



**Florida  
Health Care  
Plans**



An Independent Licensee of the Blue Cross and Blue Shield Association

# COVER FLORIDA MEMBER HANDBOOK



## FLORIDA HEALTH CARE PLANS

VOLUSIA & FLAGLER COUNTIES

# TABLE OF CONTENTS

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

<b>INTRODUCTION</b>	1
<b>ADMINISTRATIVE PROVISIONS</b>	3
<b>ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATES</b>	3
<b>PRE-EXISTING CONDITIONS EXCLUSION PERIOD</b>	6
<b>TERMINATION OF COVER FLORIDA COVERAGE</b>	7
<b>THIS PLAN AND OTHER PAYMENT ARRANGEMENTS</b>	8
<b>CLAIMS PROVISIONS</b>	11
<b>GRIEVANCE PROCEDURE</b>	14
<b>COVERAGE PROVISIONS</b>	17
COVERAGE ACCESS RULES	17
CHOOSING A PRIMARY CARE PHYSICIAN	17
ADDITIONAL HEALTH CARE PROVIDER INFORMATION	18
PRESCRIPTION DRUG COVERAGE	18
REFERRALS	21
INITIAL CLAIM DETERMINATION NOTICE	22
SPECIALTY CARE	23
EMERGENCY SERVICES AND CARE	23
WITHIN THE SERVICE AREA	23
OUTSIDE THE SERVICE AREA	23
CALENDAR YEAR DEDUCTIBLE	24
COPAYMENTS	24
COINSURANCE PERCENTAGE	24
DISCRETIONARY AUTHORITY	24
CONFORMITY WITH STATE STATUTES	24
<b>PLAN COVERED SERVICES</b>	25
PREVENTIVE SERVICES	25
OFFICE VISITS	25
OFFICE SURGERY	25
BEHAVIORAL HEALTH SERVICES	25

DURABLE MEDICAL EQUIPMENT & PROSTETICS.....25  
DIABETES MONITORING/SUPPLIES .....25  
PRESCRIPTION DRUG BENEFITS .....25  
INPATIENT HOSPITAL .....25  
EMERGENCY CARE/URGENT CARE.....26  
OUTPATIENT SERVICES.....26  
**EXCLUSIONS AND LIMITATIONS .....26**  
**GLOSSARY OF COVERAGE TERMS .....31**

# INTRODUCTION

## *WELCOME!*

Florida Health Care Plans (FHCP), a state certified, federally qualified, health maintenance organization (HMO) Accredited by URAC, is pleased to offer this Cover Florida plan to residents of Volusia and Flagler Counties, and welcomes you to the Cover Florida program.

**THIS IS A LIMITED BENEFIT PROGRAM. The Cover Florida program is intended to expand the availability of health care options for uninsured residents by developing an affordable health care product that emphasizes coverage for basic and preventive health care services. Many services normally offered under a health plan will not be included in this coverage, or will have coverage limitations. It is important that you read through this entire document and refer to your benefit sheets to understand these limitations and restrictions.**

Since 1974, FHCP has satisfied the health care needs of a growing number of local employers, both large and small, and persons covered under Medicare. We are pleased and proud to have been chosen to participate in efforts to provide health care to even more of our community through this Cover Florida Health Care Access Program.

As a member of Florida Health Care Plans, you have certain rights and responsibilities, and you must take an active role in the management of your health care. When you become enrolled in our Plan, FHCP assumes the financial responsibility for medical services described in this handbook. Unlike most insurance programs that simply pay your medical bills, FHCP views your health care as a partnership between FHCP and you by providing preventive health care. In this way, together we can help prevent minor medical concerns from becoming major medical problems.

This handbook provides important information about the coverage provided under this Plan, explaining:

- A. What rules the Covered Person must follow in accessing care;
- B. What services and supplies are covered; and
- C. What services and supplies are not covered.

This handbook provides helpful information about the Cover Florida Plan and how to use your benefits. We urge you to keep this handbook available in a convenient location for easy reference and share this information with others who may be involved in your care.

If you have any questions please call Member Services at 386-615-4022 or 1-877-615-4022. The hearing impaired may call TRS Relay 711.

### **FHCP's Mission Statement**

To provide FHCP members with health care and related services through dedicated enrollees and service partners who manage both the quality and the cost of health care.

### **FHCP's Vision Statement**

To set the standard for managed health care in our community. We intend to be acknowledged as the leader by our members, enrollees, service partners, and Governing Body.

## FHCP's Quality Policy

In our community, we manage both the quality and the cost of health care provided to the members of our health plan. We are committed to understanding the health care needs and meeting the requirements of our members, fellow enrollees, and service partners. We will strive to do our jobs right the first time, every time.

## Member Rights

Unless medically contraindicated, you are assured of the rights that follow:

- A. To reasonable response to your requests and needs for treatment or service within the scope of FHCP's capacity, mission, and applicable laws and regulations;
- B. To be informed about consent to accept or refuse recommended treatment;
- C. To present grievances, without compromise to future health care, if you feel these rights have not been provided;
- D. To be treated with dignity and consideration as an individual with personal value and belief systems, with compassion and respect, with reasonable protection from harm, and with appropriate privacy;
- E. To receive quality health care with respect and dignity regardless of race, age, sex, religious beliefs, source of payment, health status, or need for health services;
- F. To be informed about your diagnoses, testings, treatments, and prognoses. When concern for your health makes it inadvisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual;
- G. To be assured of confidential treatment of disclosures and records, and to be afforded an opportunity to approve or refuse the release of such information, except when release is required by law;
- H. To refuse treatment to the extent permitted by law and be informed of the consequences of your refusal. When refusal of treatment by the Covered Person or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the Covered Person may be terminated upon reasonable notice;
- I. To participate in decisions involving your health care, including ethical issues and cultural and spiritual beliefs, unless concerns for your health contraindicates;
- J. To refuse to participate in experimental research;
- K. To know the name of the Physician coordinating your care, and to request a change in writing of your Primary Care Provider; and
- L. To make decisions concerning such medical care, including the right to accept or refuse medical treatment or surgical treatment and the right to formulate advance directives (i.e. "Living Wills", etc.) in accordance with the Federal Law titled "Patient Self Determination Act" and the Florida Statutes Chapter 765 "Health Care Advance Directives". These rights shall also include the right to appoint another, either by Power of Attorney or by designation of a Health Care Surrogate, to make health care decisions for you and to provide informed consent if you are incapable of doing so.

## Member Responsibilities

Complying with the following list of Member Responsibilities is important to assure you of the highest quality of care at a reasonable cost. The list also indicates the importance of your contribution in the outcome of your care:

- A. To provide accurate and complete information about present complaints, past illnesses, medications, and unexpected changes in your condition;
- B. To understand and follow recommended treatment plan(s);
- C. To keep appointments reliably and promptly or notify Florida Health Care Plans when unable to do so;
- D. To follow safety rules and posted signs;
- E. To be considerate and respectful of all medical personnel and other Members;
- F. To understand that you are responsible for your actions and the possible consequences, if you refuse treatment or do not follow Physician's instructions;
- G. To get all health care through Florida Health Care Plans, except for emergency care;
- H. To know your medicines and take them according to instructions;

- I. To report emergency treatment to Florida Health Care Plans' Business Office as soon as possible;
- J. To present your Florida Health Care Plans' identification card each time you go to pick up a prescription; and
- K. To use emergency room facilities only for medical emergencies and serious accidents.

## ADMINISTRATIVE PROVISIONS

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

- A. Who is eligible for benefits under this Cover Florida Plan, when coverage becomes effective, when coverage terminates;
- B. How this Cover Florida Plan will relate to other situations where payment is made for the services covered under this Cover Florida Plan; and
- C. How the Covered Person can appeal to FHCP on coverage decisions.

## ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATES

### Eligibility and Effective Dates

This Cover Florida plan is limited to residents of this state who live within FHCP's service area, and who meet all of the following requirements:

1. Between 19 and 64 years of age, inclusive, or dependent children of Covered Person,
2. Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare, Medicaid, or Kidcare, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements.
3. Have not been covered by any health insurance program during the past six months unless coverage under a health insurance program was terminated within the previous 6 months due to:
  - a. Loss of a job that provided an employer-sponsored health benefit plan;
  - b. Exhaustion of coverage that was continued under COBRA;
  - c. Reaching the limiting age under the policy;
  - d. Death of, divorce from, a spouse who was provided an employer-sponsored health benefit plan.

### Change of Status

Should any of the following occur, FHCP must immediately be notified:

- A. Change in name, address, telephone number or next of kin from that listed on Enrollment Application.
- B. Change of residence outside the FHCP Service Area.
- C. Enrollment with another comparable health care plan, insurance plan, Medicaid, or other governmental insurance program.

### Enrollment

Eligible Enrollees and eligible dependents who become covered under this Cover Florida Plan will be referred to as "Covered Persons". To become a Covered Person, the enrollee must:

- A. Complete and submit a written request for coverage, using enrollment forms approved by FHCP;
- B. Provide any additional information needed to determine eligibility, if requested by FHCP; and
- C. Agree to pay his or her portion of the required Premium within 30 days of .

### Effective Date

The effective date of a covered person under this Cover Florida Plan, will be the first of the month following approval of a Cover Florida application.

Services or supplies that are payable as benefits under this Cover Florida Plan are covered commencing on the enrollee's effective date. However, services or supplies for a condition that is covered under an extension of Cover Florida health benefits from a previous employer-related health plan, health insurance plan, or other benefit arrangement will not be covered under this Cover Florida Plan until the extension for the condition under the prior plan ends.

### Dependent Enrollment

The term "Covered Dependent" means a child under the age of 19 who is an Eligible Dependent of a Covered Person under this Cover Florida Plan. Each Covered Dependent will be subject to a child premium identified on the appropriate benefit sheet. To enroll an Eligible Dependent the Covered Person must:

- A. Complete and submit a written request for such dependent's coverage, using enrollment forms approved by FHCP;
- B. Enroll the Covered Dependent in the same plan that the Enrollee is enrolled in;
- C. Provide any information needed to determine the dependent's eligibility, if requested by FHCP; and
- D. Agree to pay his or her portion of the appropriate dependent Premium for the dependent's coverage.

### Dependent Effective Date

To add dependents on the Covered Person's effective date, the Covered Person must enroll his or her Eligible Dependents at the same time he or she initially enrolls. To add a newborn, an adopted newborn, or an adopted child as a dependent after the Covered Person's effective date, the Covered Person must enroll the dependent within the time frames specified in the Newborn and Adopted Children provisions.

To add any other dependent including foster children or court ordered coverage for a minor child after the Covered Person's effective date, the Covered Person must enroll the dependent within thirty days after eligibility as a dependent begins or thirty days after the court order is issued.

The effective date of a dependent's coverage under this Cover Florida Plan depends on when the dependent is enrolled:

If the dependent is a newborn or adopted child who first becomes eligible after the Covered Person's effective date, and the Covered Person enrolls the dependent within the time frames specified in the Newborn or the Adopted Children provisions, that dependent's coverage will become effective on the date of birth for a newborn or adopted newborn and date of placement for an adopted child.

If, on the date dependent coverage becomes effective, the dependent is covered for a condition under an extension of benefits from a previous health plan, health insurance plan, or other coverage arrangement, coverage under this Cover Florida Plan for extension related services or supplies for that condition will not begin until the extension under the prior plan ends.

If the dependent is a late enrollee, and has not had coverage for 63 days prior to the effective date, pre-existing exclusion provisions will apply.

### Coverage for Newborn Children

All health coverage applicable for children under this Plan will be provided for the newborn child of the Covered Person from the moment of birth if the Covered Person has dependent coverage. Newborn coverage shall take effect at the moment of birth provided FHCP is notified by the Covered Person to enroll the child.

### Coverage for Adopted Children

All health benefits applicable to children will be payable with respect to a child adopted by the Covered Person if the Covered Person elects dependent coverage for each child. Coverage is provided to a child the Covered Person proposes to adopt who is placed in the Covered Person's residence in compliance with chapter 63, Florida Statutes. A newly born infant adopted by the Covered Person 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 that the child is not ultimately placed in the Covered Person's residence in compliance with chapter 63, Florida Statutes.

The Covered Person's adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if coverage is applied for in advance as specified herein.

### Coverage for Foster Children

Coverage for a foster child or a child otherwise placed in the Covered Person's custody by a court order, prior to the child's 19th birthday, will be provided from the date of placement if on the date of placement the Covered Person elects dependent coverage for that child. This coverage will be subject to the pre-existing condition waiting period of 12 months for any conditions manifested or treated in the six month period prior to the date of the court ordered custody. No coverage will be provided under this provision for the child who is not ultimately placed in the Covered Person's home. For children in the Covered Person's custody, coverage will terminate the date the Covered Person no longer has legal custody.

### Dependent as an Enrollee

A Covered Dependent may become eligible as a Covered Person as long as he or she meets the eligibility requirements. However, the Covered Dependent may no longer be covered as a dependent child if eligible for benefits as a Covered Person. In addition, a person may not be covered under this Cover Florida Plan as a dependent of more than one enrollee.

### Following Access Rules

If Covered Persons do not follow the Access Rules described in this section, the Covered Person risks having services and supplies received not covered by this Plan. In such a circumstance, the Covered Person would be responsible for reimbursing the plan for the reasonable cost of the services rendered.

Covered Persons must remember that services that are provided or received without having been prescribed, directed, or authorized in advance by FHCP's Medical Director or his or her designee, by the Covered Person's Primary Care Physician, or if the service is beyond the scope of practice authorized for that Health Care Provider under state law, except in the case of Emergency Services and Care for an Emergency Medical Condition as defined and allowed in this Plan, are not covered unless such services otherwise have been expressly authorized under the terms of this Plan. Except for Emergency Services and Care for an Emergency Medical Condition, and direct access to GYNs and dermatologists, all services must be received from Participating Providers on referral from FHCP or the Primary Care Physician.

Also, Covered Persons must understand that services that, in FHCP's opinion, are not Medically Necessary will not be covered. The ordering of a service by a Physician, whether Participating or Non-Participating, other than the Covered Person's Primary Care Physician or when expressly authorized by the Primary Care Physician, does not in itself make such service Medically Necessary or a Covered Service.

## PRE-EXISTING CONDITIONS EXCLUSION PERIOD

There is no coverage for Health Care Services to treat a Pre-existing Condition or Conditions arising from a Pre-existing Condition until 12 months has lapsed from the Effective Date of this plan. This limitation also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

### **General Pre-existing Conditions Exclusion Period Limitations:**

All covered persons and dependents will be subject to the Pre-existing Conditions exclusionary period, except newborn or adopted dependents who are properly enrolled. However, credit will be given for the time an eligible Covered Person or dependent was covered under previous Creditable Coverage if there was previous Creditable Coverage with no more than a 63 consecutive day break in coverage prior to the earlier of the Covered Person's:

1. the Effective Date of coverage

If there was a break in coverage of 63 consecutive days or more, no credit will be given for prior Creditable Coverage.

Prior health insurance and/or Cover Florida health plans are required to provide a certification of Creditable Coverage to the Covered Person upon termination of their coverage.

FHCP reserves the right to collect from the Covered Person the cost of any service or supply paid in error for a pre-existing condition.

**A 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 month period immediately preceding the earlier of:

1. the Effective Date of the Covered Person's coverage

A Pre-existing Condition does not include:

1. genetic information in the absence of a diagnosis of the Condition;  
(Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family Covered Person. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes.)
3. routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or
4. conditions arising from domestic violence.

A pre-existing condition exclusion period applies to any covered person which has not been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date.

**Creditable Coverage** is any of the following health care coverage under which an individual may have been previously covered:

1. A Group health plan;
2. Health insurance coverage;
3. Part A and Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid, other than coverage consisting solely of benefits under Section 1928 of the program for distribution of pediatric vaccines);

5. Chapter 55 of Title 10, United States Code (medical and dental care for Covered Persons and certain former Covered Persons of the uniformed services and their dependents);
6. A medical care program of the Indian Health Services or of a tribal organization;
7. A State health benefits risk pool (FCHA);
8. A health plan offered under chapter 89 of Title 5, United States Code;
9. A public health plan; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504 [E]).

## TERMINATION OF COVERAGE

The following sections explain when coverage will end.

### Termination of Enrollee Coverage

Coverage under this Plan will end automatically at 12:01 a.m., local standard time, on the earliest of the date:

- A. The Covered Person has failed to pay Premium due within 30 days of due date.
- B. The Covered Person fails to pay the appropriate cost sharing; a required copayment, deductible or coinsurance payable to FHCP or a Provider in accordance with the terms of this plan. When the cost sharing dollars payable exceed \$300, Covered Person shall be allowed 90 days to pay required cost sharing.
- C. The Covered Person becomes covered under another health benefit plan or eligible for coverage through a public health insurance program, such as Medicare, Medicaid.
- D. The Covered Person's coverage is terminated for cause (See the Termination of Individual Coverage provision below).
- E. The Covered Person no longer lives or works in the Service Area.
- F. The Covered Person otherwise fails to continue to meet each of the eligibility requirements under this Plan.

### Termination of a Dependent's Coverage

A Covered Dependent's coverage under this Plan will end automatically at 12:01 a.m., local standard time, on the earliest of the following dates:

- A. The Covered Person's coverage terminates for any reason.
- B. The Covered dependent otherwise fails to continue to meet each of the dependent eligibility requirements under this Plan.
- C. The Covered dependent becomes covered under another health benefits plan.
- E. The Covered dependent's coverage is terminated for cause (See the Termination of Individual Coverage provision below).
- F. The Covered dependent no longer lives or works in the Service Area.
- G. A court order, including a qualified medical child support order, covering a dependent child is no longer in effect, or a change in marital status that makes a person ineligible under the terms of this Plan.

### Termination of an Individual's Coverage

- A. Unless otherwise prohibited by law, if in FHCP's opinion any of the following events occur, FHCP may terminate a Covered Person's coverage as specified below:
1. The date specified by FHCP 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 Cover Florida 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, FHCP will:
    - a. make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of FHCP'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 FHCP that all coverage will terminate due to: (a) fraud or material misrepresentation in applying for or presenting any claim for benefits under this Cover Florida Plan; or (b) permitting the use of his or her Covered Membership Card by any other person or (c) furnishing of false or incomplete information on the enrollment forms, or other forms completed for FHCP, by or on behalf of the Covered Person 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. FHCP 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 FHCP if the Covered Person leaves FHCP's Service Area with the intention to relocate or establish a new residence.
  4. The date specified by FHCP if a Covered Dependent reaches the limiting age as specified in the Eligibility Section of this Cover Florida Plan or if a court order, including a qualified medical child support order, covering a dependent child is no longer in effect.
- B. Any termination made under these provisions is subject to review in accordance with the Grievance Procedure described herein.

**NOTE: "Time Limit on Certain Defenses", 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.**

### Certificate of Creditable Coverage

Within thirty (30) days of FHCP receiving notification of termination, a Certificate of Coverage will be mailed to the Covered Person's home. This Certificate will indicate the period of time the Covered Person was enrolled in a Cover Florida plan with FHCP and provides evidence of a Covered Person's coverage with FHCP that may be needed when applying for health coverage in the future.

## THIS PLAN AND OTHER PAYMENT ARRANGEMENTS

### Coordination of Benefits

We reserve the right to coordinate the benefits of this Plan with the benefits of any other coverage. This provision explains how that coordination will take place.

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

### **Plans Affected**

If any of the other insurance plans a Covered Person has, covers at least a portion of a health care service or supply which is covered under this Plan, coordination may take place. The plans that will be considered are the following:

- A. Any plan, program, or insurance established pursuant to worker's compensation legislation or other legislation of similar purpose; or an insurance Plan, including an automobile insurance Plan, provided any non-Cover Florida Plan contains a coordination of benefits provision;

Each policy, plan, or other arrangement for benefits or services that the Covered Person has will be considered separately with respect to that portion of any such plan, contract, or other arrangement, which reserves the right to take the benefits or services of other programs into consideration in determining its benefits and that portion which does not. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed as a benefit paid.

### **Subrogation and Right of Recovery**

Sometimes, the situations that cause a Covered Person to need the benefits and supplies provided under this Plan also result in actions by the Covered Person to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that FHCP has already provided to the Covered Person. To protect FHCP from this type of duplicate payment, FHCP reserves the right to get involved in that recovery process. FHCP's right to get involved is called "subrogation".

- A. If FHCP has paid for services or supplies to a Covered Person under this Plan, the Covered Person will, to the extent of such services or supplies rendered, have subrogated FHCP to all causes of action and rights of recovery that the Covered Person may have or has against any persons and/or organizations that are related to the incident that necessitated the rendering of the services or supplies. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.
- B. The Covered Person must promptly execute and deliver instruments and papers related to these subrogation rights as may be requested by FHCP. Further, the Covered Person shall promptly notify FHCP of any settlement negotiations prior to entering into a settlement agreement affecting FHCP's subrogation rights.
- C. In no event should a Covered Person fail to take any action where action is appropriate, or take any action that may prejudice FHCP's subrogation rights. No waiver, release of liability, settlement, or other documents executed by a Covered Person without prior notice to and approval by FHCP, shall be binding upon FHCP.

FHCP retains the right to recover such payments and/or the reasonable value of the benefits provided from any person or organization to the fullest extent permitted by law.

### **Right to Receive and Release Information**

FHCP has the right to receive and release necessary information. By accepting coverage under this Plan, the Covered Person gives permission for FHCP to obtain from or release to any employee of FHCP or other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a claim and to implement such provisions. We may obtain or release this information without consent from or notice to anyone. Any person who claims benefits under this Plan agrees to furnish to FHCP information that may be necessary to implement this provision.

### **Facility of Payment**

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

### **Right of Recovery**

If FHCP makes larger payments than is required under this Plan, then We have the right to recover any excess benefit payment from any person to whom or for whom such payments were made, or their legal representatives.

### **Non-duplication of Government Programs**

The benefits of this Plan shall not duplicate any benefits under governmental programs such as Workers' Compensation Act, to the extent allowed by law. In any event, if this Plan has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to FHCP to the extent of such duplication.

### **Non-duplication of Other Coverage**

The benefits under this Plan do not duplicate any benefits to which Covered Persons are entitled by law, and/or for which they are eligible under any coverage provisions of any other plan, program, or contract.

### **Cooperation of Covered Persons**

Each Covered Person shall cooperate with FHCP and shall execute and submit to FHCP such consents, releases, assignments, and other documents as may be requested by FHCP, in order to administer and exercise its rights under the subrogation provision or to process claims. Failure to do so may result in the reduction of benefit payments under this Plan.

### **Reimbursement for Provider Services**

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

In the event the Covered Person requires Emergency Services and Care from a Non-Participating Provider while inside or outside the Service Area; or, if FHCP refers the Covered Person to a Non-Participating Provider, the Covered Person will be reimbursed for the cost of the services at the Participating Provider level **IF** Emergency Services is a covered benefit.

### **Right to Require Medical Exams**

FHCP has the right to require medical exams be performed on any claimant for whom a claim is pending as often as We may reasonably require. If We require a medical exam, it will be performed at Our expense. We also have the right to request an autopsy in the case of death, if state law so permits.

### **Unusual Circumstances**

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

## Medicare Eligibles

### The Effect of Medicare Coverage

When a Covered Person becomes eligible for Medicare they are no longer eligible for coverage under the Cover Florida Plan,

## Individuals with End Stage Renal Disease

Primary coverage is provided for the covered persons and/or their dependents who are covered under the Cover Florida Plan and who are entitled to Medicare coverage because of ESRD, pursuant to the following terms:

- A. Covered person must inform FHCP that he/she will be undergoing a regular course of renal dialysis or will receive or already have received a kidney transplant, the beginning date of such dialysis, or the date of such transplant, and any other identifying information requested.
- B. An enrolled individual is no longer eligible for Cover Florida coverage when:
  1. The individual becomes entitled to Medicare Part A ESRD benefits; or
  2. The individual would have become entitled to Medicare Part A ESRD benefits if a timely application had been made.

## CLAIMS PROVISIONS

The following provisions apply in the event the Covered Person needs to file a claim. Please be aware that claims may only be filed for Covered Services. Please refer to your Covered Services section of this handbook and your Benefit Sheet for coverage and limitation details.

### For Non-Participating Provider Services Inside the United States

In the event that a Covered Person requires emergency services from a non-participating provider, call the FHCP Medical Member Services Department at 1-877-615-4022, to report the emergency as soon as medically possible. Before leaving the hospital or provider's office, obtain a copy of any dictation or sign a medical release form to give legal permission to release the records to the FHCP Medical Claims Department upon their request. Bring or send all claims, bills, and medical records to the FHCP Medical Claims Department at 1340 Ridgewood Avenue, Holly Hill, Florida or send the information to FHCP Medical Claims Department, P.O. Box 9910, Daytona Beach, Florida 32120-9910.

### For Non-Participating Provider Services Outside the United States

If a Covered Person requires emergency services from a non-participating provider outside the United States or on a cruise ship, it is the Member's responsibility to obtain all medical records before leaving the hospital or provider's office. **THESE RECORDS ARE IMPOSSIBLE TO OBTAIN BY FHCP AND MUST BE OBTAINED BY THE MEMBER.** It is the member's responsibility to have all hospital/provider claims, bills, and medical records translated into English before submitting for payment, and the cost incurred for the translating of these items is the responsibility of the Covered Person and not reimbursable by FHCP. Send all claims, bills, and medical records to FHCP Medical Claims Department, P.O. Box 9910, Daytona Beach, Florida 32120-9910.

### Medical Payment Guidelines for Non-Participating Provider Care

If the Covered Person requires care from a Non-Participating Provider, and such care has been authorized by FHCP, then FHCP's payment for Covered Services will be determined according to the FHCP guidelines in effect at the time the service was rendered. These guidelines apply to Covered Services only and are not in addition to all of the other provisions, limitations, and exclusions contained in this Plan. These guidelines include, but are not limited to, the following:

- A. The payment of expenses for Covered Services received from Non-Participating Providers is limited to payment for services and supplies, which, in the opinion of FHCP, are the most cost-effective setting, procedure, treatment, supply, or service. For example, services are limited to the most cost-effective prosthetic device, orthotic device, or durable medical equipment which, in the opinion of FHCP, will restore to the Covered Person the function lost due to the Condition.
- B. Multiple surgical procedures are more than one surgical procedure performed on the same or different areas of the body during the same operative session. This includes bilateral procedures and all surgical procedures performed on the same date of service. The Allowable Charge for all such procedures, other than the primary procedure, will be 50% of the Allowable Charge for that procedure(s).
- C. Incidental surgical procedures are one or more than one surgical procedure performed through the same incision or operative approach as the primary surgical procedure which, in the opinion of FHCP, are not clearly identified and/or do not add significant time or complexity to the surgical session. FHCP's payment is limited to the Allowable Charge for the primary surgical procedure, and there is no additional allowance for any incidental procedure.
- D. The Allowable Charge for services rendered by a Physician acting in a surgical assistant role is limited to 16% of the Allowable Charge for the surgical procedure; provided no intern, resident, or other staff Physician is available. Surgical assistant services must be rendered by a Physician to be eligible for payment.
- E. Payment for Physician services will be limited to the professional component of such services when provided in an inpatient or outpatient facility **and only if this is a covered benefit.**
- F. The Allowable Charge for allergy testing is based upon the type and number of tests performed by the Physician or other medical health care Provider. The Allowable Charge for allergy immunotherapy is based upon the type and number of doses per vial.
- G. FHCP's payment for many services and/or supplies is included within the Allowable Charges for the primary procedure, and therefore, no additional amount is payable by FHCP or the Covered Person for any services and/or supplies that are covered under this plan. Examples include, but are not limited to:
  - 1. Payment for Physician or Health Care Provider services (e.g., Physician office and Hospital visits) is included in the Allowable Charge for the procedure with which the service is associated. Examples include but are not limited to surgical procedures; electric shock therapy; dialysis; and therapeutic/diagnostic radiology services.
  - 2. When multiple visits are provided by the same Physician on the same date, payment is limited to one visit which was the highest allowance.
  - 3. Payment for debridement, wound repair, splinting, strapping, unna boot, cast application and removal, and other related services is included in the Allowable Charge for fracture care, dislocation treatment, or other surgical services.
  - 4. Payment for a pathology consultant provided during surgery is included in the Allowable Charge for a frozen section examination.
  - 5. FHCP's payment for a service includes all components of the service when the service can be described by a single procedure code, or when the service is an essential part of the associated therapeutic/diagnostic service. For example, an RBC is part of a complete blood count, and a KUB is part of a barium enema.
- H. FHCP's payment is based on the Allowable Charge for the actual service rendered (for example, not based on the Allowable Charge for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the week or time of day the procedure is performed.
- I. Payment for psychological testing is limited to 50% of the Allowable Charge for each hour of testing after the first two hours of testing, not to exceed 8 hours during a 12 month period.
- J. Payment for Hospital critical care, after the first hour of such care, is limited to 16.6% of the critical care Allowable Charge for each additional ½ hour, and further limited to 4 ½ hours of critical care if this is a covered benefit.

### Submission of Claims for Medical Expenses

For services rendered by Participating Providers, no written proof of loss from the Covered Person is needed. Participating providers are responsible for submitting claims for covered expenses directly to FHCP on the Covered Person's behalf. Also, health care providers who have entered into a reimbursement agreement with FHCP have agreed not to bill the Covered Person an amount greater than the difference between allowed charges and the benefit amount paid by FHCP. The Covered Person will need to complete and sign all necessary papers and authorize participating providers to release those medical records which may be necessary to complete the processing of the claim. Benefit payments for covered services received from a participating provider will be forwarded directly to the provider.

For services rendered by Non-Participating Providers, a claim for services must be submitted to FHCP within six months after the date of injury or sickness for which claim is made. If it was not reasonably possible to submit a claim in the time required, FHCP will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the claim must be submitted no later than 1 year from the time specified unless the claimant was legally incapacitated.

### **Time Payment of Claims**

After receiving claims for medical services, FHCP will reimburse all claims or any portion of any claim from a Covered Person or a Covered Person's assignees, for payment under this Cover Florida Plan within 20 days of receipt of an electronic claim from a Provider, or 40 days after receipt of a paper claim by FHCP. If a claim or portion of a claim is contested by FHCP, the Covered Person or the Covered Person's assignees will be notified in writing that the claim is contested, within 40 days after the receipt of the claim by FHCP. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim, along with any additional information required to process the claim if necessary.

If such additional information is necessary in order to process the claim, the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information. If the Member fails to supply the requested information within the 45-day period, the claim shall be denied. A Member may appeal a claim as set forth in the Appeals Section.

FHCP, upon receipt of additional information requested from a Covered Person or the Covered Person's assignees, will pay or deny the contested claim or portion of the contested paper claim within 120 days.

FHCP will pay or deny any paper claim no later than 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, postpaid envelope or, if not so posted, on the date of delivery.

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

Upon written notification by a Covered Person, FHCP will investigate any claim of improper billing by a physician, hospital, or other health care provider. FHCP will determine if the Covered Person was properly billed for only those procedures and services that the Covered Person actually received. If FHCP determines that the Covered Person has been improperly billed, FHCP will notify the Covered Person and the provider of its 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, FHCP will pay to the Covered Person 20 percent of the amount of the reduction, up to \$500.

### **Payment of Claims**

For services rendered by Providers, benefits are payable to the Covered Person. However, with FHCP's written consent, a Covered Person may direct FHCP to pay all or any part of the medical benefits to the medical care provider on whose charge the claim was based. FHCP is under no obligation to honor such assignments from Non-Participating Providers.

In the event that payment to the Covered Person is not possible, and the Covered person to whom benefits would otherwise be payable is a minor or, in the opinion of FHCP, is not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, FHCP may, at its option, make payment to the person or institution appearing to have assumed his or her custody and support. All benefits will be paid when FHCP receives proper written proof of claim.

Any time a payment is due to a Covered Person from FHCP and in the event payment to the Covered Person is not possible, FHCP may make payment to:

- A. Any person or persons related to the Covered Person by blood or marriage who appears entitled to the payment; or
- B. In the case of death of the Covered Person, the executors or administrators of the Member's estate.

FHCP will be discharged from liability to the extent of any such payments made in good faith.

### **Legal Actions and Limitations**

No action at law or in equity may be brought to recover under this Plan until at least 60 days after written proof of claim has been filed with FHCP. If action is taken after the 60 day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

## **GRIEVANCE PROCEDURE**

Florida Health Care Plans, (hereinafter referred to as FHCP) has a grievance and appeal procedure, which complies with applicable State and Federal law ("The Grievance Procedure"). FHCP will try to resolve any problems that may be encountered over the telephone, but sometimes, additional steps are necessary. In these cases, FHCP has a Grievance Procedure available that provides channels for Members, or a provider acting on a Member's behalf, to voice concerns and have them reviewed and addressed at several levels within the organization.

There are situations when Members have questions or concerns about their care or are dissatisfied with their Health Plan services. The vast majority of Member concerns are received and handled verbally. They may be expressed verbally at the time of the incident or a subsequent telephone call. Such inquiries can be handled in a timely manner by the FHCP Member Services Department. The FHCP Member Services Department manages the complaint/grievance resolution process including the maintenance of related records.

### **Informal Complaint Procedure**

FHCP encourages Members to resolve individual concerns on an informal basis. Any Member who has a concern regarding a matter arising under this Plan should first contact FHCP's Member Services Department for verbal resolution. Member Services can be reached by calling (386) 615-4022 or 1-800-352-9824, Ext. 4022. The Member Services Counselor will attempt to resolve the Member's concern within two (2) business days. If the Covered Person is not satisfied, he or she may file a written grievance.

### **Formal Grievance (Appeal) Procedure**

In the event the Member's concern cannot be resolved at the informal level, and the Member is still dissatisfied, he/she will be advised regarding their right to file a formal Grievance in writing. A Member's letter must be submitted within 180 days of the adverse occurrence.

A Member may appeal a Pre-Service Claim (Routine Referral) or Post-Service Claim in writing within 180 days of receiving the Adverse Benefit Determination. The Member's letter, along with any supporting documentation, comments, records, or other pertinent information, is to be addressed and/or submitted to the Member Services Department as follows:

**Florida Health Care Plans  
1340 Ridgewood Avenue  
Holly Hill, Florida 32117  
ATTN: Member Services Department  
Fax Number: (386) 676-7149**

If you need assistance in preparing a written grievance, a Member Services Counselor will work with you and will forward you a copy of the written document when completed for your approval and signature.

#### Verbal Grievance Process

- 1 All verbal complaints must be answered within 2 business days.
- 2 If an enrollee is not satisfied, he or she may file a written grievance

#### Written Grievance Process

- 3 A grievance can be urgent, meaning the plan has 72 hours to respond and must include a medical director's participation in the decision; **if the grievance is non urgent, plan has 60 days to resolve.**
- 4 A plan may hold a hearing made up of plan representatives (plus medical director, if a medical issue/Grievance Committee) within that 60 day timeframe. Plans shall notify enrollee of the decision within 5 days of determination

#### Benefit Determination

FHCP shall provide a Member with written or electronic notification of FHCP's benefit determination upon review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Member. This notice will include the following:

1. **Specific reason(s) for the Adverse Benefit Determination.**
2. Reference to the specific FHCP provisions on which the Adverse Benefit Determination is based.
3. A statement that the Member is entitled to receive, upon request and free of charge reasonable access to, and copies of, any relevant documentation.
4. A statement describing additional appeal procedure available to the Member, Member's properly appointed authorized representative, or a provider acting on the Member's behalf which is the Statewide Subscriber Assistance Panel, in addition to other appeal rights such as Binding Arbitration in accordance with both State (Statute 641.511) and Federal law.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol, or other similar criterion or a statement explaining the rule, guideline, protocol, or other similar criterion shall be provided free of charge to the Member upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Member's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

## Grievance Committee

If the final decision is not acceptable to the Member, Member's properly appointed authorized representative, or a provider acting on the Member's behalf, the Member may appeal in writing to the Subscriber Assistance Program (SAP) or the Florida Department of Financial Services (FDfs) within 365 days of receipt of the final decision letter. The Member also has the right to contact SAP or FDfs at any time to inform them of an unresolved grievance.

The Agency for Health Care Administration's Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire FHCP Grievance process nor if the member has instituted an action pending in the state or federal court.

### **Subscriber Assistance Program**

Agency for Health Care Administration  
2727 Mahan Drive, Mail Stop 27  
Tallahassee, Florida 32308  
Telephone 1-888-419-3456 or 850-921-5458

### **The Florida Department of Financial Services**

Office of Insurance Regulation, Division of Consumer Services  
200 East Gaines Street  
Tallahassee, Florida 32399  
Telephone 1-800-342-2762

## Urgent Grievance

Urgent Grievances are defined as those grievances:

- A. Involving coverage determinations that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. Coverage for the requested service is therefore denied, reduced, or terminated; and
- B. When the standard time frame of the grievance procedure would seriously jeopardize the Covered Person's life, health or ability to regain maximum function; and
- C. Which are not the result of a retrospective review.

Examples of urgent grievances include, but are not limited to:

- A. Member's life or health or the Member's ability to regain maximum function is in jeopardy;
- B. Discontinuation of service.

An urgent grievance may be requested orally or in writing by the Covered Person, or a provider authorized to act on behalf of the Covered Person that is directly involved in the treatment or diagnosis of the Covered Person. Communications involving the urgent grievance may be transmitted by telephone, facsimile, or the most expeditious method available.

The urgent grievance will be evaluated by a health care professional who has not been involved in the initial adverse determination.

In the case of an urgent grievance request, FHCP's Medical Director will review the request, and if the request meets the definition of an urgent grievance, FHCP will expedite review of the grievance under the following time frames:

- A. Within 24 hours after receipt, FHCP will forward a Covered Person's request for an expedited review to a Medical Director.
- B. FHCP will make a decision regarding an urgent grievance no more than 72 hours after receipt of the request of the review.

- C. FHCP will provide written confirmation of our decision concerning an urgent grievance within 2 working days after providing notification of our decision, if the initial notification was not in writing.

If the expedited review does not resolve the difference of opinion between FHCP and the Covered Person, or a provider authorized to act on behalf of the Covered Person, the Covered Person may contact the Statewide Subscriber Assistance Program (SAP) at the address and phone number listed above, or may choose to follow FHCP's formal grievance process.

## COVERAGE PROVISIONS – THIS IS A LIMITED COVERAGE HEALTH PLAN

This section provides important information about the coverage provided under this Plan, explaining:

- A. What rules the Covered Person must follow in accessing care;
- B. What services and supplies are covered; and
- C. What services and supplies are not covered.

### Coverage Access Rules

It is important that Covered Persons become familiar with the rules for accessing health care services through FHCP. The following sections explain the role of FHCP and the Primary Care Physician, how to access primary and specialty care through FHCP, and what to do if Emergency Services and Care is needed.

### Choosing a Primary Care Physician

The first and most important decision each Covered Person must make when joining a health maintenance organization is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of specialists, are obtained. The Covered Person is free to choose any Primary Care Physician listed in FHCP's published list of Primary Care Physicians whose practice is open to additional Covered Persons. This choice should be made when the Covered Person enrolls. If the Covered Person fails to choose a Primary Care Physician when enrolling, FHCP will assign one to the Covered Person and notify the Covered Person of that assignment. Some important rules apply to the Covered Person's Primary Care Physician relationship:

- A. The Primary Care Physician selected by the Covered Person will maintain a Physician-patient relationship with the Covered Person, and will be solely responsible for providing, authorizing, and coordinating all medical services for the Covered Person.
- B. The Covered Person must look to the Primary Care Physician to direct his/her care and should accept procedures and/or treatment recommended by the Primary Care Physician.
- C. Except for Emergency Medical Conditions and direct access to Participating, GYNs and dermatologists, all services must be received from the Covered Person's Primary Care Physician, from Participating Providers on referral from the Primary Care Physician, or through another Health Care Provider designated by FHCP.
- D. FHCP wants the Covered Person and the Primary Care Physician to have a good relationship. To be certain this relationship is conducive to effective health care, both the Covered Person and the Primary Care Physician may request a change in the Primary Care Physician assignment:
  - 1. The Covered Person may request transfer of his or her health care to another Primary Care Physician whose practice is open to enrollment of additional Covered Persons. The Covered Person shall be limited to not more than four (4) transfer requests within a Calendar Year. A Covered Person should contact Member Services and request transfer of care to the newly selected Primary Care Physician. Such transfer shall be effective the day following the request.

2. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with the Covered Person. In such circumstances, the Primary Care Physician may request that the Covered Person be directed to select another Primary Care Physician.
- E. If for any reason the Primary Care Physician or other contracting Health Care Provider fails to or is unable to provide the Covered Person with services they have agreed to provide, FHCP agrees to provide, arrange, or pay for services equivalent to those described in the Covered Services section up to the date for which payment has been made by the Covered Person. If Non-Participating Providers are used, they will be reimbursed at the Allowed Charge amount, as defined in the Reimbursement For Non-Participating Provider Services provision and the Glossary of Coverage Terms.

If the Primary Care Physician selected by the Covered Person terminates his or her agreement with FHCP, FHCP will assist the Covered Person in selecting another Primary Care Physician whose practice is open to new Covered Persons.

### **Additional Health Care Provider Information**

- A. If a Participating Provider terminates his or her contract with FHCP or is terminated by Us for any reason other than for cause, a Covered Person receiving active treatment may continue coverage and care with that Provider (as long as the terminated provider agrees to continue treating the patient at the contracted reimbursement rate) when Medically Necessary and through completion of treatment of a condition for which the Covered Person was receiving care at the time of the termination until:
1. The Covered Person selects another treating provider, or during the next open enrollment period, whichever is longer, but not longer than six (6) months after termination of the provider's contract.
- B. A provider may refuse to continue to provide care to a Covered Person who is abusive, non-compliant, or in arrears in payment for services provided.
- C. When payment is provided for surgical first assisting benefits or services, payment will also be provided for the services of a registered nurse first assistant or enrollees of a physician assistant or nurse first assistant who performs such services that are within the scope of their professional license and only when their services are used as a substitute. If such services are provided by a registered nurse first assistant, FHCP will only pay the reimbursement for such provider and will not also pay for the supervising physician.

### **PRESCRIPTION DRUG COVERAGE**

**Including ancillary supplies** are covered when prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of his or her license, and is received by the Covered Person.

Prescription drugs purchased from a Participating or Non-Participating Pharmacy are subject to the following provisions. Unless otherwise specified, in order to be covered, Prescription Drugs **MUST BE**:

- A. **GENERIC**
- B. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;
- C. dispensed by a Pharmacist;
- D. be Medically Necessary;
- E. not otherwise limited or excluded; and
- F. must be included in the Preferred Drug List approved by FHCP.

### **In an Emergency:**

Always present your FHCP Membership card to allow the doctor or hospital to verify coverage with FHCP. Your coverage with FHCP includes generic prescriptions written during emergency situations.

**Pharmacy Alternatives and Payment Rules:**

The prescription drug fee is set forth in the Schedule of Benefits. The Covered Person's ID Card must be presented to a Participating Pharmacy each time a prescription is filled or refilled. The applicable prescription drug Copayment must be paid by the Covered Person each time a prescription is filled or refilled at a Participating Pharmacy.

When prescription drugs are purchased from a Non-Participating Pharmacy due to an Emergency Medical Condition or at the direction of the Covered Person's Primary Care Physician, the Covered Person is required to pay the full cost of the prescription and then obtain an itemized paid receipt and submit a claim to FHCP. FHCP will reimburse the Covered Person for the Allowable amount for such prescription drugs less the applicable Copayment. If the Covered Person does not have an Emergency Medical Condition or does not have authorization from the Covered Person's Primary Care Physician, prescriptions filled or refilled at a Non-Participating Pharmacy are **not covered**.

The amount which must be paid by the Covered Person for Covered Prescription Drugs and/or ancillary supplies may vary depending on:

1. the participation status of the Pharmacy selected (i.e., Participating pharmacy versus Non-Participating Pharmacy);
2. whether the Prescription Drug is a Preferred Generic Prescription Drug or a Non-Preferred Generic Prescription Drug; and,
3. whether the Prescription Drug is on the Formulary.

Prescription drugs may be Preferred or Non-Preferred Generic Prescription Drugs, each having a separate Copayment amount as outlined on the Schedule of Benefits. Prescription drugs not identified as Generic Prescription drugs on the Formulary are not covered, but may also be available, unless specifically excluded by this Plan. Non-Preferred drugs are subject to the same requirements specified herein for Preferred drugs and subject to the Non-Preferred Prescription Drug Copayment specified in the Schedule of Benefits.

**Mail Order Pharmacy:**

To get order forms and information about filling your prescriptions by mail, call Member Services at 386-615-4022 or 1-800-352-9824. Please note that you must use the FHCP mail order pharmacy to have your prescription covered. Prescription drugs that are ordered from any other mail order pharmacy are not covered. You can use FHCP's mail order pharmacy to fill prescriptions for "*maintenance drugs*" if this is a benefit offered by your plan. These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. If you plan to be away for three months or less, you may be able to order your prescription drugs ahead of time through FHCP's mail order pharmacy. There is no out-of-service-area benefit for prescription drugs. Drugs you get from non-plan pharmacies while out of our service area will not be covered, regardless of the circumstances, unless they are part of care for a medical emergency or urgently needed care.

**Covered prescription drugs:**

- A. Include any drug, medicine, medication, or oral contraceptive that, under Federal or State law, may be dispensed only by prescription from a Physician, or any compounded prescription containing such drug, medicine, or medication;
- B. Includes covered syringes and needles dispensed only by prescription from a Physician;
- C. Must be prescribed by a Physician or Health Care Provider for the treatment of a Condition;
- D. Must be dispensed by a Pharmacist;
- E. Are limited to the lesser of a 31 day supply or unit of use (mail order provides up to a 93-day supply);
- F. Must be a generic medication;

- G. Include prescription refills, but refills will not be covered until at least 75% of the previous prescription has been used by the Covered Person, (based on the dosage schedule prescribed by the Physician); and
- H. They are included in the Preferred Drug List approved by FHCP.

**Diabetic Supplies:**

The following Diabetic supplies are covered with a prescription in generic only: Test Strips, Lancets, Glucometer. The appropriate copay applies for each item (available at FHCP Pharmacies only).

**Injectables** – only as Incidental to a Health Care Provider’s professional service

“Incidental to a Health Care Provider’s professional service” means that the injectables are furnished as an effective integral, although incidental, part of the Health Care Provider’s personal professional services in the course of diagnosis or treatment of a specific injury or illness. In addition, the injection must be given by the Physician or under the Physician’s supervision if it is the indicated effective method of administration. This does not mean, however, that to be considered “incidental to”, each injection must always be at the occasion of the actual rendition of a personal professional service of the Health Care Provider. Such injections could be considered to be “incidental to” when furnished during a course of treatment where the Health Care Provider performs the initial service and subsequent services of a frequency which reflect his active participation in and the management of the course of treatment. Infusions of cancer chemotherapy drugs are considered to be procedures and not injections.

When a Health Care Provider gives the Covered Person a subcutaneous, intramuscular, intravenous, or intraarterial injection, no additional payment will be made for the administration of the injection. Payment is made separately for the drug or biological injected, but the cost of the other supplies and the administration of the drug or biological is included in the payment for the visit or other services rendered.

**No coverage is provided for:**

- A. Any drug, medicine, or medication that is consumed at the place where the prescription is given or that is dispensed by a Health Care Provider;
- B. Any portion of a prescription or refill that exceeds a 31-day supply or unit of use, whichever is less (mail order provides up to a 93-day supply);
- C. Prescription refills in excess of the number specified by the Health Care Provider or dispensed more than 6 months from the date of the Health Care Provider original order;
- D. The administration of covered medication unless otherwise covered herein;
- E. Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he or she is a patient in a Hospital, Skilled Nursing Facility, convalescent Hospital, inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis;
- F. Prescriptions that are paid or received without charge under local, state, or federal programs, including Worker’s Compensation;
- G. Prescriptions ordered or received in excess of any maximums covered under this benefit and not covered under any other provision in this Plan;
- H. Any drug, medicine, or medication labeled “Caution-Limited by Federal Law to Investigational Use.” Any experimental drug or drug used for non-FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the Covered Person; or Prescription Drugs which have not been approved by the FDA, as required by federal law, for distribution and delivery into interstate commerce;
- I. Immunizing agents, biological serums, or allergy serums;
- J. Any drug or medicine that is lawfully obtainable without a prescription;
- K. Prescriptions filled at a Non-Participating Pharmacy, except for prescriptions required during Emergency Care;
- L. Nutritional supplements given as a medicine between meals to boost protein-caloric intake or the mainstay of a daily nutritional plan;

- M. Therapeutic devices or appliances, including hypodermic needles/syringes, support garments, and other non-medical substances, regardless of intended use;
- N. Any appetite suppressant and/or other Prescription or Non-prescription Drug indicated, or used, for purposes of weight reduction or control;
- O. Nicotine suppressants and smoking cessation products;
- P. Any drug used for cosmetic purposes or the alteration of one's appearance including but not limited to Minoxidil, Rogaine, Renova, and Bleaching Agents;
- Q. Drugs listed in the Homeopathic Pharmacopoeia;
- R. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;
- S. Any costs related to the mailing, sending, or delivery of prescription drugs.
- T. Infertility Agents;
- U. Transdermal Scopolamine patches;
- V. Erectile Dysfunction Agents;
- W. Abortifacients
- X. Injectables, unless incidental to an office visit as described above.

## Referrals

### A. Routine Referral

Initial Claim – A Pre-Service Claim shall be deemed to be filed on the date received by FHCP. We shall notify the Member of Our benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 14 days after We receive the Pre-Service Claim. FHCP may extend this period one time for up to 14 days, provided that FHCP determines that such an extension is necessary due to matters beyond control and notifies the Member, before the expiration of the initial 14-day period, of the circumstances requiring the extension of time and the date by which the Health Plan expects to render a decision.

If such an extension is necessary because the Provider failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Provider shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

### B. Urgent Referral

**Initial Claim. An Urgent Care Claim shall be deemed to be filed on the date received by FHCP. We shall notify the Member of Our benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after We receive, either orally or in writing, the Urgent Care Claim, unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Health Plan. This type of claim will be processed at the time of the office visit.**

FHCP may notify the Member of its benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification shall be provided to the Member no later than 3 days after the oral notification. A Member or a provider acting on behalf of the Member, who is not satisfied with the benefit determination, may appeal an Urgent Care Claim to:

**Subscriber Assistance Program**  
Agency for Health Care Administration  
2727 Mahan Drive, Mail Stop 27  
Tallahassee, Florida 32308  
Telephone 1-888-419-3456 or 850-921-5458

### **C. Concurrent Care Claims**

Any reduction or termination by the Health Plan of Concurrent Care (other than by plan amendment or termination) before the end of an approved period of time or number of treatments shall constitute an Adverse Benefit Determination. FHCP shall notify the Member of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that relates to an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and FHCP shall notify the Member of the benefit determination, whether adverse or not, within 24 hours after the Health Plan receives the Claim, provided that any such Claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with this Grievance Procedure.

### **Initial Claim Determination Notice**

FHCP shall provide a Member with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Member, the following:

- 1. The specific reason(s) for the Adverse Benefit Determination.**
2. Reference to the specific Health Plan provisions on which the determination is based.
3. A description of any additional material or information necessary for the Member to perfect the claim and an explanation of why such material or information is necessary.
4. A description of FHCP's review procedures and the time limits applicable to such procedures, including, when applicable a statement of the Member's right to bring a civil action under section 502(a) of the Enrollee Retirement Income Security Act of 1974, as amended (ERISA), following an Adverse Benefit Determination on final review.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Member upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Member's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.
7. In the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim.

### Specialty Care

The Primary Care Physician selected by the Covered Person will, with FHCP's authorization, refer the Covered Person to Participating specialists or facilities when Medically Necessary, using a referral form authorized by FHCP. The referral form will identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the Covered Person's Condition.

Once the approved referral form has been obtained, the Covered Person may make an appointment with the specialist at his/her convenience provided it is within sixty (60) days from the date of issue of the referral.

When additional services or visits are suggested by the specialist, Covered Persons should first consult with their Primary Care Physician to obtain additional authorization/referrals.

The Covered Person's Primary Care Physician will consult with FHCP and the specialist and coordinate the Covered Person's care. This procedure provides the Covered Person with continuity of treatment by the Physician who is most familiar with the Covered Person's medical history and who understands the Covered Person's total health profile.

If a specialist, beyond those Participating with FHCP, is required, the Primary Care Physician will authorize such treatment only if authorized by FHCP. An agreed upon treatment plan will then be implemented.

### Emergency Services and Care – please see Covered Services section of this handbook to determine benefit limits.

The procedure the Covered Person should follow for Emergency Services and Care for an Emergency Medical Condition as defined in this Cover Florida Plan, depends on whether the treatment is rendered inside or outside the Service Area. In either instance, if the use of a Participating or Non-Participating Hospital Emergency Room is not due to an Emergency Medical Condition for a Condition covered by this Plan, the only payment made will be for the determination of whether an Emergency Medical Condition existed. If an Emergency Medical Condition did not exist, no further benefits will be paid. **Emergency services are NOT covered on all Cover Florida plans.**

#### Within The Service Area

If Emergency Services and Care are required within the Service Area, the Covered Person must notify FHCP and his/her Primary Care Physician. The Covered Person should, in the instance of an Emergency Medical Condition, seek Emergency Services and Care and then contact FHCP and his/her Primary Care Physician, not later than 48 hours after services are received, if the Covered Person is lucid and able to communicate. If not, the Covered Person or a member of the Covered Person's family should notify the FHCP Primary Care Physician as soon as reasonably possible.

#### Outside The Service Area

Emergency Services and Care for an Emergency Medical Condition provided outside the Service Area will be covered if the Covered Person sustains an accidental injury or becomes ill while temporarily away from the Service Area.

If the Covered Person requires treatment for an Emergency Medical Condition while outside the Service Area, Emergency Services and Care may be sought. Only initial treatment is covered without FHCP's and the Primary Care Physician's approval. The Covered Person should notify FHCP and the Primary Care Physician as soon thereafter as is practical, so that the Primary Care Physician and FHCP may initiate necessary follow-up care.

If the Covered Person is admitted to a Hospital for an Emergency Medical Condition, by a Physician other than the Covered Person's Primary Care Physician, the Covered Person or a member of the Covered Person's family should notify FHCP and the Primary Care Physician at the earliest time reasonably possible to allow the Primary Care Physician to coordinate any necessary follow-up care.

### Calendar Year Deductible

This deductible is a flat dollar amount as specified for Single Covered Person in the Schedule of Benefits, and must be satisfied each Calendar Year.

Once the Deductible amount specified in the Schedule of Benefits is reached, the Calendar Year Deductible will be considered satisfied. Expenses that are not considered Covered Services will not be counted towards the satisfaction of the Calendar Year Deductible. Ineligible expenses, including out-of-pocket expenses related to charges for services not covered by this Cover Florida Plan, Prescription Copayments or Coinsurance, any charges in excess of the Allowable charge, or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will **not** count toward satisfying the Calendar Year Deductible Requirement.

### Copayments

For some services, the Covered Person is responsible for paying a portion of the cost of Covered Services. Usually, this portion is a flat dollar amount referred to as a Copayment. Copayments are due at the time of service. The Copayment requirements for this Plan are set forth in the Schedule of Benefits.

### Coinsurance Percentage

The Covered Person may be responsible for paying a percentage of Covered Services in addition to the deductible in any Calendar Year. This percentage that the Covered Person is responsible for is called the Coinsurance Percentage. The Coinsurance Percentage for this Cover Florida Plan, if applicable, is shown in the Schedule of Benefits.

When charges are incurred for covered services or supplies provided by Participating Providers, this Cover Florida Plan calculates all coinsurance amounts by applying the Coinsurance Percentage to the Allowable Charge.

### Discretionary Authority

FHCP has the discretionary authority to determine eligibility, to construe terms of this Plan, and to make decisions concerning claims for benefits under the terms of this Plan.

### Conformity with State Statutes

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

## PLAN COVERED SERVICES

This section describes the services that are covered under this Plan and those that are not covered. It is important that this whole section be reviewed to be sure both Covered Service details and the limitations and exclusions are understood. Please also refer to the Schedule of Benefits for important information regarding covered services, limitations, and exclusions. **ALL OF THESE PROVISIONS SHOULD BE READ CAREFULLY TO UNDERSTAND THE BENEFITS PROVIDED UNDER THIS PLAN.**

**THESE PLANS CONTAIN EXCLUSION LIMITATIONS AND COST SHARING. PLEASE REFER TO BENEFIT SCHEDULES FOR DETAILED INFORMATION.**

**“COVERED” MEANS COVERED IN ACCORDANCE WITH BENEFIT LIMITATIONS EXPRESSED ON DETAILED BENEFIT SCHEDULES ATTACHED HERETO. (Preventive Plans – Attachment 1, Catastrophic Plans – Attachment 2)**

	Preventive Plans	Catastrophic Plans
<p><b><u>Preventive Health Services</u></b>                      Immunizations                      Annual Health Assessment                      Well-Woman Services                      Well-Care Services                      Preventive Screenings (Mammograms, cervical cancer, colorectal, prostate, and bone density)</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Office Visits</u></b>                      For the diagnosis and treatment of illness or injury</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Office Surgery</u></b>                      In a provider office location, including ancillary services, anesthesia and supplies incident to office surgery provided during surgical session.</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Behavioral Health Services</u></b>                      Individual Therapy, Group Therapy, Medication Management</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Durable Medical Equipment &amp; Prosthetics</u></b>                      Includes therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Diabetes Monitoring/Supplies</u></b>                      Diabetes outpatient self-management education, Test Strips/Sensors, Lancets, Glucometer</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Prescription Drug Benefits</u></b> – Please refer to Prescription Drug Benefits in Coverage Provisions Section on Page 18                      Generic only                      Florida Health Care Plans pharmacy                      Mail Order Pharmacy</p>	<b>Covered</b>	<b>Covered</b>
<p><b><u>Inpatient Hospital</u></b>                      12 Day limit per calendar year.</p>	<b>NA</b>	<b>Covered</b>

	<b>Preventive Plans</b>	<b>Catastrophic Plans</b>
<b><u>Hospital Emergency Care Services</u></b>	<b>NA</b>	<b>Covered</b>
<b><u>Urgent Care Services</u></b>	<b>NA</b>	<b>Covered</b>
<b><u>Outpatient Services</u></b> Facility Services Surgery in Ambulatory Surgical Center, Outpatient Medical Facility, Or Hospital Diagnostic Services	<b><u>Only</u> Diagnostic Services Covered when services rendered in a provider office</b>	<b>Covered</b>
<b>EXCLUSIONS AND LIMITATIONS PROVISIONS</b>		
In addition to Access Rule Conditions and the Pre-existing Condition limitations noted above, the following services and/or supplies are excluded from coverage, and are not Covered Services under this Plan:		
<b>Abortion</b> , including any service or supply related to an elective abortion.	Not Covered	Not Covered
<b>Acupuncture</b>	Not Covered	Not Covered
<b>Alcohol and Substance Abuse Treatment</b>	Not Covered	Not Covered
<b>Ambulance services.</b>	Not Covered	Not Covered
<b>Arch supports</b> , orthotic inserts, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use	Not Covered	Not Covered
<b>Autopsy or postmortem examination services</b> , unless specifically requested by FHCP.	Not Covered	Not Covered
<b>Biofeedback</b> services and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, and pain control.	Not Covered	Not Covered
<b>Blood</b> , (if replaced) including whole blood, blood plasma, blood components, and blood derivatives	Not Covered	Not Covered
<b>Chiropractic Services</b>	Not Covered	Not Covered
<b>Circumcisions</b> , when elective or for religious purposes	Not Covered	Not Covered
<b>Complications of Non-Covered Services</b> , including the diagnosis or treatment of any Condition which arises as a complication of a non-covered services (e.g. services or supplies to treat complication of a pre-existing condition or cosmetic surgery) are not covered under this Plan.	Not Covered	Not Covered
<b>Contraceptive appliances</b> , except as specifically provided for in the Preventive Medical and Reproductive Care Services Benefit or Prescription Drug Benefit.	Not Covered	Not Covered
<b>Cosmetic surgery (plastic and reconstructive surgery)</b> and other services and supplies to improve the Covered Person's	Not Covered	Not Covered

	<b>Preventive Plans</b>	<b>Catastrophic Plans</b>
appearance or self-perception, including without limitation: procedures or supplies to correct baldness or the appearance of skin (wrinkling). The restoration of bodily function, or the correction of a deformity resulting from disease, injury, or congenital or developmental abnormalities, is covered.		
<b>Costs incurred by the Covered Person related to the following:</b>		
A. 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.	Not Covered	Not Covered
B. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.		
<b>Custodial care</b> , including any service or supply of a custodial nature primarily intended to assist the Covered Person in the activities of daily living. This includes rest homes, home health aides (sitters), home parents, domestic maid services, and respite care.	Not Covered	Not Covered
<b>Dental care</b> ; routine dental procedures including, but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment including palatal expansion devices, bruxism appliances, dental x-rays, and routine intra-oral surgical procedures are not covered.  Likewise, 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 jaw disorders (CMJ) are excluded.	Not Covered	Not Covered
<b>Dietary</b> regimens or treatments for reducing or controlling weight.	Not Covered	Not Covered
<b>Erectile Dysfunction</b> , any service, supply, or drug for erectile dysfunction regardless of the etiology.	Not Covered	Not Covered
<b>Experimental and Investigational treatment</b>	Not Covered	Not Covered
<b>Eye care, including:</b>		
A. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the Covered Services section.	Not Covered	Not Covered
B. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.		
C. Training or orthoptics, including eye exercises unless otherwise covered by a rider or endorsement attached to this coverage document.		
<b>Family planning services</b> , other than those services specifically described in the Covered Services section.	Not Covered	Not Covered
<b>Foot care (routine)</b> , including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses.	Not Covered	Not Covered
<b>Hearing aids</b> (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.	Not Covered	Not Covered
<b>Hearing Exam</b> , Services of a licensed audiologist to determine and measure the hearing function loss.	Not Covered	Not Covered
<b>Home health care services</b>	Not Covered	Not Covered

	<b>Preventive Plans</b>	<b>Catastrophic Plans</b>
<b>Home infusion therapy</b>	Not Covered	Not Covered
<b>Hospice Services</b>	Not Covered	Not Covered
<b>Hypnotism</b> or hypnotic anesthesia.	Not Covered	Not Covered
<b>Imaging Services</b> , including CT Scans, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), and Nuclear Studies.	Not Covered	Not Covered
<b>Immunizations and physical examinations</b> , when required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.	Not Covered	Not Covered
<b>Infertility treatment, services and supplies</b> , including infertility testing, treatment of infertility, diagnostic procedures, and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.	Not Covered	Not Covered
<b>Injectables</b> , injectable medication	Not Covered	Not Covered
<b>Massage Therapy</b>	Not Covered	Not Covered
<b>Maternity Coverage</b>	Not Covered	Not Covered
<b>Maternity services</b>	Not Covered	Not Covered
<b>Mental health services and supplies</b> which are (a) rendered in connection with a Condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, (c) for marriage and juvenile counseling, (d) court ordered care or testing or required as a condition of parole or probation; (e) testing for aptitude, ability, intelligence, or interest, or (f) cognitive remediation.	Not Covered	Not Covered
<b>Military service-connected medical care</b> for which the Covered Person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the Covered Person.	Not Covered	Not Covered
<b>Non-network provider services</b> , unless authorized in advance by FHCP	Not Covered	Not Covered
<b>Non-prescription drugs</b> , including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.	Not Covered	Not Covered
<b>Obesity treatment</b> , including surgical operations and medical procedures for the treatment of morbid obesity.	Not Covered	Not Covered
<b>Obstetrical and Maternity Care</b>	Not Covered	Not Covered
<b>Occupational injury</b> , expenses in connection with any condition for which a Covered Person has received, whether by settlement or by adjudication, any benefit under Worker's Compensation or Occupational Disease Law or similar law. If the Covered Person enters into a settlement giving up rights to recover past or future medical benefits, FHCP will not cover past or future medical services that are subject of or related to that settlement. In addition, if a Covered Person is paid by a Worker's Compensation program that limits Benefits if other than specified Health Care Providers are used and the Covered person receives care or services from a Health Care Provider not specified by the program, FHCP will not cover the balance of any costs	Not Covered	Not Covered

	<b>Preventive Plans</b>	<b>Catastrophic Plans</b>
remaining after the program has paid.		
<b>Orthomolecular therapy</b> , including nutrients, vitamins, and food supplements.	Not Covered	Not Covered
<b>Over the counter items</b> , supplies that can be obtained without a prescription, including but not limited to ace bandages, elastic stockings, gauze, and dressings.	Not Covered	Not Covered
<b>Personal comfort</b> , hygiene or convenience items, including services and supplies deemed to be not Medically Necessary by FHCP and not directly related to the care of the Covered Person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses, motel/hotel accommodations, air conditioning, humidifiers, or physical fitness equipment.	Not Covered	Not Covered
<b>Podiatry Services</b>	Not Covered	Not Covered
<b>Private duty nursing care.</b>	Not Covered	Not Covered
<b>Rehabilitative Services</b>	Not Covered	Not Covered
<b>Rehabilitative therapy services</b> , including cardiac, speech, occupational, and physical therapy.	Not Covered	Not Covered
<b>Reversal of voluntary</b> , surgically-induced sterility, including the reversal of tubal ligations and vasectomies.	Not Covered	Not Covered
<p><b>Services or supplies that are:</b></p> <p>A. Determined to be not Medically Necessary;</p> <p>B. Not specifically listed in Covered Services section unless such services are specifically required to be covered by state or federal law this Plan will provide coverage on a primary or secondary basis as required by state or federal law.</p> <p>C. Court ordered care or treatment, unless otherwise covered in this Plan.</p> <p>D. For the treatment of a Condition resulting from:</p> <ol style="list-style-type: none"> <li>1. War or an act of war, whether declared or not;</li> <li>2. Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;</li> <li>3. Engaging in an illegal occupation;</li> <li>4. Services in the armed forces;</li> <li>5. Intentionally self-inflicted injuries, suicide, or attempted suicide, without regard to the mental state of the Covered Person; or</li> <li>6. Being under the influence of alcohol or any narcotic unless taken on the specific advice of a Physician.</li> </ol> <p>E. Received prior to a Covered Person's effective date or received on or after the date a Covered Person's coverage terminates under this Plan.</p> <p>F. Provided by a Physician or other Health Care Provider related to the Covered Person by blood or marriage.</p> <p>G. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or Cover Florida .</p> <p>H. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change.</p> <p>I. Supplied at no charge when health coverage is not present, and if applicable, any charges associated with the Copayment requirements which are waived by a Health Care Provider.</p>	Not Covered	Not Covered

	<b>Preventive Plans</b>	<b>Catastrophic Plans</b>
<b>Sexual reassignment or modification services</b> , including any service or supply related to such treatment, including psychiatric services.	Not Covered	Not Covered
<b>Shoe inserts (orthotics)</b> , including heel inserts are not covered.	Not Covered	Not Covered
<b>Skilled nursing facility services</b>	Not Covered	Not Covered
<b>Smoking cessation programs</b> , 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 nicotine products (e.g., gum, transdermal patches, etc.).	Not Covered	Not Covered
<b>Speech Exams</b>	Not Covered	Not Covered
<b>Spine and Back Disorder Treatment</b> , (Chiropractic)	Not Covered	Not Covered
<b>Training and educational programs</b> , including programs primarily for pain management or vocational rehabilitation.	Not Covered	Not Covered
<b>Transportation</b> service that is non-emergency transportation between institutional care facilities, or to and from the Covered Person's residence.	Not Covered	Not Covered
<b>Vision Exams &amp; Services</b> , including eyeglasses, contact lenses, surgical procedures	Not Covered	Not Covered
<b>Voluntary sterilization</b> , including tubal ligations and vasectomies.	Not Covered	Not Covered
<b>Volunteer services</b> or services which would normally be provided free of charge.	Not Covered	Not Covered
<b>Weight control Services</b> , including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise program; equipment; whether or not it is part of a treatment plan for a Covered Condition.	Not Covered	Not Covered
<b>Wigs or cranial prosthesis</b> , except when related to restoration after cancer or brain tumor treatment.	Not Covered	Not Covered

## GLOSSARY OF COVERAGE TERMS

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

**ACCIDENTAL DENTAL INJURY** is an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional and unexpected event or force. It does not include injuries to natural teeth caused by biting or chewing.

**ADVERSE BENEFIT DETERMINATION** means any denial, reduction, or termination of coverage, benefits, or payment (in whole or in part) under this Policy with respect to a Referral or a Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision shall also constitute an Adverse Benefit Determination.

**AGENCY** means the Agency for Health Care Administration.

**ALLOWANCE OR ALLOWABLE CHARGE** means the lesser of the actual billed charges or the FHCP Fee Schedule in effect at the time of service, for Area 2, Volusia County, Florida. Any amount in excess of allowable charges is the Member's responsibility and will not be applied to the Member's annual deductible or out-of-pocket maximum. Payments to all providers are computed less any applicable copayments, deductibles, or coinsurance for which the member is liable.

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

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

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

**CLAIM** means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to the Member (not just proposed or recommended) that is received by FHCP in a format acceptable to FHCP.

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

**CONCURRENT CARE DECISION** means a decision by FHCP to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if FHCP had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

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

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

- A. Due to a Covered Condition; and
- B. Authorized by a licensed medical health care provider with admission privileges.

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

**COPAYMENT** means those amounts payable by the Covered Person at the time of service 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 Plan. The Copayment is normally expressed as a dollar amount.

**COST SHARE** means the amount of the Covered Person’s financial responsibility as specifically set forth in the Schedule of Benefits and any rider or endorsement attached to this Cover Florida Plan. Cost Share includes any applicable combination of Deductibles, Coinsurance, or Copayments.

**COVER FLORIDA PLAN** means a consumer choice benefit plan approved under this section which guarantees payment or coverage for specified benefits provided to an enrollee.

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

**COVERED PERSON** means the Enrollee and any Eligible Dependents covered under this Plan. Eligibility requirements for Covered Person and dependents are specified in the eligibility provisions.

**COVERED PRESCRIPTION DRUG(S)** means a Drug which, under federal or state law, requires a Prescription and which is covered in the Covered Services section of this Plan.

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

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

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

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

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

**EFFECTIVE DATE** with respect to the Covered Person and to Covered Dependents properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the Plan Information Page; and with respect to Covered Persons who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Eligibility and Enrollment Sections of this Plan.

**ELIGIBLE DEPENDENT** means a Covered Person's:

- A. Natural, newborn, adopted, Foster, or step-child(ren) under 19 years of age; or
- B. A child for whom the Covered Person has been court-appointed as legal guardian or legal custodian;

Who meets and continues to meet all of the eligibility requirements described in the Eligibility Section of this Plan. Eligible Dependent also includes a newborn child of a Covered Dependent child if properly enrolled. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

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

**EMERGENCY MEDICAL CONDITION** means:

- A. 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 a patient, including a pregnant woman or a fetus.
  - 2. Serious impairment to bodily functions.
  - 3. Serious dysfunction of any bodily organ or part.
- B. With respect to a pregnant woman:
  - 1. That there is inadequate time to affect 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** means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

**ENROLLEE** means an individual who has been determined to be eligible for and is receiving health insurance coverage under a Cover Florida plan and has complied with the terms and conditions of the Cover Florida Plan.

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

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

- A. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Person;
- B. 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.
- C. 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.
- D. 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 medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

Reliable evidence means (as determined by FHCP):

- A. Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
- B. 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;
- C. The written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
- D. The written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
- E. 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.

**FORMULARY** means a list of prescription drug items recommended for use under this plan that are available for use by Covered Persons (see PREFERRED DRUG LIST).

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

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

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

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

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

**INJURY** means an accidental bodily injury that:

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

**MAIL ORDER PHARMACY** means an FHCP In-house Pharmacy which coordinates mailing of prescription drugs to the covered person for a fee as set forth in the Schedule of Benefits or rider attached to this plan.

**MASTECTOMY** means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

**MEDICALLY NECESSARY** - A medical service or supply that is required for the identification, treatment, or management of a Condition is Medically necessary if, in the opinion of FHCP, it is: (1) consistent with the symptom, diagnosis, and treatment of the Covered Person's Condition; (2) widely accepted by the practitioners' peer Cover Florida as efficacious and reasonably safe based upon scientific evidence; (3) universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; (4) not Experimental or Investigational; (5) not for cosmetic purposes; (6) not primarily for the convenience of the Covered Person, the Covered Person's family, the Physician, or other Provider, and (7) the most appropriate level of service, care, or supply which can safely be provided to the Covered Person. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Covered Person in an alternative setting.

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

**MEMBER** means the Eligible Enrollee and if applicable, the Covered Person's eligible Dependents, covered under this Plan.

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

**NON-PARTICIPATING HOSPITAL** means a Hospital which has not made an agreement with FHCP to provide services to Covered Persons.

**NON-PARTICIPATING PHARMACY** means a Pharmacy that has not made an agreement with FHCP to provide services to Covered Persons.

**NON-PARTICIPATING PHYSICIAN** means a Physician who has not made an agreement with FHCP to provide services to Covered Persons.

**NON-PARTICIPATING PROVIDER** means a Non-Participating Hospital, a Non-Participating Physician, or a Non-Participating Health Care Provider who has not made an agreement with FHCP to provide services to Covered Persons.

**NON-PREFERRED PRESCRIPTION DRUG** refers to any generic drug that is identified on FHCP's Preferred Drug List as a non-preferred prescription drug.

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

- A. Acting within the scope of that person's license; or
- B. Authorized by a Physician; and
- C. Not a member of the Covered Person's immediate family.

**OFFICE** means the Office of Insurance Regulation.

**PARTICIPATING HOSPITAL** means a Hospital which has made an agreement with FHCP to provide service to Covered Persons.

**PARTICIPATING PHARMACY** means a Pharmacy which has made an agreement with FHCP to provide service to Covered Persons; the FHCP Mail Order Pharmacy is also a Participating Pharmacy.

**PARTICIPATING PHYSICIAN** means a Physician who has made an agreement with FHCP to provide service to Covered Persons.

**PARTICIPATING PROVIDER** means a Participating Hospital, a Participating Physician, or a Participating Health Care Provider who has made an agreement with FHCP to provide services to Covered Persons.

**PHARMACIST** means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his or her license.

**PHARMACY** means a licensed establishment where prescription medications are dispensed by a pharmacist.

**PHYSICIAN** is a person properly licensed to practice medicine pursuant to Florida law, or another state's applicable laws, including but not limited to:

- A. Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.);
- B. Doctors of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.);
- C. Doctors of Optometry (O.D.);

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

**PREFERRED DRUG LIST** means a list of prescription drug items recommended for use under this plan that are available for use by Covered Persons (see FORMULARY).

**PREFERRED GENERIC PRESCRIPTION DRUG** refers to a drug which is chemically the same (has the same active ingredients) as the brand-name drug. These drugs are usually referred to by their common chemical names. Generic drugs can be produced and sold after the patent has expired on a brand-name drug. Generic drugs must meet the same FDA standards as their brand-name counterparts and are identified on FHCP's Preferred Drug List as a preferred drug.

**PREMIUM** any payments required by a health contract for coverage, by whatever name called, are deemed part of the premium. This includes but is not limited to any monthly subscription fee, co-payment, deductible, co-insurance, or similar fee or charge.

**PRESCRIPTION** means a direct order for the preparation and use of a medication. This order may be given by a Physician to a Pharmacist for the benefit of and use by a Covered Person. The medication must be obtainable only by prescription. The prescription may be given to the Pharmacist verbally or in writing by the Physician.

**PRIMARY CARE PHYSICIAN** means a Participating Physician who has been chosen by the Covered Person to be responsible for providing, prescribing, directing, and authorizing all care and treatment for the Covered Person.

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

**REFERRAL** means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to the Member.

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

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

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

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

**SUBSCRIBER** means the individual or covered person specified in this Plan who has elected coverage for himself/herself and his/her dependents (if any), who meets the eligibility requirements described in this Plan and is enrolled under this Plan, and for whom the premium required under this Plan has been received by FHCP.

**URGENT CARE** means medical screening, examination, and evaluation received in an Urgent Care Center or rendered in your Primary Care Physician's office after-hours and the Covered Services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

**URGENT GRIEVANCE** means a Grievance regarding an Adverse Determination when the standard time frame of the Grievance procedure would seriously jeopardize the life or health of a Member or would jeopardize the Member's ability to regain maximum function.

**URGENT REFERRAL** means any request or application for coverage or benefits for medical care or treatment that if not provided within 72 hours: (1) could seriously jeopardize the Member's life or health or his or her ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Member's Condition, would subject the Member to severe pain that cannot be adequately managed without the proposed services being rendered.

**WE, US, OUR** means Florida Health Care Plans, Inc.

**YOU, YOURS** means the Covered Person.