



***Florida
Health Care
Plans***



An Independent Licensee of the Blue Cross and Blue Shield Association

STATE OF FLORIDA MEMBER HANDBOOK

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GENERAL CONTRACT PROVISION

ADMINISTRATION

The Employer must provide FHCP with the information it needs to administer this Contract and to compute the subscription fees due. FHCP has the right to examine the Employer's records on any issues necessary for the proper administration of this Contract at any reasonable time while this Contract is in force.

ENTIRE CONTRACT

The entire Contract is made up of this Contract, as already defined herein, the Employer's application, and the applications of all Covered Employees and Covered Dependents. All statements made by the Employer or by a Covered Employee are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No such statement will void this Contract, reduce the benefits it provides, or be used in defense to a claim for coverage unless it is contained in a written application and a copy is furnished to the person making such statement.

CHANGES TO THIS CONTRACT

No change to this Contract will be effective unless made by an amendment or rider that has been signed by a duly authorized officer of FHCP. No agent or Employee may change this Contract or waive any of its provisions except as set forth in this paragraph.

ASSIGNMENT

Neither this Contract, nor the benefits provided under this Contract, may be assigned except as specifically described in this Contract.

MISSTATEMENTS

If information about a Member's age, sex, family composition, geographic location, or tobacco use is misstated, FHCP may adjust the subscription fees to correctly reflect the true information.

COMMENCEMENT OF COVERAGE

On the Effective Date shown on the Contract Information Page of this Contract, FHCP agrees to provide the coverage stipulated in this Contract to all Covered Employees and their Covered Dependents, if any. Such coverage begins on the Member's effective date, with FHCP accepting no liability for benefits related to expenses incurred prior to the Member's effective date or after the Member's termination date, except as described in the Extension of Benefits provision set forth herein.

TERMS OF RENEWAL

This Contract is a conditionally renewable Contract. This means the Contract renews each year on the Contract Anniversary Date shown on the Contract Information Page. FHCP guarantees the Employer the right to renew the Contract each year, at the Employer's option. However, FHCP may refuse to renew this Contract, and all coverage provided under this Contract, if one of the following circumstances has occurred:

- A. Nonpayment of the required subscription fees as of the subscription fees due date by the Employer;
- B. Fraud or misrepresentation by the Employer, with respect to persons covered under this Contract;
- C. Noncompliance with FHCP's minimum Group participation requirements; or
- D. Material and significant change in the risk characteristics of the Employer because the Employer is no longer engaged in the business in which it was engaged when this Contract started. If, based on the occurrence of one or more of the above circumstances, and FHCP decides not to renew this Contract, FHCP will give the Employer at least 30 days advance notice, in writing, of its intent to refuse renewal of this Contract.

GENERAL RESPONSIBILITIES OF THE EMPLOYER

The Employer shall offer to all Employees the opportunity to become a Covered Employee under this Contract. Such offer shall be made in such a fashion that Employees are made aware, and understand, that this Contract contains a benefit structure that requires the use of a Primary Care Physician and Participating Providers.

FINANCIAL RESPONSIBILITIES OF THE EMPLOYER

The Employer may require an Employee to pay some portion of the subscription fees. However, the Employer must contribute the same amount toward the cost of all health benefit plans established and maintained by the Employer.

FHCP reserves the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Recovery efforts will relate to benefit payments made for services or supplies rendered subsequent to the Member's termination date and prior to the date FHCP receives notice of coverage termination from the Employer. The Employer shall cooperate with and support such recovery efforts.

In the event that the Employer does not comply with the notice requirements set forth in the Monthly Subscription Fees Statement section, the Employer shall be solely liable to FHCP for any services or supplies rendered subsequent to the date notice of Member termination was due.

WAITING PERIOD FOR EMPLOYEES

The waiting period is the length of time an Employee must wait before becoming eligible for coverage. The waiting period designated by the Employer is shown on the Contract Information Page.

An Employee becomes eligible for coverage on the date he or she completes any waiting period established by the Employer, subject to any Eligibility Exceptions noted on the Contract Information Page.

RESPONSIBILITIES OF FLORIDA HEALTH CARE PLANS

In consideration of the payment of subscription fees by the Employer, FHCP shall provide health care coverage for Members. In doing so, FHCP may enter into agreements with providers of health care, one or more other health plans or insurers and such other individuals and entities as may be necessary to enable FHCP to fulfill its obligations under this Contract.

Florida Health Care Plans agrees to provide coverage without discrimination because of race, color, sex, religion, national origin or any other basis prohibited by law.

MEMBER HANDBOOK

FHCP will issue a Member Handbook to each Covered Employee. The Handbook will describe the benefits provided under this Contract and the limitations of this Contract. Nothing in the Handbook will change or void the terms of this Contract.

TERMINATION OF THIS CONTRACT BY THE EMPLOYER

The Employer may terminate this Contract as of any subscription fees due date by giving FHCP at least 30 days prior written notice. In such event, no benefits will be provided on or after such termination date, except as specifically set forth in this Contract.

TERMINATION OF THIS CONTRACT BY FHCP

FHCP may terminate this Contract as of any subscription fees due date if the Employer has not paid the required subscription fees by the end of the Grace Period, as defined in the Grace Period provision.

FHCP may also terminate this Contract if it elects to terminate all of the Contracts it has issued to Employers in this state. In that case, FHCP will provide notice, at least 60 days in advance, to the Florida Department of Insurance and to the Employer. If FHCP terminates this Contract, any unused subscription fees will be returned to the Employer.

MEMBER'S RIGHTS AND RESPONSIBILITIES

FHCP is committed to providing Members with health care and related services through dedicated employees and services partners who manage both the quality and the cost of health care. Our vision is to set the standard for health care in our community. We intend to be acknowledged as the leader by our Members, Employees, Service Partners and Governing Body. 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 employees, and Service Partners. We will strive to do our jobs right the first time, every time.

As a Member of FHCP you have certain rights and responsibilities. Your rights are in keeping with FHCP's commitment to provide you with quality care and services at a reasonable cost. Your responsibilities are to assist us in achieving this goal.

Rights

1. To reasonable response to your request and need for treatment or service within FHCP's capacity, and applicable laws and regulations
2. To be informed about consent to or refusal of recommended treatment.
3. To present Grievances without compromise to future health care, if you feel these rights have not been provided.
4. To file an Appeal. Contact FHCP's Member Services Department.
5. 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.
6. To received quality health care with respect and dignity regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
7. To be informed about your diagnoses, treatments, and prognoses. When concerns for your health make it in advisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual.
8. 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.
9. To refuse treatment to the extent permitted by law and be informed of the consequences of your refusal. When refusal of treatment by the member or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the member may be terminated upon reasonable notice.
10. To participate in decisions involving your health care, including ethical issues and cultural and spiritual beliefs, unless concerns for your health contraindicate.
11. To information about FHCP, it's providers and practitioners as well as your member rights and responsibilities
12. To participate in discussions involving medically necessary treatment options regardless of cost and/or benefit coverage.
13. To refuse to participate in experimental research.
14. To know the name of the physician coordinating your health care and to request a change in writing of your primary care physician.
15. 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 Statute 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.
16. To make recommendations regarding the Organizations Member Rights and Responsibilities policy.

Responsibilities

1. To provide accurate and complete information about present complaints, past illnesses, medications, and unexpected changes in your condition.
2. To promptly respond to FHCPs request for information regarding you and/or your dependents in relation to covered services.
3. To understand, ask questions and follow recommended treatment plan(s) to the best of your ability.
4. To understand your health problems and to participate in developing mutually agreed upon goals to the best of your ability.
5. To keep appointments reliably and arrive on time or to notify the provider, ideally 24 hours in advance, if you are unable to keep an appointment.
6. To follow safety rules and posted signs.

7. To demonstrate respect and consideration towards medical personnel and other Members.
8. To understand that you are responsible for your actions and the possible consequences, if you refuse treatment or do not follow the provider's instructions.
9. To receive all of your health care through FHCP with the exception of emergency care.
10. To know your medicines and take them according to the instructions provided.
11. To report emergency treatment to FHCP as soon possible.
12. To present your FHCP membership identification card each time you drop off and pick up a prescription.
13. To use emergency room facilities only for medical emergencies and serious accidents.
14. To be financially responsible for any Copayments, Co-insurance and/or Deductibles and to provide current information concerning your FHCP membership status to the provider.
15. To provide current information concerning your FHCP membership status to your Provider.

ADMINISTRATIVE PROVISIONS

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

1. Who is eligible for benefits under this Health Plan, when coverage becomes effective, when coverage terminates, and what the covered person can do to continue coverage or convert to other coverage;
2. How this Health Plan shall relate to other plans under which covered persons have coverage or other situations where payment is made for the services covered under this Health Plan; and
3. How the covered person can appeal to the Health Plan and the state on benefit decisions.

ELIGIBILITY AND EFFECTIVE DATES

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the state. In addition, the individual must reside in the Health Plan's service area unless, by mutual agreement between the state and the Health Plan, the individual is allowed to enroll in the county where the individual works. The following sections explain eligibility and effective dates of this coverage.

ELIGIBILITY UNDER THE HEALTH PLAN

To be eligible for coverage under this Health Plan, an individual shall be either:

1. An **employee**, which means any state officer or an individual who works for the state on a full-time or part-time basis and who is filling a salaried position, but in no case shall the term eligible employee include persons paid from other personal services (OPS) funds.
2. A **retiree**, which means any state officer or state employee who retires under a state of Florida retirement system or a state optional annuity or retirement program or is placed on disability retirement under the state of Florida retirement system and who was insured under the state group insurance program at the time of retirement and who begins receiving retirement benefits immediately after retirement from state office or employment. Eligible retiree also means a person who retired prior to January 1, 1976, under any of the state administered retirement systems and who is not eligible to receive any benefits under social security.
3. A **surviving spouse**, which means the following:
 - a. The widow or widower of an employee or retiree if such widow or widower was covered as a dependent under the family coverage of the employee or retiree at the time of the employee's or retiree's death;
 - b. The widow or widower of an employee or retiree who died prior to July 1, 1979; or
 - c. The widow or widower of a person who retired prior to January 1, 1976, under any of the state administered retirement systems and who is not eligible to receive any benefits under social security; and
 - d. Any such widow or widower shall cease to be a surviving spouse upon his or her re-marriage.

4. A **dependent**, which means the following:
 - a. The wife or husband of the employee and any eligible children;
 - b. The wife or husband of the retiree and any eligible children;
 - c. The eligible children of a surviving spouse; and
 - d. The newborn children of an eligible child provided such newborn children are born on or subsequent to October 1, 1984. Coverage for such newborn children shall terminate 18 months after the birth of the newborn children.
5. A **child**, which means the employee's or retiree's unmarried own child, adopted child or child placed in the employee's or retiree's home for the purpose of adoption in accordance with chapter 63, Florida Statutes, a step-child who the employee can claim as an exemption on his or her federal income tax return, a child for whom legal guardianship has been established pursuant to chapter 744, Florida Statutes, a foster child, or any other unmarried child for whom the employee or retiree has been granted court ordered temporary or other custody. Such children shall be eligible for coverage as follows:
 - a. Is under the age of 26 or is still within the Calendar Year in which he or she reaches age 26:
 - b. Coverage for a dependent child between the ages of 27 and 30 may continue, if they are:
 - i. Unmarried without dependents of their own; and
 - ii. A Florida resident or a full- or part-time student; and
 - iii. Not covered under any other health plan or policy; and
 - iv. Not entitled to coverage under Medicare
 - c. Children who are mentally or physically handicapped shall be eligible to continue coverage after attainment of the above age limits and while the employee's or retiree's family coverage is in effect provided such children are incapable of self-sustaining employment by reason of such mental or physical handicap and chiefly dependent upon the employee, retiree, or surviving spouse for support and maintenance; or
 - d. Children who are over the above age limits at the time of the employee's or retiree's initial enrollment and who are mentally or physically handicapped shall be eligible for coverage if they are incapable of self-sustaining employment by reason of such mental or physical handicap and chiefly dependent upon the employee, retiree, or surviving spouse for support and maintenance; and
 - e. After age 26, when an eligible child marries, all coverage shall cease for that child at the end of the month in which the marriage occurs.

The Health Plan shall be responsible for: (1) requesting, verifying, and maintaining documentation for eligible children who reach the maximum age requirements to determine school enrollment or handicap status; (2) must be a Florida resident; and (3) relaying such information to the Department of Management Services.

ENROLLMENT PERIODS

There are three types of time periods for coverage enrollment under this Health Plan:

1. The **initial enrollment period** is the period of time during which an employee is first eligible to enroll and begins on the employee's initial date of employment and ends 31 days later. If the employee is a state officer, such officer may enroll within 31 days after he or she begins a new term of office.
2. The **annual open enrollment period** is the period of time designated each calendar year during which: 1) eligible employees may enroll in the Health Plan or, 2) eligible employees, retirees, surviving spouses or COBRA participants may transfer from their present plan to any other plan available without application of waiting periods or exclusions based on health status as conditions of enrollment or transfer.
3. A **special enrollment period** is the period of time during which eligible employees, retirees, surviving spouses, and COBRA participants may enroll. Special enrollment periods shall be required under the following circumstances:
 - a. To permit the transfer from a defunct plan to another qualified plan; or
 - b. Legislative mandate allowing retired state employees coverage under this Health Plan.

EMPLOYEE ENROLLMENT

Eligible employees who become insured under this Health Plan shall be included in the definition of “covered persons.” To become a covered person, the employee shall:

1. Complete and submit, through his or her employing agency, a written request for coverage, using enrollment forms provided and approved by both the Health Plan and the state; and
2. Agree to pay his or her portion of the required premium, if required by the state.

An employee who is a newly eligible employee shall enroll within the initial enrollment period. An employee, retiree, surviving spouse or COBRA participant who has been covered under another health benefit plan established and maintained by the state, and who now wants to change to this Health Plan, shall enroll for such coverage change during an annual open enrollment period or special enrollment period.

EMPLOYEE EFFECTIVE DATE

The effective date of coverage for enrollment in this Health Plan shall be the first day of the month after the month in which a full month’s premium has been received by the Department of Management Services.

DEPENDENT EFFECTIVE DATE

The effective date of a dependent’s coverage under this Health Plan depends on when the dependent is enrolled:

1. If the dependent is eligible for coverage on the group effective date, coverage for the dependent shall become effective on the group effective date if the employee enrolls the dependent for coverage at the same time he or she enrolls during the initial enrollment period.
2. If the employee through whom the dependent is eligible first becomes eligible after the group effective date and the employee enrolls himself or herself and his or her dependents during the initial enrollment period, coverage for the dependents shall be effective on the same date that the employee’s coverage becomes effective.
3. The effective date of coverage for a dependent of a covered employee shall be the date of birth or acquisition when:
 - a. the covered employee has family coverage;
 - b. the dependent becomes eligible after the covered employee’s effective date; and
 - c. the covered employee enrolls the dependent within 31 days after eligibility as a dependent begins.
4. The effective date of coverage for a dependent of a covered employee enrolled in individual coverage shall be:
 - a. the date of birth or acquisition; and
 - b. the first day of the month after the month in which a full month’s premium for family coverage has been received by the Department of Management Services.

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

PRE-EXISTING CONDITION LIMITATIONS

For health maintenance organizations under contract with the state, pre-existing condition limitations do not apply.

COVERAGE FOR NEWBORN CHILDREN

All health benefits applicable for children under this Health Plan shall be provided with respect to the newborn child of the covered person or to a covered dependent from the moment of birth if the covered person has family coverage. However, with respect to the newborn child of a covered dependent of the covered person other than the covered person’s spouse, the coverage for the newborn child terminates 18 months after the birth of the newborn.

The coverage for newborn children shall consist of coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity, and the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn’s condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.

The Department of Management Services shall be notified, in writing, within 31 days after the birth. Coverage shall not be denied for a newborn child due to the covered person’s failure to provide notice within the 31 day period of the birth of the

child if the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the birth of the newborn child. If the newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage.

COVERAGE FOR ADOPTED CHILDREN

All health benefits applicable to children shall be provided with respect to a child adopted by the covered person if the covered person has family coverage:

1. From the moment of placement in the covered person's residence in compliance with chapter 63, Florida Statutes; and
2. From the moment of birth, if a written agreement to adopt such newborn child has been entered into prior to the birth of the child.

Notice of the birth or placement of the child shall be given to the state, in writing, no later than 31 days after the occurrence. Coverage shall not be denied for a child due to the covered person's failure to provide timely notice of birth or placement of the child if the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the birth or placement of the adopted child. If the adopted newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. Covered services for the adopted child shall be the same as any other dependent child.

COVERAGE FOR FOSTER CHILDREN

Coverage for a foster child or a child otherwise placed in the covered person's custody by a court order shall be provided from the date of placement if on the date of placement the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the placement of the foster child. If the foster newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. Covered services for the foster child shall be the same as any other dependent child. No coverage shall 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 shall terminate the date the covered person no longer has legal custody.

DEPENDENT CHILD AS EMPLOYEE

A covered dependent child shall be eligible as a covered employee as long as he or she meets the eligibility requirements for a covered employee. However, a covered dependent child may be insured as a dependent if the covered parent can claim such child as an exemption on his or her federal income tax return and if such child meets all eligibility criteria for a dependent child under this Health Plan. A dependent child shall not be covered under this Health Plan as a dependent of more than one employee.

TERMINATION OF COVERAGE

The termination of coverage depends on the decisions of the state and on the covered person's continued employment relationship to the state. The following sections explain when coverage shall end and the options available to the covered person to continue or convert coverage.

COVERAGE TERMINATION

The coverage under this Health Plan for any covered person shall end at 12:01 a.m., local standard time, on the earliest of the following dates:

1. The contract between the state and the Health Plan ends;
2. The state fails to pay the premium due;
3. The covered person otherwise fails to continue to meet each of the eligibility requirements under this Health Plan;
4. The covered person's membership is terminated for cause;
5. The covered person no longer resides in the Health Plan's service area; or
6. The covered person becomes covered under another health benefit plan which is established and maintained through or in connection with the state as an alternative to this Health Plan.

DEPENDENT COVERAGE TERMINATION

The coverage under this Health Plan for any covered dependent shall end automatically at 12:01 a.m., local standard time, on the earliest of the following dates:

1. The contract between the state and the Health Plan ends;
2. The covered person's coverage ends for any reason;
3. The dependent fails to continue to meet each of the dependent eligibility requirements under this Health Plan;
4. The covered dependent's membership is terminated for cause;
5. The covered dependent no longer resides in the service area with the exception of covered dependents who are full-time or part-time students outside the service area; or
6. The dependent becomes covered under another health benefit plan which is offered through the state as an alternative to this Health Plan.

HANDICAPPED CHILDREN COVERAGE TERMINATION

If a child attains the limiting age for a covered dependent, coverage shall not terminate while that person is, and continues to be, both:

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

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage, the covered person shall have the burden of establishing that the child is and has continued to be handicapped.

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

TERMINATION OF COVERAGE FOR CAUSE

If, in the Health Plan's opinion, any of the following events occur, the Health Plan may request that the state terminate a covered person for any of the following reasons:

1. Disruptive, unruly, abusive, or uncooperative behavior to the extent that such covered person's continued membership in the Health Plan impairs the Health Plan's ability to administer this plan or to arrange for the delivery of health care services to such covered person or to other covered persons if:
 - a. an effort has been made to resolve the problem;
 - b. consideration has been given to extenuating circumstances; and
 - c. the problems, efforts, and medical conditions have been documented;
2. Fraud or material misrepresentation or omission in applying for membership or in requesting the receipt of coverage; or
3. Misuse of the membership identification card.

Any termination made under this provision is subject to review in accordance with the grievance procedures described in this Health Plan.

RIGHTS TO EXTENSION, CONVERSION AND CONTINUATION

If coverage for a covered person ends, the covered person may, depending on his or her situation, have the right to have coverage extended under the extension of benefits provision. Also, the covered person may be eligible for coverage under the federal continuation of coverage provisions or an alternative coverage plan under the conversion privilege provision.

EXTENSION OF BENEFITS (POST TERMINATION DISABILITY COVERAGE)

If the Health Plan terminates its contract with the state while a covered person is totally disabled, the benefits described in the covered benefits section shall be provided for the sickness or injury which caused such continuous total disability. This extension of benefits shall cease on the earliest of:

1. The date on which the continuous total disability ceases, but in no case longer than 12 months;

-
2. The end of the 12 month period immediately following the termination date of this Health Plan's contract with the state;
or
 3. The date on which the covered person becomes covered under any other plan providing similar benefits.

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

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

EXTENSION OF MATERNITY BENEFITS

For pregnancy, maternity benefits shall continue until the date of delivery provided the pregnancy began prior to the termination of this Health Plan. This extension shall not be based on total disability.

FEDERAL CONTINUATION PROVISIONS

Federal law permits covered persons to continue coverage under an employer established health benefit plan under certain circumstances. This law is referred to as COBRA, which stands for the "Consolidated Omnibus Budget Reconciliation Act of 1985" and includes any amendments thereto.

It shall be the state's responsibility to inform employees of their rights under COBRA. Information on employee COBRA rights may also be obtained from the United States Department of Labor.

THE CONVERSION PRIVILEGE

Covered persons whose coverage under this Health Plan has terminated for any reason other than for non-payment of premium shall have the right to apply for a conversion policy.

The new conversion plan shall be a benefit plan in use by the Health Plan for group conversions on the date of the request. The new coverage shall be issued at the rates for the Health Plan's conversion policies as filed and approved by the Florida Department of Insurance on the date coverage under this Health Plan terminates.

REQUESTING CONVERSION

A covered person who is eligible for conversion shall obtain conversion coverage without having to submit evidence of health qualification. The covered person shall apply in writing and pay the first premium on the conversion plan within 31 days after his or her coverage under this Health Plan terminates. The application form to be used and information about conversion benefits shall be obtained from the Health Plan.

Conversion shall not be available if:

1. Coverage under this Health Plan ends due to failure to pay any required premium;
2. This Health Plan is replaced by similar group coverage within 31 days of the termination date of this Health Plan;
3. The covered person is or could be covered by Medicare; or
4. The covered person is eligible for the following coverages and those benefits together with the benefits provided by the conversion plan would result in excessive duplication of benefits, such as:
 - a. Any arrangements of coverage for individuals in a group whether on an insured or self-insured basis;
 - b. Similar benefits under any state or federal program; or
 - c. Similar benefits by another group hospital, surgical, medical or major medical expense insurance policy or group hospital and medical service plan or group medical practice or any other prepayment plan or program.

COORDINATION OF BENEFITS WITH OTHER COVERAGE

COORDINATION WITH OTHER GROUP INSURANCE PLANS

If you, your spouse or your dependents are covered under this Health Plan and any other group medical insurance plan, group self-insurance, no-fault automobile insurance, a health maintenance organization or Medicare, the Health Plan shall reserve

the right to coordinate the benefits of the Plan with any other benefits you receive. When benefits are coordinated, the total benefits payable from both plans will not be more than 100% of the total allowed expenses actually incurred.

The term “group medical insurance plan” means a plan provided under a master policy issued to:

- an employer
- the trustees of a fund established by an employer or by several employers
- employers for one or more unions according to a collective bargaining agreement
- a union group, or
- any other group to which a group master policy may be legally issued in the State of Florida or any other jurisdiction for the purpose of insuring a group of individuals.

In order to ensure claims processing accuracy and appropriate coordination of benefits, the Health Plan will verify if you, your spouse, or your dependents have other insurance coverage or other insurance liability (OCL).

HOW COORDINATION WORKS

The plan that considers expenses first is the primary plan. The plan that considers expenses after the primary plan pays benefits is the secondary plan.

If the Health Plan is primary, it will pay benefits first. Benefits will be paid as they normally would under the plan, regardless of your other insurance coverage.

If the Health Plan is secondary, it will pay benefits second. In this case, benefits from this Health Plan and from the primary plan will not be more than 100% of total reasonable expenses. Also, when this Health Plan is secondary, it will not pay benefits above what it would pay if it was the primary plan.

Here are some guidelines for determining which plan pays first - or is the primary plan and which plan is the secondary plan.

FOR ALL COVERED INDIVIDUALS

The plan covering a person as an employee or member, rather than as a dependent, pays first.

The plan covering a person as an active employee, or that employee’s dependent, pays before the plan that covers a person as a laid-off or retired employee, or that employee’s dependent. In a case where the other policy or plan does not have this rule and the plans do not agree on the order of benefits, this rule will not apply.

FOR ELIGIBLE DEPENDENT CHILDREN

The plan of the parent whose birthday comes first in the calendar year pays first for covered dependent children, unless the parents are divorced or separated. If both parents have the same birthday, the plan that has covered the parent for the longest time pays first.

In the case of divorce or separation, the plan of the parent with custody pays first, except where a court decrees otherwise.

If the parent with legal custody has remarried:

- the plan of the parent with legal custody pays first
- the plan of the spouse of the parent with custody pays second
- the plan of the parent without custody pays last

... unless a court decrees otherwise.

If this plan coordinates benefits with an out-of-state plan that says the plan covering the male parent pays first - and the two plans do not agree on the order of benefits - the rules of the other plan will determine the order of benefits for eligible dependent children.

If none of the rules listed in this section apply, the plan that has covered a person for the longest time pays first.

COORDINATION WITH MEDICARE

It is important for you or your dependents to enroll for Medicare coverage when you first become eligible.

ACTIVE EMPLOYEES

If you are an active employee enrolled in Medicare Part A or Part B, the Health Plan will pay benefits for you and your

dependent spouse first. Medicare will pay second. However, if the Health Plan's payment is above what Medicare would normally allow for the service if Medicare were paying first, Medicare will not pay benefits. If you are an active employee or the spouse of an active employee and became eligible for Medicare because of age or disability, you may choose to defer Medicare Part B benefits until you or your spouse retires.

For active employees with a dependent who is disabled for reasons other than end-stage renal disease, the Health Plan will pay benefits first for the disabled dependent until he or she reaches age 65. At age 65, Medicare becomes the primary plan and will pay benefits first for any disabled dependent other than the spouse. If the disabled dependent is your spouse, your spouse's coverage under the Health Plan will continue to be primary, paying benefits first, as long as you are an active employee.

If you or your covered dependent requires treatment for end-stage renal disease, the Health Plan will pay benefits first for the first 36 months of treatment and Medicare will pay second. After that, Medicare will pay benefits first and the Health Plan will pay benefits second. If you become eligible for Medicare because of age or disability, before becoming eligible due to end-stage renal disease, however, Medicare would continue to pay first as your primary carrier and the Health Plan would pay second.

RETIRED EMPLOYEES

If you are a retiree, spouse of a retiree, or the surviving spouse of a retiree enrolled in Medicare, Medicare will pay benefits for you first. The Health Plan will pay benefits second. If you are eligible for Medicare but you have not enrolled, benefits from the Health Plan will still be paid as if Medicare had paid first as the primary plan.

Benefits from this plan and from Medicare will never be more than 100% of total reasonable expenses. Also, when this Health Plan is secondary, it will not pay benefits above what it normally would pay if it was the primary plan.

If you are covered under this Health Plan through COBRA and become eligible for Medicare, coverage under this plan will end. Your dependents may generally continue their COBRA coverage.

When Medicare is primary, this Health Plan will pay benefits up to:

- the covered expenses Medicare does not pay, up to the Medicare allowance
- the amount this Health Plan would have paid if you had no other coverage

... whichever is less.

PLAN'S RIGHT TO RECOVER AND SUE FOR LOSSES

The Health Plan reserves the right to be reimbursed for benefits paid under this plan if you have a right to recover those benefits from a third party. This provision helps the State and the Health Plan to continue providing cost-effective healthcare benefits. You will not be asked to reimburse the plan for an amount higher than the actual payments it made on your behalf.

If you or your dependents receive plan benefits for a claim that is in connection with a condition caused, directly or indirectly, by an intentional act or from the negligence or fault of any third person or entity, the health insurance plan will be subrogated to the right of recovery you or your dependent has against the other person or entity. The Health Plan's subrogation rights apply to any settlement of a claim, regardless of whether there is a lawsuit, and will not be off-set by any premiums you have paid.

This right to subrogation will be for the amount of benefits paid by the plan for healthcare services. You, your dependent or your legal representative, will be required to:

- provide the Health Plan with information pertaining to your settlement, settlement negotiations or litigation
- provide the assistance necessary to enforce this right to subrogation
- notify the Health Plan of any settlement negotiations before entering into any settlement agreement
- notify the Health Plan of any amount recovered from the person or entity that may be liable

No waiver, release of liability or other documents you execute without notice to the Health Plan shall be binding on the Health Plan.

RIGHT TO RECEIVE AND RELEASE INFORMATION

The covered person shall give permission for the Health Plan or its representatives to obtain from or release to other insurance carriers or health care providers information necessary for processing claims and/or determining other carrier liability. Covered persons shall cooperate with the Health Plan or its representatives in its effort to obtain such information by, among other ways, signing any release of information form as requested by the Health Plan or its representatives.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the Health Plan makes larger payments than are required under this Health Plan, the Health Plan shall have the right to recover any excess benefit payment from any person or organization to or for whom such payments were made, or any other person or organization the Health Plan may determine.

NON-DUPLICATION OF GOVERNMENT PROGRAMS

The benefits of this Health Plan shall not duplicate any benefits to which covered persons are entitled, or for which they are eligible, whether or not received, under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Health Plan has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to the Health Plan to the extent of such duplication.

NON-DUPLICATION OF OTHER COVERAGE

The benefits under this Health Plan shall not duplicate any benefits to which covered persons are entitled by law, and/or for which they are eligible under any extension of benefits and/or coverage provisions of any other plan, policy, program, or contract.

COOPERATION OF COVERED PERSONS

Each covered person shall cooperate with the Health Plan, and shall execute and submit to the Health Plan such consents, releases, assignments, and other documents as may be requested by the Health Plan 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 Health Plan.

MEDICARE ELIGIBLES

Medicare Part A means the social security program which provides hospital insurance benefits.

Medicare Part B means the social security program which provides physician and outpatient insurance benefits.

A covered retired person shall be considered eligible for Medicare on the earliest date in which coverage under Medicare could become effective for him or her.

CLAIMS PAYMENT

The following provisions apply in the event the Member needs to file a claim for non-participating Provider services:

REIMBURSEMENT FOR NON-PARTICIPATING PROVIDER SERVICES

The Health Plan shall provide or arrange for covered services to be received from participating providers on a direct service basis. If a covered person receives covered services from a participating provider, the Health Plan shall pay the provider directly for all care received. The covered person shall not have to submit a claim for payment, and shall be responsible only for any applicable copayments.

In the event the covered person requires emergency services from a non-participating provider while inside or outside the service area or, if the Health Plan refers the covered person to a non-participating provider, the Health Plan shall attempt to arrange for direct payment with the non-participating provider. If the non-participating provider refuses direct payment, or if such arrangements are not possible, the covered person will need to submit a claim to the Health Plan for the services, and shall be reimbursed for the cost of the services. The covered person shall not be reimbursed for more than the actual out-of-pocket expenses related to the services.

Claims for such services should be forwarded to:

Florida Health Care Plans
Medical Claims Department
P.O. Box 9910
Daytona Beach, Florida 32120-9910

The following provisions apply in the event the covered person needs to file a claim for non-participating provider services:

CLAIM FORMS

Claim forms may be required for submission of a proof of loss by a covered person for non-participating provider services.

As this procedure varies for health maintenance organizations, the covered person is responsible for following the procedures established by the Health Plan.

PROOF OF LOSS

For services rendered by non-participating providers, written proof of loss shall be given to the Health Plan. If proof of loss is not submitted and received by the Health Plan within the Health Plan's required time period, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit written proof of loss within the allowed time period and that the proof was submitted as soon as possible, the claim shall not be reduced or invalidated.

TIME OF PAYMENT OF CLAIMS

After receiving written proof of loss for a covered service, the Health Plan shall reimburse all uncontested claims or any portion of any claim received by the Health Plan from a covered person or a covered person's assignees within 30 days.

If a claim or portion of a claim is contested by the Health Plan, the covered person or the covered person's assignees shall be notified, in writing. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. The Health Plan, upon receipt of additional information requested from a covered person or the covered person's assignees, shall pay or deny the contested claim or portion of the contested claim within 30 days.

Payment shall 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.

ASSIGNMENT OF CLAIM

For covered services rendered by non-participating providers, benefits shall be payable to the covered person less any applicable copayments which are the responsibility of the covered person. The Health Plan may pay all or any part of the benefits to the health care provider on whose charge the claim is based. The Health Plan is under no obligation to honor such assignments from non-participating providers.

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 a participating hospital and practitioner network; (g) epidemic; (h) labor dispute not involving the Health Plan, participating providers shall use their best efforts to provide services and benefits within the limitations of available facilities and personnel. However, neither the Health Plan, nor any participating providers shall have any liability or obligation because of a delay or failure to provide such services or benefits. If the rendering of services or benefits under this Health Plan is delayed due to a labor dispute involving the Health Plan or participating providers, non-emergency care shall be deferred until after the resolution of the labor dispute.

COMPLAINT, GRIEVANCE & APPEALS PROCESS

Introduction

FHCP has established a process for reviewing Member Complaints, Grievances and Appeals. The purpose of this process is to facilitate review of, among other things, the Member's dissatisfaction with FHCP's administrative practices, coverage, benefit, payment decisions, or with the administrative practices and/or the quality of care provided by any Contracted Provider.

Examples of a Complaint include but are not limited to:

Access: such as the time to wait for an appointment, the wait time in the provider's office, the wait for a phone call, appointment scheduling issues, delay in services and/or cancellations.

Satisfaction: The way you are treated by an employee of FHCP, physician's staff, physician and/or any provider of a covered service.

Policy & Procedure: Including but not limited to the general, overall benefits of your plan and/or the amount you must pay for those benefits.

Quality: Any quality issue you have related to the services, supplies and/or facilities you have received or utilized that are covered under your plan.

The Complaint, Grievance and Appeal Process also permits the Member or his or her Physician to Expedite FHCP's review of certain types of Grievance and Appeals. The processes described below must be followed if the Member has a Complaint, Grievance or Appeal:

A Complaint refers to a Member contacting the FHCP Member Services Department either by telephone or in person.

A Grievance refers to any written, formal complaint.

NOTE: A Fast or Urgent Grievance may be submitted to FHCP's Member Services either verbally or in writing.

An Appeal refers to any written request for a review of a denied Pre-Service or Post-Service claim or discontinued Service that you are currently receiving.

NOTE: an Expedited Appeal request may be submitted to FHCP's Member Services either verbally or in writing.

Under the Complaint, Grievance and Appeal Process a Complaint will be handled informally in accordance with the *Informal Review* Subsection described below. A Grievance will be handled formally in accordance with the *Formal Review* Subsection described below. A request for a review of an Adverse Benefit Determination of a Pre-Service Claim (*Pre-Service Authorization*), a Post-Service Claim or a Concurrent Care Decision (*Discontinuation of a Service you are currently receiving*) is an Appeal and will be handled in accordance with the terms of this *Formal Review* Subsection.

FHCP encourages the Member to first attempt an informal resolution of any dissatisfaction by calling our Member Services Department. IF FHCP is unable to resolve the matter on an informal basis, the Member may submit his or her formal request for review in writing. (See the *Telephone Numbers and Addresses* Subsection)

Informal Review - Complaints

To advise FHCP of a Complaint, the Member should first contact the FHCP Member Services Department either by telephone or in person. The telephone number is listed on the Membership Card, and the telephone number and address of the Department is listed in *Telephone Numbers and Addresses* Subsection. The Member Services Department will work with the appropriate personnel, will review the Complaint within a reasonable time, not to exceed 14 calendar days after its submission, and attempt to resolve it to the Member's satisfaction.

If the Member remains dissatisfied with FHCP's resolution of the Complaint, he or she may submit a Grievance in accordance with the *Formal Review* Subsection below.

Important Note: The Member must provide to the Member Services Department all of the facts relevant to the Complaint. The Member’s failure to provide any requested or relevant information may delay FHCP’s review of the Complaint. Consequently, the Member is obliged to cooperate with FHCP in our review of the matter.

Formal Review – Grievances and Appeals

The Member, a provider the Member has authorized to act on his or her behalf, a State agency, or another person designated by the Member, may submit a Grievance or an Appeal. To submit or pursue a Grievance or an Appeal on behalf of a Member, a healthcare provider must previously have been directly involved in the Member’s treatment or diagnosis and have authorization from the Member to act on his or her behalf. The written communication may be mailed, faxed or e-mailed to the address, e-mail or fax number listed in the *Telephone Numbers and Addresses* Subsection. If the Member needs assistance in preparing the Grievance or Appeal he or she may contact the FHCP Member Services Department for such assistance at the telephone numbers and/or address listed in the *Telephone Number and Addresses* Subsection.

1. Initial Review:

a. Standard Grievances

In order to begin the formal review process, the Member, or the Member’s authorized representative, must write a letter explaining the facts and circumstances relating to the Grievance (formal Complaint). The Member should provide as much detail as possible and attach copies of any relevant documentation. The Grievance must be filed with FHCP’s Member Services Department within 365 days of the date of the adverse occurrence. The Member Services Department will review the Grievance with the appropriate Administration Representatives and/or the **Clinical Review / Benefits Review Panel** in accordance with the standard Grievance Procedure and advise the Member of its decision in writing within 30 calendar days of receipt of the Grievance.

b. Standard Appeals

In order to begin the formal Appeal Process, the Member or the Member’s authorized representative must write a letter requesting an Appeal and, when applicable, include any relevant documentation supporting his or her request. If the Appeal involves a Pre-Service (*Prior Authorization*) Claim denial, FHCP’s decision of the Appeal will be made within 30 calendar days of receipt of the Appeal. On occasion FHCP may require additional documentation that would benefit the Member. However FHCP may never extend this time UNLESS the Member agrees to the extension verbally and in writing. The maximum allowable extension is 14 calendar days. In the event a FHCP requests a 14 calendar day extension, FHCP will advise the Member verbally **and** in writing of the need and the reason for the extension. This notification will include a request for the Member’s signed approval of the extension. If the Member disagrees with FHCP’s request for 14 additional calendar days, FHCP will be required to make the final decision within the 30 calendar day timeframe.

If the Appeal involves a Post-Service Claim denial, FHCP’s decision regarding the Appeal will be made within 60 calendar days of receipt of the Appeal.

The Appeal will be reviewed by a licensed professional(s) who was not involved in the Initial Organization Determination and whose specialty or level of care would include the type of service(s) being requested. If this initial review is not favorable to the Member, the Appeal will automatically be forwarded to FHCP’s **Clinical Review / Benefit Review Panel** as described in the *Clinical Review / Benefit Review Panel Provision* below.

If the Appeal is regarding a Concurrent Care Decision (*Discontinuation of a Service you are currently receiving*) or under certain conditions a Pre-Service (*Prior Authorization*) Claim denial, the Member or the Member’s authorized representative may request an Expedited or Urgent Appeal as described in the *Expedited Review of Urgent Grievances and Appeals* subsection.

2. Clinical Review / Benefit Review Panel

The FHCP Review Panel will review Appeals.

STANDARD / EXPEDITED APPEALS

In the event the initial review of the Member's request for an Appeal regarding a Pre-Service (*Prior Authorization*) Claim, or Post-Service Claim was not fully favorable (*Adverse*) to the Member, the Appeal will be forwarded automatically to FHCP's Clinical Review / Benefit Review Panel for final determination. An Adverse initial review of an Appeal is a determination made that, upon review, and based on the information provided, an admission, availability of care, continued stay, Health Care Service or payment for a Health Care Service, still does not meet FHCP's requirements for Medical Necessity, Appropriateness, Health Care Setting, Level of Care, effectiveness or benefit coverage. Therefore, FHCP will automatically forward the Member's Appeal to FHCP's Clinical Review / Benefit Review Panel for a final determination. The Clinical Review / Benefit Review Panel consists of licensed professionals including Physicians licensed in the State of Florida. The Physician reviewer(s) will be of the same or like specialty of the Appeal being reviewed and will not have been involved in making either the Initial Organization Determination (*Initial Denial*) or the initial review of the Member's request for an Appeal. The Panel will make its final determination within the allotted 30 calendar days for Standard Appeals and within 72 hours for Expedited Appeals following the receipt of the Member's Appeal by FHCP. This timeframe can only be extended up to a maximum of 14 additional calendar days IF the Member has approved FHCP's request for the extension.

If the Member remains dissatisfied with the decision of the Clinical Review / Benefit Review Panel and the issue involves the Appeal of a Pre or Post-Service Claim or Concurrent Care Service the Member may request a review by the Subscriber Assistance Program. This process is outlined in the *Subscriber Assistance Program* subsection.

Expedited Review of Urgent Grievances and Appeals

Expedited Appeal: In the event of an Appeal involving an Adverse Pre-Service Claim or Discontinuation of a Service the Member is currently receiving, the Member, or a person acting on his or her behalf, may request that the review of the Appeal be expedited. In addition, if a Member disagrees with FHCP's decision that the Member's request for an Expedited Appeal did not meet the requirements for a 72 hour determination and the requested Expedited Appeal was transferred to a Standard (*30 calendar day*) Timeframe, the Member may file a request for an "Fast" (24 hour) Grievance. If the Member has an issue/complaint such as access to, or quality of, care and the Member believes that standard grievance timeframe could seriously jeopardize his/her life or health, the Member can request an "Urgent" (72 hour) Grievance.

In order for an Appeal or Grievance to be eligible for Expedited, Urgent or Fast review it must meet the following criteria as determined by FHCP:

1. The Member must be dissatisfied with a FHCP Adverse Benefit Determination;
2. As determined by FHCP, a delay in the provision of Health Care Services for the length of time permitted under the standard Grievance procedure time frames (*approximately 30 calendar days*) could seriously jeopardize the Member's life or health, or the Member's ability to regain maximum function, or 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 with the care of treatment that is the subject of the claim;
3. The health care provider involved has refused to, or will not, provide the needed medical Service without a guarantee of coverage or payment from the Member or FHCP;
4. The health care provider who is requesting the Pre-Service Claim or providing the Service that is being discontinued supports the Member's request for an Expedited Appeal;
5. The Member disagrees with FHCP's decision to transfer his or her request for an Expedited Appeal (*72 hour Timeframe*) to a Standard Appeal Timeframe (*approximately 30 calendar days*);

Expedited Appeal: The Member, an authorized representative of the Member, or a provider acting on his or her behalf, must specifically request an Expedited Appeal. For example, this request may be made by saying: “I want an Expedited Appeal”. Only the following Services that have yet to be rendered are subject to this review Process: (a) Pre-Service Claims (Pre service-Authorizations); or (b) requests for extension for Continuation of Care (*Concurrent Service(s)*) made within 24 hours prior to the termination of Authorization for such services.

Fast Grievance: Only the following condition is subject to a request for a “Fast” (24 hour) Grievance Process: (a) FHCP’s transfer of a request for an Expedited Appeal Review to a Standard Timeframe; for example, this request may be made by saying: “I want a Fast Grievance”

Urgent Grievance: A request for an “Urgent” (72 hour) Grievance can be a complaint or issue where the Member feels a standard grievance timeframe would seriously jeopardize his/her life or health. Examples of such a grievance would be an access to care or a quality of care issue.

Information necessary to evaluate an Expedited Appeal regarding a Pre-Service or Concurrent Care Claim or a “Fast” or “Urgent” Grievance complaint may be transmitted by telephone, fax, e-mail or such other expeditious method as is appropriate under the circumstances.

A request involving an Appeal of Pre-Service or Concurrent Care Claim; or a request for a Fast or Urgent Grievance, will be evaluated by Health Care Professional(s) and/or a Physician(s), licensed by the State of Florida, who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the condition, process, or treatment, which the Member, the Member’s Authorized Representative, or the Provider acting on the Member’s behalf are requesting be reviewed.

FHCP will make a decision and notify the Member, an Authorized Representative of the Member or the Provider acting on his or her behalf, as expeditiously as the Condition requires, but in no event longer than 72 hours after receipt of the request for expedited review. If additional information is necessary, FHCP will notify the Member and the Provider within 24 hours of receipt of the Claim involving Urgent Care and FHCP must receive the requested additional information within 48 hours of request. Under no circumstance will any request for an Expedited Appeal or Expedited Grievance exceed 72 hours.

If the Member requests a “Fast” Grievance regarding FHCP’s decision to transfer a request for an Expedited Appeal Review to a Standard Appeal timeframe, FHCP will make a decision and verbally notify the Member of the decision within 24 hours of the receipt of the request. The verbal notification will be followed by a written notification within 2 working days.

If the Member’s request for an Expedited Appeal arises out of a utilization review determination by FHCP that a continued hospitalization or continuation of a course of treatment is not Medically Necessary, coverage for the Hospitalization or course of treatment will continue until the Member has been notified of the determination.

FHCP will provide written confirmation of its decision concerning an Appeal involving urgently needed care within 2 working days after providing verbal notification of that decision. If the Member is not satisfied with the decision, he or she may submit an Appeal to the **Subscriber Assistance Program**.

Subscriber Assistance Program

Once a Member has completed the FHCP Appeal Process, the Member always has the right to have an Appeal reviewed by the Subscriber Assistance Program (*SAP*). The Member may submit the Appeal to the Subscriber Assistance Program within 365 days of the Clinical Review / Benefit Review Panel’s decision. Telephone numbers and addresses are listed in the *Telephone Numbers and Addresses* subsection. The Member must complete the entire Appeal Process and receive a final disposition from FHCP before pursuing review by the Subscriber Assistance Program.

Time Frames for Resolution of a Grievance and Appeal

FHCP will resolve Grievances and Appeals in a timely manner. FHCP will review Complaints and Grievances in the appropriate time frame not to exceed 30 calendar days. Appeals will be resolved within 30 calendar days after receipt of the Member request for Pre-Service Claims or within 60 calendar days for Post-Service Claims. Pre-Service Claims may be extended an additional 14 calendar days only with proper notification to the Member AND with the Member's permission. Expedited Appeals and Urgent Grievances will be resolved in most cases within 24 hours not to exceed 72 hours. Expedited Appeals and Urgent Grievances may be extended an additional 14 calendar days only with proper notification to the Member AND with the Members permission. Fast Grievances regarding FHCP's decision to transfer a request for an Expedited Appeal to a Standard Appeal timeframe will be resolved within 24 hours after receipt of the Member's request.

General Rules

General rules regarding FHCP's Complaint, Grievance and Appeals Process include the following:

1. The Member must cooperate fully with FHCP in its effort to promptly review and resolve a Complaint or Grievance. In the event the Member does not fully cooperate with FHCP, he or she will be deemed to have waived his or her right to have the Complaint, Grievance or Appeal processed within the time frames set forth above.
2. FHCP will not honor a request for Expedited Review that relates to Services that have already been performed, rendered, or provided to you, or a request that is not eligible for expedited review in accordance with the criteria set forth in the Expedited Review Appeal or Urgent Grievance Provision. FHCP will process such Grievance or Appeal, however, in accordance with the Standard Grievance and Appeal Procedures.
3. FHCP will automatically process any request for an Expedited Appeal or an Urgent Grievance within the 72 hour timeframe if that request is supported by a Physician with knowledge of the Member's Condition or who is directly involved with the Member's treatment.
4. FHCP must receive all Grievances or Appeals within one year of the date of the occurrence that initiated the Grievance or Appeal.
5. If the Appeal involves a determination that the Service did not meet FHCP's Medical Necessity guidelines for coverage of a Service or that the Service is excluded because it meets the definition of an Experimental or Investigational Service or a similar exclusion or limitation, then the Member may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Member Handbook to the Member's medical circumstances.
6. During the review process, the Service(s) in question will be reviewed without regard to the decision reached in the initial determination.
7. The Member may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Plan. If ERISA applies to the Group Plan, the Subscriber or the Subscriber's covered Dependents are entitled, after exhaustion of the appeal procedures provided for in the "Complaint and Grievance Process" Section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Telephone Numbers and Addresses

The Member may contact an FHCP Grievance / Appeals Supervisor at the number listed on the Membership Card or the numbers listed below. If a Grievance is unresolved, the Member may, at any time, contact an agency at the telephone numbers and addresses listed below.

Department of Financial Services

Office of Insurance Regulation
200 East Gaines Street
Larson Building
Tallahassee, Florida 32399-0322
1-877-693-5236

Agency for Health Care Administration (AHCA)

Subscriber Assistance Program

2727 Mahan Drive, Building 1
Mail Stop - #26
Tallahassee, Florida 32308
1-888-419-3456
1-850-412-5402

Florida Medical Quality Assurance, Inc.

(The QIO for the State of Florida)

5201 West Kennedy Blvd.
Suite 900
Tampa, FL 33609-0795
1-813-354-9111

Florida Health Care Plans, Inc.

Attention: Case Management

1340 Ridgewood Ave.
Holly Hill, FL 32117
1-386-676-7187
1-866-676-7187
(TRS Florida Relay 711)

Florida Health Care Plans, Inc.

Attention: Claims Department

P.O. Box 9910
Daytona Beach, FL 32120-9910
1-800-321-1227

Florida Health Care Plans, Inc.

Attention: Grievance / Appeals Supervisor

1340 Ridgewood Ave
Holly Hill, Florida 32117
1-386-615-4022
1-877-615-4022
(TRS Florida Relay 711)

Florida Health Care Plans, Inc.
Attention: Member Services Department
1340 Ridgewood Ave.
Holly Hill, Florida 32117
1-386-615-4022
1-877-615-4022
(TRS Florida Relay 711)

Florida Health Care Plans, Inc
Pre-Certification and Emergency Care Utilization Telephone Number
1-386-238-3215
1-800-729-8349

Florida Health Care Plans, Inc
Translation Services (*access to over 150 languages*)
Attention: Member Services Department
1340 Ridgewood Ave.
Holly Hill, Florida 32117
1-386-615-4022
1-877-615-4022
(TRS Florida Relay 711)

COVERAGE PROVISIONS

This section provides important information on the coverage provided under the Health Plan explaining:

1. What rules the covered person shall follow in accessing care;
2. What services and supplies are covered; and
3. What services and supplies are not covered.

COVERAGE ACCESS RULES

It is important that Health Plan covered persons become familiar with the rules for accessing health care services through the Health Plan. The following sections explain the role of the Health Plan and the primary care physician, how to access specialty care through the Health Plan and the primary care physician, and what to do if emergency care is needed.

THE ROLE OF THE 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 the Health Plan's published list of primary care physicians whose practice is open to additional Health Plan covered persons. This choice should be made when the covered person enrolls by contacting FHCP Member Services number listed on the provider directory. If the covered person fails to choose a primary care physician when enrolling, the Health Plan shall assign one to the covered person and notify the covered person of that assignment. The selection or assignment of a primary care physician varies for health maintenance organizations.

Some important guidelines apply to the covered person's primary care physician relationship:

1. The primary care physician shall maintain a physician-patient relationship with the covered person, and shall be responsible for providing, authorizing and coordinating all medical services for the covered person.
2. The covered person must look to the primary care physician to direct his or her care, and should accept procedures and treatment recommended by the primary care physician.
3. Except in emergency situations or as otherwise directed by the Health Plan, all services shall 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 the Health Plan. If services are not received in this manner and the covered person uses a health care provider that is not a participating provider or that has not been referred by a primary care physician, services shall not be reimbursed by the Health Plan.

4. The Health Plan wants the covered person and the primary care physician to have a good relationship. Instances may occur where the primary care physician or the covered person, for good cause, finds it impossible to establish an appropriate and viable physician-patient relationship. In such a circumstance, the primary care physician or the covered person may request another primary care physician.
5. 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, the Health Plan 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.
6. If the covered person's primary care physician terminates his or her agreement with the Health Plan, the Health Plan shall assist the covered person in selecting another primary care physician whose practice is open to new Health Plan covered persons.
7. The Member may request transfer of his or her health care to another Primary Care Physician whose practice is open to enrollment of additional FHCP Members.

SPECIALTY CARE

The primary care physician may refer the covered person to participating specialists or facilities when medically necessary. The referral shall identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the covered person's condition.

When additional services or visits are suggested by the specialist, covered persons should first consult with their primary care physician, or Health Plan.

If a specialist beyond those participating with the Health Plan is required, the primary care physician shall authorize such treatment only if authorized by the Health Plan. As the procedures for specialty care vary for health maintenance organizations, the covered person is responsible for following the procedures established by the Health Plan.

IDENTIFICATION CARD

As Participants in FHCP, Members and their dependents will be issued identification cards. Members are required to present their identification card when obtaining any covered services such as:

- A. Medical services
- B. Making routine appointments
- C. Hospital services
- D. Emergency services
- E. Prescription drugs

COVERED PERSON COPAYMENTS

For certain 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. The copayment requirements for this Health Plan are shown in the schedule of member copayments. The covered person may also call the Health Plan's customer service department for information on copayment amounts.

The total copayments the covered person is responsible for in any single calendar year shall not exceed \$1,500 for individual coverage and \$3,000 for family coverage. When the covered person has paid copayments that total the annual maximum, no further copayments shall be required by that covered person for the remainder of the calendar year. The covered person is responsible for providing documentation of the amount of copayments paid.

LIFETIME MAXIMUM COVERAGE LIMIT

There is no lifetime maximum coverage limit under this Health Plan.

COVERED BENEFITS SECTION

This section describes the benefits that shall be covered under this Health Plan. It is important that this whole section be reviewed to be sure both covered benefit details and the limitations and exclusions are understood. Also, important information is contained in the schedule of member copayments.

Expenses for the services and supplies listed below shall be considered covered services under this Health Plan if the service is:

1. Required for a condition;
2. Rendered while coverage under this Health Plan is in force;
3. Not specifically limited or excluded under this Health Plan; and
4. Received from or provided under the orders, direction or authorized approval of the covered person's primary care physician or Health Plan, except for emergency care services.

The Co-payment Amounts for which the Member is responsible for the Covered Services listed below are shown in the Schedule of Member Co-payments.

If services are received from Non-Participating Providers, the payment of costs for Covered Services is subject to FHCP Non-Participating Provider Allowed Charge guidelines (See the Reimbursement For Non-Participating Providers provision).

HOSPITAL SERVICES

Expenses for the services and supplies listed below shall be considered covered benefits when furnished to a covered person at a hospital on an inpatient or outpatient basis, if the service or supply is ordered or authorized by the covered person's primary care physician or Health Plan:

1. Room and board for semi-private accommodations, unless the Health Plan has determined that private accommodations are medically necessary;
2. Confinement in an intensive care unit, progressive care unit, cardiac care unit or a neonatal care unit;
3. Routine nursery care for a newborn child;
4. Covered drugs and medicines used by the patient while confined in the hospital;
5. Respiratory therapy (including oxygen);
6. Covered rehabilitative services;
7. Use of operating rooms, labor rooms, delivery rooms, and recovery rooms;
8. Use of emergency rooms;
9. Intravenous solutions (including glucose);
10. Dressings, including ordinary casts, splints and trusses;
11. Anesthetics, related supplies, and their administration;
12. Transfusion supplies, services, and equipment (including blood, blood plasma, and serum albumin, if not replaced);
13. Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (including electrocardiogram (EKG) and electroencephalogram (EEG));
14. X-ray (including therapy);
15. Diathermy;
16. Basal metabolism examinations;
17. Chemotherapy treatment for proven malignant disease;
18. Private duty nursing; and
19. Other covered medically necessary services and supplies.

AMBULATORY SURGICAL CENTER SERVICES AND OTHER LICENSED OUTPATIENT MEDICAL TREATMENT FACILITIES

Expenses for the services and supplies listed below shall be considered covered benefits when furnished to a covered person at a participating provider ambulatory surgical center, any other appropriately licensed outpatient medical treatment facility, or a health care provider's office, if authorized by the covered person's primary care physician or Health Plan:

1. Use of operating rooms and recovery rooms;
2. Respiratory therapy (including oxygen);

3. Covered drugs and medicines used by the patient at the outpatient facility;
4. Intravenous solutions (including glucose);
5. Dressings, including ordinary casts, splints, and trusses;
6. Anesthetics, related supplies, and their administration;
7. Transfusion supplies, services, and equipment (including blood, blood plasma, and serum albumin, if not replaced);
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (including electrocardiogram (EKG) and electroencephalogram (EEG));
9. Basal metabolism examinations;
10. X-ray (including therapy);
11. Diathermy and physical therapy;
12. Chemotherapy treatment for proven malignant disease;
13. Services provided by a birthing center licensed pursuant to section 383.30-383.335, Florida Statutes; and
14. Other covered medically necessary services and supplies.

MEDICAL SERVICES

Expenses for the medical services and supplies listed below shall be considered covered benefits if provided or authorized by the covered person's primary care physician or Health Plan:

Abortion. When deemed by FHCP to be Medically Necessary.

Alcoholism and substance abuse treatment, including expenses for the services and supplies listed in this section shall be considered covered benefits if provided to the covered person by a participating provider licensed as a mental health, substance abuse or addictions provider. Physician services must be rendered by medical doctors licensed under Chapter 458, and doctors of osteopathy licensed under Chapter 459, Florida Statutes. Other alcoholism and substance abuse care and treatment must be rendered by appropriately licensed mental health professionals as defined in the Glossary section of this Handbook. Services must be rehabilitative in nature for the purpose of aiding in the restoration of medical, mental/behavioral function based upon rehabilitative potential of the Covered Person.

Covered Services:

1. **Inpatient confinement** in a hospital for the treatment of alcoholism and/or substance abuse related medical, mental and nervous condition, if authorized by the Health Plan. Coverage includes visits from licensed mental health providers during confinement. In addition to services rendered by hospital employees, coverage also includes visits from a psychiatrist or other Physician during the admission.
2. **Psychiatric facility, Specialty Institution, Residential Facility or partial hospitalization services** shall be covered in lieu of inpatient confinement and only if the covered person's Health Plan approves a written plan of treatment submitted by a physician. Coverage shall be subject to the following:
 - a. The covered person's physician certifies the need and the Health Plan approves the written Plan of Care, for the medical or psychiatric facility care or partial hospitalization and the covered person receives skilled nursing or alcohol/substance abuse rehabilitation services related to their medical condition or addiction on a daily basis;
 - b. The admission shall be due to the covered person requiring skilled nursing and rehabilitative care for a medical, mental or nervous condition resulting from their alcohol/substance abuse; And are subject to intermittent review for continued need for services at the original intensity.
 - c. The covered person may be admitted immediately following discharge from the hospital;
 - d. Services and supplies are limited to 60 days per calendar year and may include: room and board; rehabilitative or skilled nursing care; drugs and medicines administered while an inpatient; intravenous solutions; diagnostic services, and other services and supplies.
 - e. Services shall be limited to those that require Mental Health Providers defined herein, and shall be ordered by and provided under the direction of a physician; and
 - f. Coverage includes visits with a Psychiatrist or Physician during treatment.

Exclusion: Services or supplies that maintain rather than improve a level of physical, mental or emotional function, or where it has been determined that the services shall not result in significant improvement in, or stabilization of, the Covered Person's mental, nervous condition and/or addiction within a 60 day period.

3. **Outpatient Services.** The covered person's addiction physician or Health Plan shall specifically approve a written plan of treatment and are subject to intermittent review of progress. Covered services shall be related to:
- a. Treatment of an addiction to alcohol or drugs, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy.
 - b. Management of medications that are indicated to stabilize and maintain the Covered Person's mental status.
 - c. Administration of medications that cannot be self-administered by the patient.

Allergy treatment, including allergy testing, desensitization therapy, and allergy immunotherapy, including hyposensitization serum when administered by a health care provider.

Ambulance services, when medically necessary to transport a covered person from:

1. A hospital which is unable to provide proper care to the nearest hospital that can provide proper care;
2. A hospital to a covered person's home or skilled nursing facility when medically necessary; or
3. The place a medical emergency occurs to the nearest hospital that can provide proper care.

Ambulance services by boat, airplane, or helicopter shall be provided when it is determined that:

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

Anesthesia services, when administered by a health care provider and medically necessary for a covered medical or surgical procedure.

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

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

Initial evaluation required for verification of diagnosis and treatment plan.

Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services. Applied behavior analysis services shall be provided by an individual certified pursuant to section 393.17 or an individual licensed under chapter 490 or chapter 491.

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

Casts and splints, including bite and dental splints for the treatment of temporomandibular joint (TMJ) syndrome.

Child health supervision services, which include health care services and supplies furnished to a covered person who is a dependent child and which are physician delivered or physician supervised shall be covered. This includes but is not limited to:

1. A newborn's first examination in the hospital;
2. Periodic examinations, which shall include a history and physical examination, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
3. Oral and/or injectable immunizations;
4. Laboratory tests normally performed for a well child;
5. Evaluation and management counseling and/or risk factor reduction intervention for covered dependents without symptoms or established illnesses;

6. Screening for diagnosing the presence of autism spectrum disorder;
6. Hearing screenings; and
7. Vision screening.

These services shall conform with prevailing medical standards and shall not be less than 18 visits at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, and 16 years.

Concurrent physician care, including surgical assistance provided by a physician, provided the additional physician actively participates in the covered person's treatment and: a) the condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; b) the physicians have different specialties or have the same specialty with different sub-specialties; and c) the care is authorized by the covered person's primary care physician or Health Plan.

Consultations, provided the covered person's primary care physician requests the consultation and the consulting physician prepares a written report.

Cosmetic surgery (plastic and reconstructive surgery) shall be a covered benefit if it is:

1. Necessary for the repair or alleviation of damage to a covered person if such treatment or surgery is the result of an accident sustained while the person is covered under the Health Plan and actually performed while the Health Plan is in force;
2. In connection with the correction of a congenital anomaly for an eligible dependent born while the Health Plan is in force;
3. A medically necessary procedure in the correction of an abnormal bodily function;
4. For reconstruction to an area of the body which has been altered by the treatment of a disease, provided such alteration occurred while a covered person under this Health Plan;
5. For reconstruction (including the initial prosthetic device) incident to a mastectomy when the mastectomy is performed on or after October 1, 1987, and there is evidence of malignancy; however, if there is no evidence of malignancy, such reconstruction and initial prosthetic device shall only be covered if received within two years after the date of the mastectomy if the mastectomy occurred while a covered person under this Health Plan; and
6. For a reduction mammoplasty, to reduce the size of the breast and the skin envelope if medically necessary.

Dental Services for the treatment of an accidental dental injury to sound natural teeth if the injury occurs, and the services are rendered, while the Member is covered and the treatment is received within six (6) months of the accident.

Dermatology - Direct Access. A subscriber does not need to obtain a referral or prior authorization for dermatologic office visits or minor procedures and testing performed by a dermatologist. A subscriber is limited to five (5) visits every twelve (12) months with network dermatologists.

Diagnostic procedures, lab tests or x-ray exams, including their interpretation, for the treatment of a covered condition.

Durable medical equipment and other medical supplies, when determined by the covered person's treating physician to be medically necessary for the care and treatment of a condition covered under this Health Plan. The durable medical equipment shall not, in whole or in part, serve as a comfort, hygiene, or convenience item for the covered person, shall not be used by any other party, shall not be used solely for the purpose of exercise, and shall have been manufactured specifically for medical use. At the Health Plan's option, the cost of either renting or purchasing shall be covered.

Durable medical equipment and other medical supplies are limited to:

1. Trusses, braces, walkers, canes, and crutches; however, no shoe build-up, shoe orthotic, shoe brace or shoe support shall be covered unless the shoe is attached to a brace;
2. Occlusal guards, bite or dental splints, repositioning devices, and TMJ study models for the treatment of temporomandibular joint (TMJ) syndrome;
3. Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products;
4. Oxygen and rental of equipment for the administration of oxygen, iron lung or other mechanical equipment for the treatment of respiratory paralysis;
5. Ambulatory home uterine activity monitoring devices (AHUM);

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6. Wheelchairs, hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment; and
 7. Other medical equipment and supplies as determined to be medically necessary.

EMERGENCY CARE

The procedure the covered person should follow for emergency care, as defined in this section, depends on whether the treatment is rendered inside or outside the service area.

Within The Service Area

A medical emergency within the service area is defined as: the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in permanently placing the covered person's health in jeopardy; serious impairment to bodily function; serious and permanent dysfunction to a body organ or part; or other serious medical consequences.

Symptoms must occur suddenly and unexpectedly and must be sufficiently severe to cause a covered person to seek medical assistance, regardless of the hour of day or night. Examples of medical emergencies are heart attacks, cerebrovascular accidents, poisoning, convulsions and severe bleeding. The Health Plan may determine that other similar acute conditions are or are not medical emergencies. The determination of covered benefits for services rendered in an emergency room is based on the Health Plan's review of a covered person's emergency room medical records, along with those relevant symptoms and circumstances which preceded the provision of care.

Outside The Service Area

A medical emergency outside the service area is defined as: the unexpected and immediately required care needed as a result of accidental injury or acute illness of such gravity that it is not medically feasible to bring the covered person to the primary care physician or a participating provider within the service area for treatment.

The covered person may be transported from outside the service area to the service area for continued medical management of an emergency condition at the option of the medical director or designee. The Health Plan will only exercise this option when the medical director or designee determines that such action will not have a detrimental effect on the covered person's medical condition.

The primary care physician or the Health Plan must be notified of a medical emergency within 48 hours following its onset or within a reasonable time period as dictated by the circumstance. Each case outside the service area will be reviewed individually to determine whether the medical condition constituted a medical emergency.

Eye care, limited to the following:

1. Routine or refractive eye examinations as part of the preventive medical care benefit or child health supervision services benefit;
2. The first pair of eyeglasses or contact lenses, including the examination for the prescribing or fitting thereof, only if due to an accident or cataract surgery;
3. Aphakic patients and soft lenses or sclera shells intended for use in the treatment of a covered condition; and
4. Following an injury, disease or accident to a covered person's eyes, while covered under this Health Plan.

Family planning services, including counseling and information on birth control, sex education and the prevention of sexually transmitted diseases (STD).

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

Home health care services provided by a home health agency for the appropriate treatment, therapy (including infusion therapy), equipment, medication, and supplies for a covered person as a result of a covered condition shall be covered by the Health Plan, subject to the following:

1. The covered person requires home health care visits;
2. The treating physician sends the covered person's primary care physician a home health care plan of treatment;

3. The covered person's primary care physician or Health Plan approves the plan of treatment in writing as being medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and
4. Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility.

The covered person's primary care physician or Health Plan shall review the covered person's condition to determine the medical necessity for home health care services. If the covered person's condition does not warrant the services provided by a home health agency, nurse registry or independent nurse, benefits shall be denied. At such time as documentation is provided for and benefits are found to be medically necessary and in lieu of hospitalization or continued hospitalization, benefits shall be reinstated.

Home health care services include:

1. Part-time, intermittent or continuous nursing care by registered nurses, or licensed practical nurses, nurse registries or home health agencies;
2. Physical therapy, speech therapy, occupational therapy and respiratory therapy; and
3. Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by a covered person's treating physician and other covered services provided by or for a home health agency, through a licensed nurse registry, or by an independent nurse licensed under chapter 464, Florida Statutes, to the extent that they would have been covered if the covered person had been confined in a hospital.

The covered home health care services under this benefit shall not include any service that would not have been covered had the covered person been confined in a hospital, or are solely for the convenience of the covered person. Physical therapy is subject to the limitations described under rehabilitative services.

Hospice services, in accordance with section 400.609, Florida Statutes, when hospice services are the most appropriate and cost effective treatment, as determined by the covered person's primary care physician or Health Plan. Covered persons who are diagnosed as having a terminal illness with a life expectancy up to one year may elect hospice care for such illness instead of the traditional services covered under this Health Plan.

To qualify for coverage, the covered person's primary care physician shall: (1) certify that the patient is not expected to live more than one year; (2) submit a written hospice care plan or program; and (3) submit a life expectancy certification. All hospice care expenses shall be approved in writing by the Health Plan. Covered persons who elect hospice care under this provision shall not be entitled to any other benefits under this Health Plan for the terminal illness while the hospice election is in effect. However, covered services rendered outside the hospice program for illnesses or accidents not related to the terminal illness shall be eligible for coverage subject to the Health Plan's benefits, limitations and exclusions. Under these circumstances, the following services shall be covered:

1. Hospice home care, comprised of:
 - a. Physician services, part-time or intermittent nursing care by a registered nurse or licensed practical nurse, or private duty nursing service;
 - b. Home health aides;
 - c. Inhalation (respiratory) therapy;
 - d. Oxygen;
 - e. Medical supplies, drugs and appliances;
 - f. Physical, massage, speech, and occupational therapy to maintain the quality of life, if approved by the Health Plan as appropriate for special circumstances; and
 - g. Infusion therapy.
2. Hospice inpatient care in a hospice facility, hospital, or skilled nursing facility, if approved in writing by the Health Plan, including care for pain control or acute chronic symptom management. Inpatient services shall include:
 - a. Room and board and general nursing;
 - b. Other covered hospital inpatient services previously listed; and
 - c. All other services covered under home and outpatient hospice care.

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3. Hospice outpatient care provided by the hospice at an approved location shall include:
 - a. Physician services;
 - b. Laboratory, x-ray, and diagnostic testing;
 - c. Ambulance service; and
 - d. All other services covered under home hospice care services.

Social work services, bereavement, pastoral, financial, legal and dietary counseling, day care, homemaker, chore and funeral services are required to be provided by the hospice provider pursuant to section 400.609, Florida Statutes. However, these services are not covered services under this Health Plan.

The hospice treatment program shall:

1. Meet the standards outlined by the National Hospice Association;
2. Be recognized as an approved hospice program by the Health Plan;
3. Be licensed, certified, and registered as required by Florida law; and
4. Be directed by the covered person's primary care physician or the Health Plan and coordinated by a registered nurse, with a treatment plan that provides an organized system of hospice facility care, uses a hospice team, and has around-the-clock care available.

Immunizations, when medically necessary.

Injectables. Injectable drugs and biologicals are covered only if:

- A. Such injectables cannot be self-administered and are furnished "incident to a Physician's covered professional services";
- B. They are reasonable and necessary for the diagnosis or treatment of the covered illness or injury for which they are administered according to accepted standards of FHCP;
- C. They have not been determined by the FDA to be "less-than-effective";
- D. The injection is considered the indicated effective method of administration according to the accepted standards of medical practice for the covered condition;
- E. The frequency, amount, and duration of the course of injectable drug or biological meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections; and
- F. They are included in a formulary approved by FHCP.

"Incident to a Physician's professional service" means that the injectables are furnished as an effective integral, although incidental, part of the Physician'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 direct supervision by employees of the Physician or FHCP. This does not mean, however, that to be considered "incident to", each injection always be the occasion of the actual rendition or a personal professional service of the Physician. Such injections could be considered to be "incident to" when furnished during a course of treatment where the Physician performs the initial service and subsequent services of a frequency which reflect his/her 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 Physician gives the Member a subcutaneous, intramuscular, intravenous or intra-arterial injection, no additional coverage will be provided for the administration of the injection. Coverage is arranged 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 coverage for the visit or other services rendered.

Insulin, including the needles and syringes needed for insulin administration when dispensed by a participating pharmacy or provider. However, the covered person shall have a physician's authorization for such supplies on record with the pharmacy where the supplies are purchased.

Mammograms performed for breast cancer screening, but limited to the following:

1. A baseline mammogram for women age 35 through 39;
2. A mammogram for women age 40 through 49, every two years or more frequently based upon the covered person's primary care physician;

3. A mammogram every year for women age 50 and over; and
4. A mammogram for covered persons of any age if deemed medically necessary by the covered person's primary care physician.

Except for mammograms done more frequently than every two years for women 40 years of age or older, but younger than 50 years of age, benefits are payable when, with or without a prescription from a Physician, the Member obtains a mammogram in a medical office, medical treatment facility, or through a health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast cancer screening.

Mental and nervous condition treatment, including expenses for the services and supplies listed in this section shall be considered covered services if provided to the Covered Person by a licensed mental health provider. Physician services must be rendered by medical doctors licensed under Chapter 458, and doctors of osteopathy licensed under Chapter 459, Florida Statutes. Other mental/behavioral health care and treatment must be rendered by appropriately licensed mental health professionals as defined in the Glossary section of this Handbook. Services must be rehabilitative in nature for the purpose of aiding in the restoration of mental/behavioral function based upon rehabilitative potential of the Covered Person.

Covered Services:

1. **Inpatient confinement** in a hospital for the treatment of a mental and nervous condition, if authorized by the Health Plan. Coverage includes visits from licensed mental health providers during confinement. In addition to services rendered by hospital employees, coverage also includes visits from a psychiatrist or other Physician during the admission.
2. **Psychiatric facility, Specialty Institution, Residential Facility or partial hospitalization services** shall be covered in lieu of inpatient confinement and only if the covered person's Health Plan approves a written plan of treatment submitted by a physician. Coverage shall be subject to the following:
 - a. The covered person's psychiatric physician certifies the need for the psychiatric facility care or partial hospitalization and the covered person receives psychiatric skilled nursing or rehabilitation services on a daily basis;
 - b. The admission to the psychiatric facility or partial hospitalization program shall be due to the covered person requiring skilled nursing and rehabilitative care for a mental or nervous condition;
 - c. The covered person may be admitted to the psychiatric facility or partial hospitalization program immediately following discharge from the hospital;
 - d. Services and supplies are limited to 60 days per calendar year and may include: room and board; rehabilitative or skilled nursing care; drugs and medicines administered while an inpatient; intravenous solutions; diagnostic services, and other services and supplies.
 - e. Services shall be limited to those that require Mental Health Providers defined herein, and shall be ordered by and provided under the direction of a physician; and
 - f. Coverage includes visits with a Psychiatrist or Physician during treatment.

Exclusion: Services or supplies that maintain rather than improve a level of physical, mental or emotional function, or where it has been determined that the services shall not result in significant improvement in, or stabilization of, the Covered Person's mental or nervous condition within a 60 day period;

3. **Outpatient Services.** The covered person's psychiatric physician or Health Plan shall specifically approve a written plan of treatment. Covered services shall be related to:
 - a. Treatment of a mental and nervous condition, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy.
 - b. Management of medications that are indicated to stabilize and maintain the Covered Person's mental status.
 - c. Administration of medications that cannot be self-administered by the patient.

Newborn well-baby nursery services, while the newborn is hospital confined immediately following birth. These services also include the services provided by certified nurse midwives and midwives licensed pursuant to chapter 467, Florida Statutes, and birthing centers licensed pursuant to chapter 383, Florida Statutes.

Nutrition Counseling, when medically necessary.

Obstetrical services, for the covered employee or covered spouse, received on an inpatient or outpatient basis, including medically necessary prenatal and postnatal care of the mother. These services also include the services provided by certified nurse midwives licensed pursuant to chapter 464, Florida Statutes, and midwives licensed pursuant to chapter 467, Florida Statutes. However, medically necessary services in connection with the pregnancy of eligible children due to the following complications of pregnancy shall be covered by the Health Plan:

1. Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy;
2. Conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
3. a non-elective cesarean section;
4. an ectopic pregnancy which is terminated; and
5. a spontaneous termination of pregnancy, which occurs before the twenty-second (22nd) week of gestation.

NOTE: Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy which do not constitute a nosologically distinct complication of pregnancy.

Oral surgery, for the surgical treatment of a non-dental injury to teeth, fractured or dislocated jaw, excision of tumors, cysts, abscesses and lesions of the mouth, and surgical treatment of temporomandibular joint (TMJ) syndrome when medically necessary. This benefit includes coverage for services related to an accident or injury occurring while, and as a result of, biting or chewing.

Oxygen, including the use of equipment for its administration.

Pap smears.

Pathologist services, on an inpatient or outpatient basis related to covered services.

Pre-admission tests, if medically necessary and when ordered or authorized by the covered person's primary care physician or Health Plan. However, the following conditions shall be met:

1. The tests shall be ordered or authorized by the covered person's primary care physician; and
2. The tests shall be performed in a facility accepted by the hospital and the Health Plan in place of the same tests which would normally be done while hospital confined.

Prescription Drugs, When a participating provider prescribes a drug, you may have your prescription filled at any of the FHCP's participating pharmacies, a list of which are included in FHCP's Provider Directory. Prescription drugs are subject to FHCP's preferred drug list and the provisions noted below.

To fill a prescription, simply present your FHCP ID card to the pharmacist along with the script. You will pay a copayment for up to a 30 day supply per prescription. The copayments are reflected on your benefit schedule.

The Florida Boards of Medicine and Pharmacy, pursuant to chapter 465, Florida Statutes, have established a negative drug formulary. No drug substitution shall be allowed for the following:

1. Digitoxin
2. Conjugated estrogen
3. Dicumarol
4. Chlorpromazine (solid oral dosage forms)
5. Theophylline (controlled release)
6. Pancrelipase (oral dosage forms)

Drugs That Are Covered by FHCP

- Covered drugs shall include:
- Insulin
- Needles and syringes with insulin
- Oral Contraceptives
- FDA-approved glucose strips and tablets
- Prepackaged items, such as insulin with needles or syringes, dispensed for the number of days' usage prescribed, or package quantity, whichever is greater.
- Prescription refills once a usage percentage of the previous prescription, as established by FHCP, has been met based on the dosage schedule prescribed by the physician or other participating provider.
- Prescription Drugs to deter smoking. This benefit is limited up to a six-month supply per calendar year, with a lifetime maximum benefit of no more than nine months.

Drugs That Are Not Covered By FHCP

- Any drug, medicine or medication that is consumed at the place where the prescription is given (provider's office or health care facility).
- Any drug, medicine or medication that is dispensed by a physician or other participating provider (other than a pharmacy).
- Prescription refills in excess of the number specified by the physician or dispensed more than one year from the date of the physician's or other participating provider authorized to prescribe drugs within the scope of his or her license original order.
- The administration of covered medication.
- 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.
- Medication that is covered by Worker's Compensation or Occupational disease Laws or by any state or governmental agency.
- Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in FHCP.
- 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.
- Immunizing agents
- Non federal legend or over-the-counter drugs;
- Devices or appliances, including, but not limited to, hypodermic needles/syringes (exception: those items associated with an insulin prescription or prepackaged with other medications), support garments, and other non-medical substances, regardless of intended use;
- Retin-A for cosmetic purposes;
- Anti-obesity drugs;
- Erectile Dysfunction drugs;
- Over the counter Nicotine suppressants and smoking cessation products and services;
- Amphetamines and/or anorexians for weight loss;
- Hormone treatment in preparation for sexual reassignment;
- Any costs related to the mailing, sending or delivery of prescription drugs; and
- Prescriptions filled at a non-participating pharmacy, except for prescriptions required during emergency care.

See pages 34 to 37 for a complete listing of plan limitations and exclusions.

Preventive medical services, shall include but are not limited to:

A periodic health assessment examination performed or authorized by the covered person's primary care physician, which may include:

1. A health history;
2. A physical examination; to include height, weight and blood pressure
3. Laboratory tests which include urinalysis for blood, sugar, and acetone, and hemoglobin and cholesterol, Triglyceride; HDL/LDL
4. A stool for occult blood;
5. A tuberculin skin test;
6. Tests for sexually transmitted diseases; to include HIV and Chlamydia
7. Vision screening; and
8. Hearing screening.

For women, this examination may include a mammogram or a gynecological exam that also includes a manual breast exam, a pelvic exam, and a pap smear. For men, this examination may include a prostate gland screening.

This shall not include exams required for travel, or those needed for school, employment, insurance, or governmental licensing, unless the service is within the scope of, and coinciding with, the periodic health assessment exam. Only one exam per calendar year is allowed.

Prosthetic or orthotic devices, if medically necessary, including the initial placement of the most cost effective prosthetic or orthotic device, fitting, adjustments, and repair. Only when attached to a brace shall shoe orthotics be covered. The Health Plan shall also cover the replacement of such prosthetic or orthotic devices if it is determined by the covered person's primary care physician or the Health Plan to be necessary because of growth or change.

Radiologist services, on an inpatient or outpatient basis for covered services.

Rehabilitative services, including spine and back disorder treatment, manipulative services, physical, and speech therapy. The covered person's primary care physician or Health Plan shall specifically approve a written plan of treatment and agree that the covered person's condition should improve significantly within 60 days of the date therapy begins.

Coverage includes the services of licensed physical therapists, respiratory or inhalation therapists, chiropractors and physicians, and speech therapists, for the purpose of aiding in the restoration of normal physical function.

Rehabilitative services provided while the covered person is hospital confined shall be covered for the duration of the hospital confinement. Outpatient rehabilitative services are limited to 60 visits per injury.

Rehabilitative services do not include:

1. Services or supplies provided to a covered person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services;
2. Services or supplies that maintain rather than improves a level of physical function, or where it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60 day period; or
3. Other therapy types including recreational, educational, marital or sleep therapy.

Respiratory therapy, including the services of respiratory or inhalation therapists and oxygen.

Second medical opinions, may be obtained if the Health Plan or covered person requests it for an elective surgery, or when a covered person questions the appropriateness or necessity of a covered surgical procedure, or is subject to a serious injury or illness.

With prior notice to the Health Plan, the covered person may obtain the second medical opinion from any licensed physician within the Health Plan's service area. All medically necessary tests relating to the second medical opinion may, however, be conducted by participating providers of the Health Plan.

If a participating physician is selected by the covered person, there shall be no cost to the covered person other than any applicable copayment. If a non-participating physician is selected by the covered person, the Health Plan shall pay 60 percent of the usual and customary charges for those services in the community in which they were rendered as determined by the

Health Plan and the covered person shall be responsible for the remainder of the fee.

The Health plan may restrict the use of second medical opinions in connection with a particular diagnosis or treatment to a maximum of three per calendar year.

Once a second medical opinion has been rendered, the Health Plan shall review and determine the treatment obligations of the Health Plan and that judgment shall be controlling. Any treatment obtained by the covered person that is not authorized by the Health Plan shall be at the covered person's expense.

Skilled nursing facility services shall be covered only if the covered person's primary care physician or Health Plan approves a written plan of treatment submitted by a physician and only if the covered person's primary care physician or Health Plan agrees that such skilled level services shall be provided in lieu of hospitalization or continued hospitalization and shall be subject to the following:

1. The covered person's primary care physician certifies the need for the skilled nursing facility and the covered person receives skilled nursing care or services on a daily basis;
2. The transfer to the skilled nursing facility shall be because the covered person requires skilled care for a condition (or related condition) which was treated in the hospital;
3. The covered person shall be admitted to the skilled nursing facility immediately following discharge from the hospital;
4. Services and supplies are limited to 60 days of confinement per calendar year and may include: room and board; respiratory therapy (e.g., oxygen); drugs and medicines administered while an inpatient; intravenous solutions; dressings, including ordinary casts; anesthetics and their administration; transfusion supplies and equipment; diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG)); chemotherapy treatment for proven malignant disease; and other medically necessary services and supplies; and
5. Services shall be skilled level services, and shall be ordered by and provided under the direction of a physician.

Sterilization, limited to tubal ligations and vasectomies when medically appropriate.

Surgical procedures, performed on an inpatient or outpatient basis.

Transplantation of a covered tissue and organ transplant, as defined in this section, if approved by the Health Plan, and if performed at a facility approved by the Health Plan subject to the conditions and limitations described in this section and if in accordance with generally accepted professional medical standards and not experimental or investigational.

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

1. Cornea;
2. Heart;
3. Heart/lung;
4. Whole single lung or whole bilateral lung;
5. Liver;
6. Kidney;
7. Kidney/pancreas; and
8. Bone marrow.

Coverage for bone marrow transplant procedures shall be updated as rules are recommended by the Bone Marrow Transplant Advisory Panel and adopted by the Secretary of the Department of Health and Rehabilitative Services pursuant to section 627.4236, Florida Statutes.

As used in this Health Plan, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the

term “bone marrow transplant” includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved for this transplant benefit, prior approval from the Health Plan shall be required in advance of the procedure. The covered person’s primary care physician shall notify the Health Plan in advance of the covered person’s initial evaluation for the procedure in order for the Health Plan to determine if the transplant services shall be covered. For approval of the transplant itself, the Health Plan shall be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval shall be based on written criteria and procedures established by the Health Plan. The transplant procedure shall be performed in a facility that has been authorized by the Health Plan. If approval is not given, benefits shall not be provided for the transplant procedure.

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

1. The organ involved is not listed in this section;
2. The Health Plan is not contacted for authorization prior to referral for transplant evaluation of the procedure;
3. The Health Plan does not approve coverage for the procedure;
4. Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received;
5. The expense relates to the transplantation of any non-human organ or tissue;
6. The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ;
7. The organ is sold rather than donated to the covered person;
8. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan; or
9. A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of such transplant.

The following services and supplies shall not be covered:

1. Artificial heart devices used as a bridge to transplant;
2. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; and
3. Any service or supply in connection with identification of a donor from a local, state, or national listing.

Once the transplant procedure is approved, the Health Plan shall advise the covered person’s primary care physician of those facilities that have been authorized for the type of transplant procedure involved. Benefits shall be payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in a facility that has been licensed as a transplant facility.

For approved transplant procedures, and all related complications, the Health Plan shall cover only the following services:

1. Hospital expenses and medical expenses shall be paid under the hospital services benefit and medical services benefit in this Health Plan, in accordance with the same terms and conditions as the Health Plan shall pay benefits for care and treatment of any other covered condition; and
2. Organ acquisition and donor costs. However, donor costs shall not be payable under this Health Plan if they are payable in whole or in part by any other insurance health plan, organization or person other than the donor’s family or estate.

EXCLUSIONS AND LIMITATIONS

FOLLOWING COVERAGE ACCESS RULES

If covered persons do not follow the coverage access rules described in this section, the covered person risks having services and supplies received not covered by this Health Plan. In such a circumstance, the covered person would be responsible for reimbursing the Health Plan.

Also, covered persons shall understand that the ordering of a service by a physician does not in itself make such service medically necessary or a covered service.

EXCLUSIONS AND LIMITATIONS

The following services and supplies may be limited or excluded from coverage under this Health Plan unless a specific exception is noted. Exceptions may be subject to certain coverage limitations.

Abortion: elective abortions performed at any time during a pregnancy; or services in connection with the pregnancy of eligible children; however, medically necessary services due to the following complications of pregnancy are covered by the Health Plan:

1. Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy;
2. Conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
3. a non-elective cesarean section;
4. an ectopic pregnancy which is terminated; and
5. a spontaneous termination of pregnancy, which occurs before the twenty-second (22nd) week of gestation.

NOTE: Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy which do not constitute a nosologically distinct complication of pregnancy.

Acupuncture services.

Alcohol or Substance Abuse Coverage Exclusions:

1. Chronic maintenance alcohol/drug, mental health or behavioral therapy that is not intended to rehabilitate the patient to an appropriate functional level for the patient's medical, mental and/or nervous condition.
2. Other therapy types including but not limited to recreational, educational, marital or sleep therapy;
3. Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes services rendered by group homes (facilities), residential homes, long-term residential mental health facilities, residential (i.e. "half-way") houses, home health aides (sitters), home mothers, domestic maid services, and respite care.
4. Services rendered by non-licensed counselors, friends, or peer support groups.

Arch supports, orthopedic shoes, sneakers, or support hose, or similar type devices/appliances regardless of intended use.

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

Biofeedback services, and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, mind expansion, elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard seminar training (EST).

Complications of non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service (e.g., services or supplies to treat a complication of cosmetic surgery shall not be covered under this Health Plan).

Cosmetic surgery (plastic and reconstructive surgery), and any other service and supply to improve the covered person's appearance or self-perception, such as electrolysis, procedures or supplies to correct baldness, or the appearance of skin (wrinkling).

Costs incurred by the Health Plan, related to:

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

Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services, and respite care.

Dental care or any treatment relating to the teeth, jaws, or adjacent structures (e.g., periodontium), including but not limited

to: extraction or cleaning of the teeth; implant, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic, or orthognathic treatment; rapid palatal expanders; continuous passive motion (CPM) devices.

Dietary regimens, treatments, food, food substitutes, vitamins or exercise programs for reducing or controlling weight.

Experimental or investigational treatment, as defined in the glossary.

Eye care, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the covered benefits section;
2. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; and
3. Training or orthoptics, including eye exercises.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease, injury or accident. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Health Plan to be medically necessary.

Hearing aids, (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers; however, hearing tests shall be a covered service when associated with covered ear surgery.

Hypnotism, medical hypnotherapy or hypnotic anesthesia.

Immunizations and physical examinations, 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.

Infertility treatment and supplies, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Marital therapy.

Massage therapy.

Mental Health Coverage Exclusions:

1. Chronic maintenance mental health or behavioral therapy that is not intended to rehabilitate the patient to an appropriate functional level for the patient's mental and/or nervous condition.
2. Other therapy types, unless such therapy is ordered by a physician to specifically treat a mental or nervous condition. Other therapy types include, but are not limited to, recreational, educational, marital or sleep therapy;
3. Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes services rendered by group homes (facilities), residential homes, long-term residential mental health facilities, residential (i.e. "half-way") houses, home health aides (sitters), home mothers, domestic maid services, and respite care.

Military service-connected medical care, 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.

Non-prescription drugs and supplies, including any non-prescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods, or blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.

Obesity and weight reduction treatment, including surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be medically necessary by the Health Plan such as intestinal or stomach by-pass surgery and a weight loss program required by the covered person's primary care physician prior to surgery.

Occupational therapy, unless provided as a home health care service or hospice service.

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

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not medically necessary by the Health Plan and not directly related to the care of the covered person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than medically necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel accommodations, air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment.

Recreational therapy.

Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies.

Services or supplies, that are:

1. Determined not to be medically necessary;
2. Not specifically listed in the covered benefits section unless such services are specifically required to be covered by state or federal law. This Health Plan shall provide coverage on a primary or secondary basis as required by state or federal law;
3. Court ordered care or treatment, unless otherwise covered in this Health Plan;
4. For the treatment of a condition resulting from:
 - a. War or an act of war, whether declared or not;
 - b. Participation in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony;
 - c. Engaging in an illegal occupation;
 - d. Services in the armed forces; or
5. Received prior to a covered person's effective date or received on or after the date a covered person's coverage terminates under this Health Plan, unless coverage is extended in accordance with the extension of benefits provision in the administrative provisions section;
6. Provided by a physician or other health care provider who normally resides in the covered person's home;
7. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;
8. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;
9. Supplied at no charge; or
10. Determined by the Health Plan not to be the most cost-effective setting, procedure, or treatment.

Sexual reassignment, reproduction or modification services, including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prosthesis, genetic tests to determine paternity or sex of a child, or the insertion of penile prosthesis except when necessary in the treatment of organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, postprostatectomy, postpriapism, and epispaidas and exstrophy.

Sleep therapy.

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and Nicorette gum or patch.

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

Transfusion, autologous.

Transportation services, that is non-emergency transportation between institutional care facilities, or to and from the covered person's residence.

Volunteer services, or services which would normally be provided free of charge to a covered person.

Weight control/loss programs, including but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

Wigs.

Work related condition services, to the extent the covered person is covered or required to be covered by a workers' compensation law. If the covered person enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, this Health Plan shall not cover past or future medical services that are the subject of or related to that settlement. In addition, if the covered person is covered by a workers' compensation program that limits benefits if other than specified health care providers are used and the covered person receives care or services from a health care provider not specified by the program, this Health Plan shall not cover the balance of any costs remaining after the program has paid.

GLOSSARY

ACCIDENT shall mean accidental bodily injury sustained by the covered person which results in and is the direct cause of medical expenses independent of illness.

ACCIDENTAL DENTAL INJURY shall mean an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional, and unexpected event or force. It shall include injuries caused by biting or chewing.

AMBULANCE shall mean any private or publicly owned land, air, or water vehicle licensed pursuant to chapter 401, part III, Florida Statutes, or for services rendered outside Florida other states' applicable laws, that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, air, land, or water transportation of persons who are in need of medical or surgical attention.

AMBULATORY SURGICAL CENTER a facility

- licensed by the appropriate state agency to provide surgical care
- to which a patient is admitted and discharged within the same working day, and
- that is not part of a hospital.

BIRTH CENTER shall mean any facility, institution, or place, where births are planned to occur following a normal, uncomplicated, low risk pregnancy. The facility must be licensed under state law. A facility is not considered a birth center if it is an ambulatory surgical center, a hospital or part of a hospital.

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

COMPLAINT means any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to FHCP's contract and which is submitted to FHCP or to the Agency For Health Care Administration or Department of Insurance, a state agency. A complaint is a part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined herein.

CONDITION shall mean any disease, illness, injury, accident, bodily dysfunction, pregnancy, drug addiction, alcoholism or mental or nervous disorder. For any preventive care benefits provided in this Health Plan, condition shall include the prevention of sickness.

CONFINEMENT shall mean an approved medically necessary stay as an inpatient in a hospital that is:

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

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

CONTRACT OR GROUP CONTRACT means this agreement between FHCP and the Group together with the Member Handbook, executed subscriber enrollment forms, executed subscriber enrollment change of status form and the schedules, appendices, and endorsements attached or appended hereto.

COPAYMENT shall mean those amounts payable by the covered person, at the time of service, as specifically set forth in the schedule of member copayments. The copayment shall be expressed as a dollar amount.

COVERED PERSON shall mean eligible employees, retirees, surviving spouses, COBRA participants, or any eligible dependents included for coverage under this Health Plan.

COVERED SERVICES OR SUPPLIES shall mean healthcare services and supplies, including pharmaceuticals and chemical compounds, which are medically necessary or preventive medical services and child health supervision services not otherwise excluded by the Health Plan.

CUSTODIAL CARE shall mean care or services that:

- are maintenance in nature,
- can be provided by or taught to home caregivers,
- do not require the skill of a registered nurse,
- are designed to help the covered person with daily living activities, such as: help walking, getting in and out of bed, bathing, dressing, eating, or taking medicine, and
- are not expected to improve the covered person's medical condition.

Care or services that meet this definition are not covered by the Health Plan. See exclusion on page 18.

ELECTIVE ADMISSION shall mean a hospital admission which is not of an urgent or emergency nature and can be scheduled in advance and at a time which is convenient for the covered person and the covered person's physician without risking the covered person's well being.

ELECTIVE SURGERY shall mean surgery of a non-emergency nature in which the covered person can elect when, or if, surgery can be done.

EMERGENCY CARE means covered inpatient or outpatient services which are furnished in or out of the Service Area and are needed immediately because of an injury or sudden illness and are needed because the time required to reach a FHCP Provider may have meant risk of permanent damage to your health.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT shall mean any evaluation, treatment, therapy, or device that:

1. cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health if approval for marketing has not been given at the time such is provided to the covered person;
2. is the subject of an ongoing Phase I, or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or is under study to determine: maximum dosage, toxicity, safety, efficacy, or efficacy or to determine the efficacy as compared to standard treatment for the condition;
3. is generally regarded by experts as requiring more study to determine: maximum dosage, toxicity, safety, efficacy, or to determine the efficacy compared to standard treatment for the condition;
4. has not been proven safe and effective for the treatment of the condition based on 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;
5. is not accepted in consensus by practicing doctors as safe or effective for the condition;
6. is not regularly used by practicing doctors to treat patients with the same or similar condition.

FHCP means Florida Health Care Plans.

FHCP PHYSICIAN means a person legally qualified and licensed to practice medicine, dentistry, osteopathy, or surgery in the state of Florida and with whom FHCP has a written agreement to render services provided under this Contract under the general direction of the FHCP Medical Director.

FULL-TIME POSITION shall mean any position authorized for the normally established work period, either daily, weekly, monthly, or annually; however, in no case shall such full-time position involve less than eight months during any 12-month period.

GRACE PERIOD means that if any required subscription fees are not paid on or before the date it is due, they may be paid during the Grace Period immediately following that subscription fees due date.

GRIEVANCE means a written complaint submitted by or on behalf of the subscriber to FHCP or a state agency regarding the:

- A. Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- B. Claims payment, handling, or reimbursement for health care services, or
- C. Matters pertaining to the contractual relationship between a subscriber and FHCP.

A grievance does not include a written complaint submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVII of the Social Security Act.

GROUP EFFECTIVE DATE shall mean the effective date of the contract with the Health Plan.

HEALTH CARE PROVIDER OR PROVIDERS shall mean comprehensive outpatient rehabilitative facilities, dialysis centers, durable medical equipment suppliers, and the following health care professionals and facilities licensed pursuant to the noted chapter in Florida Statutes, or for services rendered outside Florida other states' applicable laws: advanced registered nurse practitioners (464), ambulance (401), ambulatory surgical centers (395), anesthesiologists (458), audiologists (468), birthing centers (383), certified nurse midwives (464), certified registered nurse anesthetists (464), chiropractors (460), clinical laboratories (483), clinical social workers (491), dentists (466), home health agencies (400), hospice (400), hospitals (395), lithotripsy facilities (395), marriage and family therapists (491), mental health counselors (491), midwives (467), nurse clinicians (464), nurse practitioners (464), nurses (464), opticians (484), optometrists (463), oral surgeons (458), osteopaths (459), pharmacies (465), pharmacists (465), physical therapists (486), physicians (458), physician assistants (458, 459, 460), podiatrists (461), psychologists (490), rehabilitation facilities (395), residential treatment facilities (394), respiratory therapists (468), skilled nursing facilities (400), speech-language pathologists (468), specialty facilities (394), substance abuse facilities (394).

HEALTH PLAN shall mean Florida Health Care Plans (FHCP)

HOME HEALTH AIDE shall mean a person certified by an accredited junior college or vocational technical school as having completed an approved course of study.

HOME HEALTH AGENCY an institution or agency licensed by the appropriate state agency to provide an approved plan of service for people who are confined and convalescing at home instead of the hospital. A home health agency may operate independently or as part of a hospital.

HOSPICE an autonomous, centrally administered, nurse-coordinated program providing home, outpatient and inpatient care for a covered person who is terminally ill and members of the covered person's family. At a hospice, a team of healthcare providers assist in providing palliative and supportive care to meet the special needs arising during the final stages of illness and during dying and bereavement. The team of providers includes a doctor and nurse and may also include a social worker, a clergy member or counselor and volunteers.

HOSPITAL licensed institution providing medical care and treatment to a patient as a result of illness, accident or mental or nervous disorder on an inpatient or outpatient basis at the patient's expense and that meets all the following:

1. It is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities. Licensed institutions in rural, sparsely-populated geographic regions, however, may not be accredited.
2. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed doctors. A facility may be considered a hospital if it does not have major surgical facilities but provides primarily rehabilitative services for treatment of physical disability.
3. It continuously provides 24 hours a day nursing service by or under the supervision of registered graduate nurses.

The term hospital shall not include a specialty institution or residential facility; or a U.S. Government hospital or any other

hospital operated by a governmental unit, unless a charge is made by such hospital that the patient is legally required to pay without regard to the existence of insurance.

ILLNESS shall mean physical sickness or disease, pregnancy, bodily injury, or congenital anomaly.

INJURY shall mean an accidental bodily harm that:

1. Is caused by a sudden and unexpected event or force;
2. Is sustained while the covered person's coverage is in force; and
3. Results in and is the direct cause of medical expenses independent of illness.

INPATIENT shall mean a covered person who has been admitted upon the orders of a physician as a bed patient for medically necessary services and/or treatment in a hospital or other covered facility.

INTENSIVE CARE UNIT shall mean a specialized area in a hospital where an acutely ill, inpatient receives intensive care or treatment. Included in the hospital's charge for such units are the services of specially trained professional staff and nurses, supplies, the use of any and all equipment and the patient's board. A coronary care unit is also considered an intensive care unit.

INTER-DISCIPLINARY TEAM shall mean the working unit composed by the integration of the various helping professionals and lay persons providing hospice care. Such team shall, at a minimum, consist of a physician licensed pursuant to chapter 458 or 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a nurse licensed pursuant to chapter 464, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a social worker licensed pursuant to chapter 491, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a member of the clergy or counselor, and volunteers. Such team shall be primarily concerned with controlling the physical, sociological and psychological symptoms of degenerative disease.

MANIPULATIVE SERVICES shall mean a term of physical medicine involving the skillful and trained use of the hands to treat diseases or symptoms resulting from misalignment of the spine. Manipulative services do not include massage therapy.

MEDICAL SUPPLIES OR EQUIPMENT shall mean supplies or equipment that are:

1. Ordered by a physician;
2. Of no further use when medical need ends;
3. Usable only by the covered person;
4. Not primarily for the patient's comfort or hygiene;
5. Not for environmental control;
6. Not for exercise; and
7. Manufactured specifically for medical use.

MEDICALLY NECESSARY services required to identify or treat the illness, injury or mental or nervous disorder a physician has diagnosed or reasonably suspects. The service must:

1. Be consistent with the symptom, diagnosis and treatment of the patient's condition;
2. Be in accordance with standards of good medical practice;
3. Be required for reasons other than convenience of the patient or the doctor;
4. Be approved by the appropriate medical body or board for the illness or injury in question; and
5. Be the most appropriate, level of medical supply, service, or care which can be safely provided.

The fact that a service is prescribed by a doctor does not necessarily mean the service is medically necessary or a covered service. The Health Plan determines whether a service or supply is medically necessary.

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

MEDICARE I shall mean individual coverage for retirees or surviving spouses who are eligible for Medicare.

MEDICARE II shall mean family coverage for retirees or surviving spouses with one or more eligible dependents where at least one, but not all, covered persons are eligible for Medicare.

MEDICARE III shall mean family coverage for retirees and their spouses only, both of whom are eligible for Medicare.

MENTAL AND NERVOUS DISORDER shall mean any and all disorders listed 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.

MENTAL HEALTH PROVIDERS shall mean psychiatrists licensed pursuant to chapter 458 and 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws; psychologists licensed pursuant to chapter 490, Florida Statutes, or for services rendered outside Florida other states' applicable laws; clinical social workers, marriage and family therapists, and mental health counselors licensed pursuant to chapter 491, Florida Statutes, or for services rendered outside Florida other states' applicable laws; medical doctors licensed pursuant to chapter 458, Florida Statutes, or for services rendered outside Florida other states' applicable laws; and doctors of osteopathy licensed pursuant to chapter 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws.

MID-WIFE shall mean a person licensed pursuant to chapter 467, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to practice midwifery including a certified nurse midwife licensed pursuant to chapter 464, Florida Statutes, or for services rendered outside Florida other states' applicable laws.

NON-PARTICIPATING HOSPITAL shall mean a hospital which has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PHARMACY shall mean a pharmacy that has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PHYSICIAN shall mean a physician who has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PROVIDER shall mean a hospital, a physician, or a health care provider who has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NO-SHOW means a missed appointment with a FHCP Provider where the Member has failed to notify the Provider of such cancellation at least 24 hours in advance of the appointment.

NURSING SERVICES shall mean services provided by an advanced registered nurse practitioner (A.R.N.P.), registered nurse (R.N.), or a licensed practical nurse (L.P.N.), who is licensed pursuant to chapter 464, Florida Statutes and:

1. Acting within the scope of that person's license; or
2. Authorized by a physician; and
3. Not a member of the covered person's immediate family.

OUTPATIENT shall mean a patient who is receiving medically necessary care or treatment ordered by a physician and who is not an inpatient.

OUTPATIENT HEALTH CARE FACILITY shall mean a licensed facility other than a doctor's, physical therapist's, or midwife's office, that provides medically necessary outpatient services for treatment of an illness or injury - other than mental or nervous disorders, drug addiction or alcoholism

PALLIATIVE CARE shall mean the reduction or abatement of pain and other troubling symptoms through services provided by members of the hospice team of healthcare providers.

PARTICIPATING HOSPITAL shall mean a hospital which has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PHARMACY shall mean a pharmacy which has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PHYSICIAN shall mean a physician who has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PROVIDER shall mean a hospital, doctor, pharmacy, medical laboratory or other health care provider who has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PART-TIME POSITION shall mean any position authorized for less than the entire normally established work period, either daily, weekly, monthly, or annually.

PHARMACIST shall mean a person who is licensed pursuant to chapter 465, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

PHARMACY shall mean an establishment licensed pursuant to chapter 465, Florida Statutes, or for services rendered outside Florida other states' applicable laws, where prescription medications are dispensed by a pharmacist.

PHYSICAL THERAPIST shall mean a person who is duly registered or licensed pursuant to chapter 486, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to engage in physical therapy practice.

PHYSICIAN shall mean a person properly licensed to practice medicine pursuant to Florida Statutes, as noted, or for services rendered outside Florida other states' applicable laws, including:

1. A doctor of medicine (458) or doctor of osteopathy (459);
2. A licensed dentist (466) who performs specific surgical or non-dental procedures covered by the Health Plan, or who renders services due to injuries resulting from accidents, provided such procedures or services are within the scope of the dentist's professional license;
3. A licensed optometrist (463) who performs procedures covered by the Health Plan provided such procedures are within the scope of the optometrist's professional license;
4. A licensed podiatrist (461) who performs procedures covered by the Health Plan provided such procedures are within the scope of the podiatrist's professional license;
5. A licensed psychologist (section 490.003(3)) when providing a medically necessary covered service; or
6. A licensed chiropractor (460) who performs procedures covered by the Health Plan provided such procedures are within the scope of the chiropractor's professional license.

PLAN shall mean the State of Florida Employees' Group Insurance Program.

POLICY shall mean the written document which describes the covered benefits provided under the State of Florida Employees' Group Insurance Program.

PRESCRIPTION shall mean a direct order for the preparation of a medication for the benefit of and use by a covered person. This order may be given to the pharmacist verbally or in writing by the physician or other participating provider authorized to prescribe drugs within the scope of his or her license. The medication shall be obtainable only by prescription.

PRESCRIPTION DRUGS shall mean drugs and medicines requiring a written prescription for drugs approved by the United States Food and Drug Administration and dispensed by a licensed pharmacist. Over-the-counter drugs, investigational or experimental drugs, oral contraceptives for contraception, drugs used for cosmetic purposes, Nicorette and similar drugs used to deter smoking are not included for coverage even though a physician or other participating provider authorized to prescribe drugs within the scope of his or her license may write a prescription for such.

PRIMARY CARE PHYSICIAN shall mean a participating doctor who has been chosen by the covered person to be responsible for providing, prescribing, directing, and authorizing all care and treatment of the covered person.

PRIVATE ROOM shall mean a hospital room with one bed accommodation in which an inpatient receives board and general nursing care included in the hospital's charge for such room.

PROGRESSIVE CARE UNIT shall mean a specialized area in a hospital furnished with appropriate equipment for monitoring and medically supervising inpatients who are no longer considered to be critical or require intensive care or treatment but who have not improved enough to be returned to a routine hospital care environment.

PSYCHIATRIC FACILITY shall mean a facility licensed pursuant to chapter 394, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to provide for the medically necessary care and treatment of mental and nervous disorders. For the purposes of this Health Plan, a psychiatric facility is not a hospital, as defined in this Health Plan.

RESIDE or RESIDENCE means those living quarters actually occupied by a Member, on a permanent basis, for purposes of eating, sleeping and other domestic activities.

SEMI-PRIVATE ROOM shall mean a hospital room with two bed accommodations in which an inpatient receives board and general nursing care included in the hospital's charge for such room.

SERVICE AREA the geographic area shown in the service area attachment to this Health Plan, as approved by the Florida Department of Financial Services.

SICKNESS shall mean a bodily disease for which expenses are incurred while coverage under this Health Plan is in force.

SKILLED NURSING CARE shall mean care which is furnished by, or under the direct supervision of, licensed registered nurses (under the general direction of the physician) to achieve the medically desired result and to ensure the covered person's safety. Skilled nursing care may include providing direct care, when the ability to provide the service requires specialized and/or professional training; observation and assessment of the covered person's medical needs; or supervision of a medical treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired medical results.

SKILLED NURSING FACILITY shall mean an licensed institution or a distinct part of a hospital, primarily engaged in providing inpatients:

1. Skilled nursing care by or under the supervision of a licensed registered nurse;
2. Rehabilitative services by or under the supervision of licensed physical therapists;
3. Other medically necessary related health services.

SPECIALTY INSTITUTION OR RESIDENTIAL FACILITY shall mean a licensed facility providing an inpatient rehabilitation program for the treatment alcohol or drug abuse or mental or nervous conditions. The program must be accredited by the Joint Commission of the Accreditation of Hospitals (JCAH) and licensed by the Department of Children and Family Services.

STATE shall mean the state of Florida.

STATE OFFICER shall mean any constitutional state officer, any elected state officer paid by state warrant, or any appointed state officer who is commissioned by the Governor and who is paid by state warrant.

TERMINALLY ILL means a person has a life expectancy of one year or less because of a chronic, progressive illness that is incurable according to the person's doctor.

TREATING PHYSICIAN shall mean the physician responsible for providing primary or specialty care to a covered person on an inpatient or outpatient basis.

WELL-BABY NURSERY SERVICES services and supplies associated with the care of a healthy newborn child.

Blue Card[®] Program

Introduction

When amounts are paid or payable by Florida Health Care Plans, Inc. (FHCP) under this Handbook to a provider outside the State of Florida who is not in FHCP's network, payment to the out-of-state provider may be determined based on the provider arrangements, if any, that the Blue Cross and/or Blue Shield Plan has with the provider in the area where Services are provided. In those instances the Blue Cross and/or Blue Shield Plan in that area is called a "Host Blue." FHCP will

coordinate with the appropriate Host Blue when payment and financial responsibilities are to be so handled. This is done by use of a special national program of the Blue Cross and Blue Shield Association called the BlueCard® Program.

Program

When the Member obtains Covered Services through the BlueCard® Program outside of the State of Florida, the terms and conditions of this Member Handbook will still apply. FHCP will reimburse the Host Blue for Covered Services calculated on the lower of:

- the billed charges for the Member's Covered Services; or,
- the negotiated price that the on-site Host Blue passes on to FHCP.

The amount of reimbursement to the Host Blue does not include any amount the Member is required to pay under this Member Handbook.

Often the negotiated price will consist of a simple discount that reflects the actual price paid by the Host Blue. However, sometimes it is an estimated final price that factors into the actual price, expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Member's health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with the Member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than the estimated price. The negotiated price will also be prospectively adjusted in the future to correct for over- or underestimation of past prices. However, the amount the Member pays for Covered Services is considered a final payment.

A Member's financial responsibilities may vary depending upon the provider chosen under the BlueCard Program, the Member's copayment, coinsurance and/or deductible and the services rendered. For information or assistance on the BlueCard® participation status of providers, call the FHCP Member Services Department telephone number listed on the back of the Membership Card.

Under the BlueCard® Program, the Member's financial responsibility may include:

1. The payment of any applicable Deductible, Copayment and/or Coinsurance requirements;
2. The payment of expenses that are limited, excluded, or not covered;
3. The payment of any expenses in excess of any benefit maximum limitations; and
4. The payment of any expenses for Services where coverage authorization from FHCP was required and not obtained.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard® Program method noted above or require a surcharge, FHCP would then calculate the Member's liability for any Covered Services in accordance with the applicable state statute in effect at the time the Member received his or her care.