprising part of the Agreement. The terms and conditions regarding payment of the Premium for this Rider are as set forth in the Agreement.
3. Nothing contained in this Rider shall be held to vary, alter, waive, supplement, or extend any of the terms, conditions, provisions, agreements or limitations of the Agreement, other than as specifically set forth below, and the provision of the Covered Services contemplated in this Rider shall be governed by the terms and conditions of the Agreement.
4. Coverage under this Rider shall commence and terminate in accordance with the terms of the Agreement.
5. If a Member incurs charges for any Covered Service provided under this Rider, in order to receive reimbursement from Coventry for the amount of the charge, a claim must be submitted to Coventry as soon as reasonably practicable following the date on which the Covered Service occurred, but in no event later than

sixty (60) days after such occurrence.

C. Benefits and Limitations

1. Inpatient Benefits. Inpatient benefits for Mental Health Treatments are limited to those Mental Health Treatments, which are deemed to be responsive to short-term treatment and not to be chronic or organic in nature.
2. Outpatient Benefit. The benefit shall consist of outpatient services for consultations, treatment, evaluation and/or crisis intervention for Mental Health Treatments. To be Covered Services, such services must be provided by a physician, a psychologist licensed pursuant to Chapter 490, Florida Statutes, a mental health counselor, marriage and family therapist, or clinical social worker, in each case licensed pursuant to Chapter 491, Florida Statutes.
3. Partial Hospitalization Benefits. Partial Hospitalization benefits are limited to the treatment of Mental Health Treatments which are deemed to be responsive to short term treatment and not to be chronic or organic in nature. Partial Hospitalization shall be available in lieu of hospital confinement on the basis that each inpatient day equals two (2) Partial Hospitalization days. Partial Hospitalization must be approved in advance. In any benefit year, if Partial Hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid shall not exceed the cost of the number of days of inpatient benefits for psychiatric services, including physician fees.
4. The benefits available to members hereunder shall not include coverage for treatment pursuant to voluntary or involuntary confinement under Florida's Baker Act, Florida Statutes 394.451-394.4789, whether such confinement is considered to be routine or an Emergency, except within the limits stated above.

This Rider will be effective as of the Effective Date of the PPO Policy to which it is attached.

Coventry Health and Life Insurance Company



Shirley Smith
Senior Vice President, Legal (Corporate)

Coventry Health and Life Insurance Company
Rider to Open Access Contract/Certificate of Coverage
Broward County Board of County Commissioners
CDH with Out-of-Network

In consideration of the payment of all applicable premiums, the Coventry Health and Life Insurance Company (hereinafter referred to as “Coventry”) Group Master Contract and PPO Certificate of Insurance is hereby amended and supplemented by the terms and conditions of this Rider.

This Rider gives You the option of receiving Covered Services from Non-Participating Providers (Out-of-Network). Services rendered by Non-Participating Providers will be paid at the Out-of-Network level of benefits pursuant to the terms and conditions stated herein and on the Schedule of Benefits. For Covered Services rendered by Non-Participating Providers, You will have to pay Annual Deductible and Coinsurance, and there may be limits and certain advance notification requirements. Please review this Rider carefully and keep it with Your PPO Certificate of Insurance.

I. Definitions

All capitalized by undefined terms used in this Rider have the meaning ascribed to them in Your PPO Certificate of Insurance. The following definitions are added:

- A. Annual Deductible:** the amount You must pay each Calendar Year for Covered Services before Coventry begins to pay any costs associated with Covered Services. Annual Deductible credit is applied toward satisfaction of both In-Network and Out-of-Network deductible. The Annual Deductible is specified in the Schedule of Benefits.
- B. Coinsurance Maximum:** the amount of Coinsurance a Covered Person will pay each Calendar Year before Coventry pays the Allowed Amount at 100% for Covered Services. Expenses used to satisfy the Coinsurance percentage apply toward satisfying the Coinsurance Maximum. The Coinsurance Maximum is combined for amounts satisfied In-Network and Out-of-Network. Deductible does not apply to Coinsurance Maximum. The Individual and Family Coinsurance Maximums are specified in the Schedule of Benefits.
- C. Lifetime Maximum Benefit:** the lifetime maximum amount payable by Coventry per Covered Person for Covered Services during the entire time a Covered Person is enrolled in Coventry, including benefits provided under additional coverage Riders. Specific Lifetime Maximum Benefit amounts are listed in the Schedule of Benefits.

II. Benefit Provisions

The following provisions are added to the Coverage Provisions Section.

A. CDH In-Network Provisions

- 1. Annual Deductible:** before Coventry will begin paying health care expenses for specified Covered Services, You must satisfy the Annual Deductible per Individual and per Family. If You have individual coverage, after You have reached Your Individual Deductible, benefits will be payable for Covered Services for the remainder of the Calendar Year. If You have family coverage, after You and Your Covered Dependents reach the Family Deductible shown on the Schedule of Benefits, no further Deductible will be applied for the rest of the Calendar Year to anyone in Your family.

The following Covered Services are NOT subject to the Annual Deductible:

- a. Outpatient Physician Services;
- b. Outpatient Speech, Physical, Occupational, Respiratory and Cardiac Therapy Services;
- c. Outpatient Diagnostic Services excluding Therapeutic services: CT Scans, PET Scans, MRI and Nuclear Medicine when rendered in a Freestanding Facility;
- d. Outpatient surgery when rendered in an Ambulatory Surgical Center;
- e. Outpatient radiation and chemotherapy when rendered in a Freestanding Facility;
- f. Second medical and surgical opinion;

- g. Human Organ Transplants;
- h. Emergency, Urgent Care and Ambulance Services;
- i. Inpatient/Outpatient Mental Health and Substance Abuse Services;
- j. Home health care;
- k. Family Planning Services: Voluntary Counseling; Intrauterine Devices; Abortions / Elective Sterilizations when rendered at a physician's office or Freestanding Facility;
- l. Durable Medical Equipment; and
- m. Insulin/diabetic supplies.

If You become covered under this Rider between January 1 and March 31 of any Calendar Year and this coverage replaces Your prior group coverage, We will reduce the Individual and Family Deductibles for that Calendar Year by the amount of covered medical Expenses You incurred under Your prior group plan which was applied towards satisfying that plan's respective deductibles between January 1 and the effective date of this coverage, but only to the extent that such covered medical Expenses would have been eligible for Coverage under this Rider. The expenses would be considered Covered Services under this POS Rider and prior coverage Deductible provisions were the same or similar to those contained in this POS Rider. You must submit your last Explanation of Benefits statement from Your prior carrier in order to receive credit for Your prior deductible expenses.

Any Annual Deductible expenses incurred under this Rider during October, November and December of a Calendar Year will be credited towards the Annual Deductible You have to satisfy in the next Calendar Year, if that deductible has not been satisfied for the previous year.

- 2. **Coinsurance:** once the Annual Deductible is met for specified Covered Services, You are responsible for paying the applicable Coinsurance.
- 3. **Coinsurance Maximum:** the maximum amount of Coinsurance You will pay each Calendar Year before Coventry pays the Allowed Amount at 100% for Covered Services per Individual and per Family for In-Network Covered Services. The Coinsurance Maximum is combined for amounts satisfied In-Network and Out-of-Network.

Expenses that will not apply towards the Coinsurance Maximum:

- a. Copayments;
- b. Expenses used to satisfy the Annual Deductible;
- c. Services that are not considered covered under this Certificate of Coverage or are specifically excluded;
- d. Charges that are not considered a covered Expense;
- e. Charges in excess of the Allowed Amount; and
- f. Expenses for services that exceed treatment limitations explained in the Certificate of Insurance.

- 4. **Lifetime Maximum Benefit:** the lifetime maximum benefit payable by Coventry per Member is \$2 million.

III. CDH Out-of-Network Provisions

This Certificate of Insurance gives You the option of obtaining services from Non-Participating Providers (Out-of-Network). Services rendered by Non-Participating Providers will be paid at the Out-of-Network level of benefits pursuant to the terms and conditions stated herein and on the Schedule of Benefits. For services rendered by Non-Participating Providers, You will have to pay Annual Deductible and Coinsurance, and there may be limits and certain advance notification requirements.

- A. **Annual Deductible:** If You have individual coverage, after You have reached Your Individual Deductible, benefits will be payable for Covered Services for the remainder of the Calendar Year. If You have family coverage, after You and Your Covered Dependents reach the Family Deductible shown on the Schedule of Benefits, no further Deductible will be applied for the rest of the Calendar Year to anyone in Your family. After the Annual Deductible is satisfied, benefits will be payable for Covered Services,

subject to any applicable Coinsurance. Services rendered by Non-Participating Providers will be paid at the Out-of-Network level of benefits pursuant to the terms and conditions stated herein and on the Schedule of Benefits. Only those eligible Expenses submitted on claims to Coventry will be credited toward the Annual Deductible. Expenses that are not eligible expenses will not be counted toward the satisfaction of the Annual Deductible. Annual Deductible credit is applied toward satisfaction of both In-Network and Out-of-Network Annual Deductible.

B. Lifetime Maximum Benefit: the lifetime maximum benefit payable by Coventry per Member is \$1 million.

C. Exclusions

The following services are NOT covered under this Rider. These services are only available from the Participating Providers as specified in the Schedule of Benefits:

1. Elective abortions
2. Dental care
3. Vision

Please refer to Your Schedule of Benefits for more details. If You are not certain whether this Rider covers a particular service, please call our toll-free number: 1-866-847-8235 or TDD # 1-888-444-7352.

D. What You Pay

1. Annual Deductible (see Schedule of Benefits for Individual/Family Deductible);
2. Coinsurance (see Schedule of Benefits for Coinsurance and Coinsurance Maximum);
3. The difference between the provider's bill and what Coventry pays.
4. An additional 20% of the benefit otherwise payable, if you do not obtain Prior Authorization for certain services as specified in the Certificate of Insurance.

Special Rules Applicable to the Calculation of Deductible and Coinsurance:

1. After You satisfy the Individual Deductible, benefits will be payable for Covered Services. If You have family coverage, after You and Your Dependents satisfy Your Family Deductible, no further Deductible will be applied for the rest of the Calendar Year.

If You have family coverage, once the sum of the Individual Deductibles satisfied for the Calendar Year reaches the Family Deductible requirement, no further payments will be required from any family member for the remainder of the Calendar Year to satisfy the Annual Deductible. The maximum amount for any family member which Coventry will apply towards satisfying the Annual Deductible is his/her Individual Deductible.

2. Deductible Carryover:
 - a) If You become covered under this Rider between January 1 and March 31 of any Calendar Year and this coverage replaces Your prior group coverage, We will reduce the Individual and Family Deductibles for that Calendar Year by the amount of covered medical Expenses You incurred under Your prior group plan which was applied towards satisfying that plan's deductibles between January 1 and the effective date of this coverage, but only to the extent that such covered medical Expenses would have been eligible for Coverage under this Rider. The expenses would be considered Covered Services under this POS Rider and prior coverage Deductible provisions were the same or similar to those contained in this POS Rider. You must submit your last Explanation of Benefits statement from Your prior carrier in order to receive credit for Your prior Deductible expenses.
 - b) Any Annual Deductible expenses incurred under this Rider during October, November and December of a Calendar Year will be credited towards the Annual Deductible You have to satisfy in the next Calendar Year, if that Annual Deductible has not been satisfied for the previous year.

3. All of the Coinsurance You pay during any Calendar Year is accumulated towards Your Coinsurance Maximum. Once You meet Your Coinsurance Maximum in any Calendar Year, Coventry will pay 100% of the Allowed Amount for all Covered Services for the remainder of that Calendar Year.
4. If You have family coverage, the total amount of Coinsurance paid by all members of the family is accumulated towards the Family Maximum. Once the Family Maximum is reached, Coventry will pay or reimburse 100% of the Allowed Amount for all further Covered Services for the remainder of the Calendar Year. The maximum amount that any one person in the family can contribute towards satisfaction of the Family Maximum is the Individual Maximum.

E. Benefit Limits

Whenever a day, treatment or visit maximum is indicated for a Covered Service on Your Schedule of Benefits, that maximum is the combined total number of days, treatments or visits You may receive under Your PPO Certificate of Insurance by Participating Providers (in-network) and by Non-Participating Providers (out-of-network).

All payments by Coventry, under this Rider, are limited to a Lifetime Maximum Benefit as reflected on the Schedule of Benefits. This is the maximum Coventry will pay for Covered Services for each Member in his or her lifetime.

F. Claims

Your Coventry ID card will tell providers to bill Coventry directly. Simply show your Coventry ID card when You obtain care from a Non-Participating Provider. Make sure the provider knows You are using Out-of-Network services and ask him/her to bill Coventry directly. If you have to pay the provider, submit a claim to:

Coventry Health and Life Insurance Company
1340 Concord Terrace
Sunrise, FL 33323

The notice must be received by Coventry within twenty (20) days after the date of the Injury or the first treatment date for the Sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the twenty (20) days period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

When We pay the claim submitted by the provider, You will receive an Explanation of Benefits (EOB) statement that will show the provider's charges, the amount We paid based on the Allowed Amount after applying Annual Deductible and Coinsurance, if applicable, and the balance You must pay, if any.

All the terms, conditions, limitations and exclusions of the Contract/Certificate of Insurance apply to the benefits provided by this Rider.

This Rider will be effective as of the Effective Date of the Contract/Certificate of Insurance to which it is attached.

Coventry Health and Life Insurance Company



**Shirley Smith
Senior Vice President, Legal (Corporate)**

**Coventry Health and Life Insurance Company
Rider to PPO Certificate of Insurance
Alcohol and Substance Abuse Treatment
Broward County Board of County Commissioners**

	In-Network	Out-of-Network
Annual Deductible (per calendar year) Individual/Family <i>(deductible credit is applied towards satisfaction of both in-network and out-of-network deductible)</i>	\$1,100 / \$2,200	\$1,500 / \$3,000
Coinsurance Maximum (per calendar year) Individual/Family	\$1,500 / \$3,000	
Alcohol / Substance Abuse Treatment	Member Responsibility	
Inpatient Detoxification	Refer to Schedule of Benefits	Refer to Schedule of Benefits
Inpatient Rehabilitation Treatment	Refer to Schedule of Benefits	Refer to Schedule of Benefits
Outpatient Treatment	Refer to Schedule of Benefits	Refer to Schedule of Benefits

This Rider is attached to and made a part of the Coventry Health and Life Insurance Company (“Coventry”) PPO Group Policy. The benefits provided by this Rider apply to the extent they are greater than those shown in the PPO Group Policy. This Rider is subject to all the provisions, of the PPO Group Policy, including the Exclusions and Limitations, contained in the Policy to the extent they are not in direct conflict with the following:

A. Definitions

All terms used in this Rider shall have the respective meanings specified in the PPO Group Policy unless the context otherwise requires.

Substance Abuse Impaired: a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.

B. Conditions

1. The benefits and services covered by this Rider are limited to the benefits and services set forth herein which are provided, prescribed, directed, or approved by Coventry, in accordance with the terms and conditions of the Agreement.
2. The Premium for this Rider is set forth in the Binder and Agreement comprising a part of the Agreement. The terms and conditions regarding payment of the Premium for this Rider are as set forth in the Agreement.
3. Nothing contained shall be held to vary, alter, waive, supplement, or extend any of the terms, conditions, provisions, agreements or limitations of the Group Master Contract to which this Rider is attached, other than as specifically stated below, and the provision of the Covered Services contemplated by this Rider shall be governed by the terms and conditions of the Agreement.
4. Coverage under this Rider shall commence and terminate in accordance with the terms of the Agreement.
5. If a Member incurs charges for any Covered Service provided under this Rider, in order to receive reimbursement from Coventry for the amount of the charge, a claim must be submitted to Coventry as soon as reasonably practicable following the date on which the Covered Service occurred, but in no event

later than sixty (60) days after such occurrence.

C. Benefits

1. Subject to the terms and conditions of the Agreement, Covered Services provided under this Rider consist solely of the diagnosis, medical treatment and appropriate alcohol and drug abuse treatment and rehabilitation programs for the abuse or addiction to alcohol and/or drugs for the care and treatment of substance abuse impaired persons.
2. Inpatient detoxification shall be considered a Covered Service to the extent set forth in the PPO Group Policy.

D. Limitations and Exclusions

1. The benefits described in this Rider will only be deemed Covered Services to the extent that treatment is approved by Coventry and provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if such services are provided in a program accredited by the Joint Commission on Accreditation of Health Organizations or approved by the State.
2. Detoxification shall not be considered as a benefit under the outpatient program. Member shall be financially responsible for charges not paid by Coventry hereunder. Such obligations incurred on the part of the Member shall be paid directly to the Provider.

This Rider will be effective as of the Effective Date of the PPO Group Policy to which it is attached.

Coventry Health and Life Insurance Company

A handwritten signature in black ink, appearing to read "Shirley Smith", is centered on the page. The signature is fluid and cursive.

Shirley Smith
Senior Vice President, Legal (Corporate)


**Coventry Health and Life Insurance Company
Rider to Certificate of Insurance
Vision
Broward County Board of County Commissioners**

➤ Eye Examinations	Copayment
Basic examination once per calendar year by a participating optometrist for:	
Eyeglasses .....	..... \$0
Contact Lenses (includes fitting for regular daily wear, extended wear and disposable lenses, 3 months of follow-up care and starter kit)	..... \$69
➤ Prescription Eyeglasses	Copayment
One pair each calendar year from the Standard Collection at a participating provider:	
Frame and Plastic Single Vision Lenses .....	..... \$29
Frame and Plastic Bifocal Lenses (FT 25 - 35 or Executive Lenses).....	..... \$49
Frame and Plastic Trifocal Lenses (FT 25 - 35 or Executive Lenses).....	..... \$59
The following lens options are available:	
Progressive No Line Bifocals and Trifocals .....	..... \$95
Lenticular .....	..... \$95
High Index Plastic.....	..... \$50
Polycarbonate.....	..... \$30
Glass .....	..... \$10
Photo Chromatic.....	..... \$20
Tints.....	..... \$10
UV Coating .....	..... \$12
Scratch Coating .....	..... \$15
Transitions .....	..... \$70
Polarized.....	..... \$45
Anti-Reflective Coating .....	..... \$36
➤ Contact Lenses	Copayment
Daily Wear .....	..... \$35 per pair
Daily Wear Replacement Lenses .....	..... \$20 per lens
Extended Wear.....	..... \$39 per pair
Extended Wear Replacement Lenses .....	..... \$25 per lens
Disposable Lenses (6 packages – 1- week or 2-week wear) .....	...\$19 per package
Frequent Replacement Lenses (6 packages – 1- week or 2-week wear) .....	...\$29 per package
Daily Disposable Lenses (30 packages – 1-day wear)	\$23.50 per package

Items not listed above may be available from the participating provider at other copayments or discounts. Copayments above may not apply to non-standard or special orders.

All the terms, conditions, limitations and exclusions of your Certificate of Insurance apply to the benefits provided by this Rider.

Coventry Health and Life Insurance Company



**Shirley Smith
Senior Vice President, Legal (Corporate)**



Broward County Board of County Commissioners - Open Access CDH with Out-of-Network

	In-Network	Out-Of-Network
Annual Deductible (Individual / Family) Deductible credit is applied towards satisfaction of both in-network and out-of-network deductible.	\$1,100 / \$2,200	\$1,500 / \$3,000
Coinsurance Maximum (Individual / Family)	\$1,500 / \$3,000	
Maximum Lifetime Benefit	\$2,000,000	\$1,000,000
Major Copayment Provisions	Member Responsibility	
Primary Care Physician (PCP) office visits	\$20 copay	30% after annual deductible
Preventive care, including physical exams, eye exams, health education and counseling and immunizations	No copay	30%, NO deductible
Well-child care to age 16 including immunizations	No copay	30%, NO deductible
Annual well-woman care, including pap smears	No copay	30%, NO deductible
Routine mammography (based on established guidelines)	No copay	30%, NO deductible
Specialist office visits	\$35 copay	30% after annual deductible
Hospital admission	20% after annual deductible	30% after annual deductible plus \$500 copay per admission
Emergency room (waived if admitted)	\$150 copay	\$200 copay
Inpatient Hospital / Physician Services	Member Responsibility	
Inpatient hospital facility services (includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, rehabilitation service, surgeon services, anesthesiologist services, specialist consultation, physician visits, maternity care, neonatal intensive care unit)	20% after annual deductible	30% after annual deductible plus \$500 copay per admission
Human organ transplants	\$5,000 copay per inpatient stay, NO deductible	30% after annual deductible
Outpatient Medical Services	Member Responsibility	
Allergy injections (Benefits are available for injections received in a Physician's office when no other health service is received)	\$20 copay	30% after annual deductible
Diagnostic procedures, tests, chest x-rays, blood tests, urinalysis, EKG's in physician's office	No copay; included in OV copay	30% after annual deductible
Outpatient diagnostic services, lab, radiology and x-ray <ul style="list-style-type: none"> • at a Hospital • at a Freestanding Facility 	\$25 copay No copay	40% after annual deductible 30% after annual deductible
Outpatient diagnostic/Therapeutic Services, CT Scans, PET Scans, MRI and Nuclear Medicine <ul style="list-style-type: none"> • at a Hospital • at a Freestanding Facility 	20% after annual deductible No copay	40% after annual deductible 30% after annual deductible
Outpatient Surgery (including physician and facility services) <ul style="list-style-type: none"> • at a Hospital • at an Ambulatory Surgical Center 	20% after annual deductible \$25 copay	40% after annual deductible 30% after annual deductible
Maternity Prenatal/Postnatal Care <ul style="list-style-type: none"> • in a Physician's office • in a Sub-Specialty office 	One time \$25 copay \$25 copay	30% after annual deductible 30% after annual deductible
Radiation and chemotherapy <ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	20% after annual deductible No copay	40% after annual deductible 30% after annual deductible
Second medical and surgical opinion	\$25 copay	30% after annual deductible
Non-Surgical Spine and Back services Limitation: 1 visit and treatment per day; 24 visits per calendar year	\$25 copay	30% after annual deductible
Mental Health, Alcohol & Substance Abuse Services	Member Responsibility	
Mental health care: <ul style="list-style-type: none"> • Inpatient / Outpatient 	No copay	30% after annual deductible
Alcohol and substance abuse care <ul style="list-style-type: none"> • Inpatient detoxification and rehabilitation • Outpatient rehabilitation treatment 	No copay No copay	30% after annual deductible 30% after annual deductible



EXHIBIT 2
Page 2 of 6

Coventry Health and Life Insurance Company

Large Group Summary of Benefits

Special Kinds of Care	Member Responsibility	
Emergency and urgent care		
<ul style="list-style-type: none"> In hospital emergency room (waived if admitted) 	\$150 copay	\$200 copay
<ul style="list-style-type: none"> In urgent care facility 	\$35 copay	30% after annual deductible
<ul style="list-style-type: none"> In physician's office 	See office visit copay	30% after annual deductible
<ul style="list-style-type: none"> Ambulance service to hospital 	\$150 per transport	\$150 per transport
Home health care Limitation: 60 visits per calendar year	\$25 copay	30% after annual deductible
Hospice care Limitation: 180 days maximum lifetime benefit	20% after annual deductible	30% after annual deductible
Skilled nursing facility care Limitation: 60 days per calendar year	20% after annual deductible	30% after annual deductible
Dialysis treatment	20% after annual deductible	30% after annual deductible
Insulin/Diabetic supplies (includes glucose monitors, test strips, lancets, etc)	\$50 copay per month, Combined copay	30% after annual deductible
Outpatient physical, speech, and occupational therapy Limitation: 60 visits per calendar year combined for all therapies	\$15 copay	30% after annual deductible
Outpatient cardiac therapy	\$25 copay	30% after annual deductible
Outpatient respiratory therapy	\$25 copay	30% after annual deductible
Durable medical equipment; other external orthotics and prosthetics Limitation: \$2,500 per calendar year	No copay	50% after annual deductible
Enteral Formulas up to age 24 Limitation: \$2,500 per calendar year	20% after annual deductible	30% after annual deductible
Hearing Aids	Not covered	Not covered
Family Planning		
<ul style="list-style-type: none"> Voluntary counseling 	\$35 copay	30% after annual deductible
<ul style="list-style-type: none"> Intrauterine Device (IUD) (device, insertion, removal) 	\$35 copay	30% after annual deductible
<ul style="list-style-type: none"> Infertility services 	Not covered	Not covered
Abortions, Medically Necessary		
<ul style="list-style-type: none"> at office visit or freestanding facility 	\$25 copay	30% after annual deductible
<ul style="list-style-type: none"> at outpatient hospital 	20% after annual deductible	40% after annual deductible
Abortions, Elective		
<ul style="list-style-type: none"> at office visit or freestanding facility 	\$35 copay	Not covered
<ul style="list-style-type: none"> at outpatient hospital 	20% after annual deductible	Not covered
Elective Sterilization		
<ul style="list-style-type: none"> at office visit or freestanding facility 	\$25 copay	30% after annual deductible
<ul style="list-style-type: none"> at outpatient hospital 	20% after annual deductible	40% after annual deductible
Value Added Benefits	Participating Providers	
Dental care – at a participating Dental provider		
<ul style="list-style-type: none"> Preventive dental care 	Cleaning, fluoride treatment & bitewing x-rays every 6 months, \$5 per service, maximum \$10 copay per visit	
<ul style="list-style-type: none"> General dental care 	Discounted fee schedule of 25%	
Vision care - at a participating Optometrist		
<ul style="list-style-type: none"> Basic eye exam 	No copay	
<ul style="list-style-type: none"> Eyeglasses (1 pair/year, single vision, bifocal, VISTA Standard Collection) 	\$29/\$49	
<ul style="list-style-type: none"> Basic examination for Contact Lenses 	\$69	
<ul style="list-style-type: none"> Daily Wear Contact Lenses 	\$35 per pair	
<ul style="list-style-type: none"> Replacement Lenses 	\$20 per lens	
<ul style="list-style-type: none"> Extended wear Contact Lenses 	\$39 per pair	
<ul style="list-style-type: none"> Replacement lenses 	\$25 per lens	
<ul style="list-style-type: none"> All other services available from participating provider 	25% discount	

Deductible and copayments do not apply toward the Coinsurance Maximum. Coinsurance amounts only apply toward the Coinsurance Maximum.

Certain Covered Services require Prior Authorization. If you do not obtain authorization for services which require a Prior Authorization, the benefit otherwise payable by VISTA is reduced by 20%. This additional out-of-pocket amount will not be used to satisfy Deductible, Coinsurance or Maximum Coinsurance requirements. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

All Out-of-Network services are subject to the Out-of-Network Deductible and applicable Coinsurance. 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 bill and the Out-of-Network Rate.

This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.

This Plan has exclusions and limitations and terms under which the plan may be continued in force or discontinued.

EXHIBIT B - VISTA PREMIUM RATES 2010
2010 MONTHLY RATES

CDH-High

Plan	PREMIUM
EE	359.10
ES	772.31
EC	660.43
FM	1,128.97
EE -1 Medicare	251.72
EC -1 Medicare	409.06
ES -2 Medicare	503.42
FM -2 Medicare	626.56
ES -1 Medicare	665.44
FM -1 Medicare	878.27

CDH-Low

Plan	PREMIUM
EE	339.42
ES	730.00
EC	624.24
FM	1,067.11
EE -1 Medicare	237.90
EC -1 Medicare	386.63
ES -2 Medicare	475.81
FM -2 Medicare	592.22
ES -1 Medicare	628.96
FM -1 Medicare	830.14

CD-OON

Plan	PREMIUM
EE	448.92
ES	965.49
EC	825.60
FM	1,411.36
EE -1 Medicare	315.11
EC -1 Medicare	579.52
ES -2 Medicare	630.23
FM -2 Medicare	720.19
ES -1 Medicare	677.72
FM -1 Medicare	990.68

Exhibit C- General Provisions/2010 Performance Guarantee			
Category	Guarantee Description	Quarterly Penalty Amount	Annual Max each item
Implementation			
ID Cards – New Hires/Status Changes	99% mailed within 10 business days after final member eligibility is received, system loaded and passes a quality assurance check.	\$2,500	\$ 10,000
ID Cards – Open Enrollment	99% mailed within 10 business days after final member eligibility is received, system loaded and passes a quality assurance check – no later than 1/15/10	\$2,500	\$ 2,500
Medical Eligibility Tape Loading”	Load all medical eligibility tapes to eligibility system within 3 business days of receipt	\$2,500	\$ 2,500
Claim Turnaround Time	90% within 15 calendar days; 98% within 30 calendar days	\$2,500	\$ 10,000
Explanation of Benefits (EOB)	EOB will be generated for all plans within 30 calendar days of receipt of filed claim	\$2,500	\$ 10,000
Financial Accuracy: percent of submitted charges process correctly. Monitored monthly and reported quarterly.	98% Gradients are 97.99%-97.76% 97.75%-97.50% 97.49%-97.25% 97.24%-97.00% Below 97.00%	\$ 500 \$1,000 \$1,500 \$2,000 \$2,500	\$ 10,000
Procedural Accuracy: percent of claims processed without non-financial error. Monitored monthly and reported quarterly.	95% Gradients are 94.99%-94.50% 94.49%-94.00% 93.99%-93.50% 93.49%-93.00% Below 93.00%	\$ 500 \$1,000 \$1,500 \$2,000 \$2,500	\$ 10,000
Average Speed to Answer. Monitored monthly and reported quarterly.	30 seconds or less Gradients are 32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds	\$ 500 \$1,000 \$1,500 \$2,000 \$2,500	\$ 10,000
Abandonment Rate. Monitored monthly and reported quarterly.	5% Gradients are 5.01%-5.50% 5.51%-6.00% 6.01%-6.50% 6.51%-7.00% Greater than 7.00%	\$ 500 \$1,000 \$1,500 \$2,000 \$2,500	\$ 10,000
Member Satisfaction Survey – must be through a third party vendor and will include health, dental and vision*	80% satisfaction score based on % responding: Satisfied, Very Satisfied and Somewhat Satisfied	\$10,000	\$ 10,000
Disease Management Engagement and ROI	Minimum ROI of 2.5:1	\$ 10,000	\$ 10,000
Communication: Account Manager responds to emails and phone calls	Within 24 business hours	\$ 100	\$ 2,500
Issue Resolution: Account Manager responds to issues in a timely manner	Within 24 business hours	\$ 100	\$ 2,500
Total Performance Guarantee at Risk From Quarterly Penalties			\$100,000
Reporting	Vista agrees to add a performance guarantee to provide reports outlined in RLI response with a penalty of \$25,000 to be paid if reporting has not been delivered by 3/31/10, with an additional \$5,000 for each month thereafter until the transition is completed to the Coventry platform. If the transition is not completed to the Coventry platform, Vista may seek to provide same	As described	No Limit –

	<p>information via a different reporting platform. Vista will report the status of transition completion to BCG on 3/31/10 and on the first business day of each successive month thereafter until complete.</p> <p>Thereafter Vista will provide access to Coventry standard online reports within 90 days after conversion and Vista will provide quarterly reports to County in the format as stated in the RLI.</p> <p>Alternative:</p> <p>County may elect in lieu of above performance guarantee and penalty to direct Vista to provide data extract as described on the November 3rd, 2009 Letter of Agreement. Final direction must be given to Vista in writing no later than November 19th, in order to proceed.</p> <p>If directed Vista will:</p> <ul style="list-style-type: none"> • Provide de-identified data to consultant and or their contracted designee within 60 days after initial implementation meeting with designated contractor. • Data extract will be in compliance with HIPAA privacy and security regulations, as amended from time to time, and all other applicable State and Federal law and regulations, until such time as Vista is otherwise notified by BCG to terminate the data exchange; in which case Vista will deliver above reports in hard copy no later than 45 days after the close of the calendar quarter. • Vista will proceed with initial implementation meeting upon written direction from County. (Go live data cannot be determined at this time based on direction not given by County.) • Initial data extract will include claims for calendar year 2008. • Ongoing Data extract will be provided within 15 days after closing of month, after 1st extract has been received by consultant designee. • Consultant or contracted designee must enter into a Business Associate agreement with Vista • The data exchange between Vista and consultant or their designee will include data fields listed in the medical paid claim extract and prescription drug paid claim extract, referenced as Attachment A and B to this agreement on letter dated November 3rd, 2009. Vista's prescription drug data will only include claims paid by Vista. • Neither BCG, consultant or designee shall disseminate data without prior consent and approval from Vista; including but not limited to the use of 	<p>\$1,000 per quarter, if reports are not received within 45 days after the close of the quarter.</p> <p>Alternative Option: If consultant and or their designee meet the conditions specified and Vista does not deliver said reports by 3/31/10 Vista will incur the same penalty as specified above until the reports are delivered; thereafter a \$1,000 penalty per month if schedule is not met</p>	<p>No Limit</p> <p>Alternative Option: No Limit</p>
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	<p>any data/information related to bid solicitations or any other publication. Data to be used for bid solicitation or other uses will be provided by Vista through a separate process and in accordance with the schedule above and/or as soon as practicable as determined by the claim timeframe requested</p> <ul style="list-style-type: none">• BCG will have access to Coventry standard online reports 90 days after conversion .		
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Exhibit D

ACORD™ CERTIFICATE OF LIABILITY INSURANCE		DATE (MM/DD/YYYY) 08/28/09
PRODUCER Arthur J. Gallagher Risk Management Services, Inc. Two Pierce Place Itasca, IL 60143-3141 Zeynep Keyifli (312) 803-7416	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
INSURED Coventry Health Care, Inc 6705 Rockledge Drive Suite 900 Bethesda, MD 20817	INSURERS AFFORDING COVERAGE	NAIC #
	INSURER A: LIBERTY MUT FIRE INS CO	23035
	INSURER B: Liberty Mut Fire Ins Co	23035
	INSURER C: TRAVELERS PROPERTY CAS CO OF AMER	25674
	INSURER D: Travelers Property Casualty Company of	25674
	INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	TB2-641-435761-029	09/01/09	09/01/10	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMP/OP AGG \$2,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	AS2-641-435761-059	09/01/09	09/01/10	COMBINED SINGLE LIMIT (Ea accident) \$2,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				
B	EXCESS/UMBRELLA LIABILITY <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE RETENTION \$	TH2-641-435761-039	09/01/09	09/01/10	EACH OCCURRENCE \$25,000,000 AGGREGATE \$25,000,000 \$ \$ \$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	TC2J-UB-281K8202-09	09/01/09	09/01/10	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
D	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	TRJ-UB-281K8527-09	09/01/09	09/01/10	E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000
	OTHER				

9/15/09
 Arthur J. Gallagher
 Risk Management Division
 Dawn Meiler, MFA
 Risk Insurance and
 Contracts Manager

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 Coverage for Florida Health Plan Administrators, LLC is effective as of 9-10-07.
 Re: Vista Healthplan, Inc., 1340 Concord Terrace, Sunrise, FL 33323.
 Broward County Board of Commissioners is shown as an additional insured solely with respect to General Liability coverage as evidenced herein as required by written contract.

CERTIFICATE HOLDER Broward County Board of Commissioners Attn: Karen Ruh 115 S. Andrews Avenue Room 514 Fort Lauderdale, FL 33301 USA	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>30</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE <div style="text-align: right;"><i>Thomas J. Gallagher</i></div>
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IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

SEP 23 2009

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

9/22/2009

PRODUCER Phone: 410-964-8900
Hilb, Rogal and Hobbs
10420 Little Patuxent Parkway
Suite 550
Columbia MD 21044

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Vista Healthplan of South Florida, Inc.
1340 Concord Terrace
Sunrise Fl 33323

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: CHC Casualty Risk Retention Gr	11531
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR	INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
		GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$
		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A		OTHER Managed Care E&O	1002009	1/1/2009	1/1/2010	Per Claim \$5,000,000 Aggregate \$20,000,000 Deductible \$0

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 Broward County Board of Commissioners are added as additional insureds where required by written contract or written agreement.

CERTIFICATE HOLDER

Broward County Board of Commissioners
 115 S. Andrews Avenue, Room 514
 Fort Lauderdale FL 33301-0000

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
John H. Wilson

ACORD_{TM} CERTIFICATE OF LIABILITY INSURANCE		DATE (MM/DD/YYYY) 12/12/2008
PRODUCER Phone: 410-964-8900 Hilb, Rogal and Hobbs 10420 Little Patuxent Parkway Suite 550 Columbia MD 21044		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.
INSURED Vista Healthplan, Inc. 1340 Concord Terrace Sunrise Fl 33323		
		INSURERS AFFORDING COVERAGE
		NAIC #
		INSURER A: CHC Casualty Risk Retention Group 1531
		INSURER B:
		INSURER C:
		INSURER D:
		INSURER E:

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L TR. RECD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJ. <input type="checkbox"/> LOC				EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (EA OCCURRENCE) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS COMP/PROP AGG \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (EA accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE \$ RETENTION \$		Digitally signed by Dawn Mehler DN: cn=Dawn Mehler, c=US, o=Broward County, ou=Risk Management, email=dmehler@broward.org		EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below		Date: 2008.12.30 17:05:00 -05'00'		<input type="checkbox"/> WC STATU. <input type="checkbox"/> OTH-TOBY LIMITS <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	OTHER Managed Care E&O	1002009	1/1/2009	1/1/2010	Per Claim \$55,000,000 Aggregate \$20,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 Broward County Board of Commissioners are added as additional insureds where required by written contract or written agreement.

CERTIFICATE HOLDER Broward County Board of Commissioners 115 S. Andrews Avenue, Room 514 Fort Lauderdale FL 33301-0000	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE <div style="text-align: right;"><i>John H. Wilton</i></div>
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