

Administrative Services Agreement

Relative to the EPN Benefit Plan

Between

AvMed, Inc. d/b/a AvMed Health Plan

And

City of Fort Lauderdale

Effective March 1, 2003

and

Amended January 1, 2004

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9400 S. DADELAND BLVD.
P.O. BOX 569004
MIAMI, FL 33256-9004

SERVICE AREAS

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Miami, FL 33156-9004
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(800) 432-6676
Miami-Dade County

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

JACKSONVILLE
1300 Riverplace Blvd.
Suite 200
(904) 858-1300
(800) 227-4184
Baker
Clay
Duval
Nassau
St. Johns

GAINESVILLE
4300 NW 89TH Blvd.
P. O. Box 749
Gainesville, FL 32606-0749
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(800) 346-0231
Alachua
Bradford
Citrus
Columbia
Dixie
Gilchrist
Hamilton
Levy
Marion
Suwannee
Union

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541 South Orlando Ave.
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Orange
Osceola
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1511 N. Westshore Blvd.
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Tampa, FL 33607
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Hernando
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Lee
Pasco
Pinellas
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Sarasota

ALL AREAS
1-800-88 AvMed
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ADMINISTRATIVE SERVICES AGREEMENT

This Agreement, made effective this 1ST day of March, 2003, by and between City of Fort Lauderdale, (the "Employer") and AvMed, Inc., a Florida corporation, d/b/a AvMed Health Plan ("AvMed").

WITNESSETH:

WHEREAS, the Employer, in its role as plan sponsor, has adopted and self-insures the program of employee health benefits described in Exhibit A (the "Plan") for the benefit of its eligible employees and their eligible dependents; and

WHEREAS, the Employer has requested AvMed to furnish certain administrative services to the Plan, including (i) receiving and processing claims for benefits under the Plan, (ii) disbursing claim payments under the Plan, and (iii) performing Plan-related administrative duties specified in Exhibit B "Basic Administrative Services"; and

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

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

I. GENERAL

The Employer engages AvMed to arrange for the provision of medical services or benefits which are Medically Necessary for the diagnosis and treatment of Members of the Employer through a network of contracted independent physicians and hospitals and other health care providers. Said services are provided in accordance with the covenants and conditions contained in this Agreement.

This Agreement is not intended to and does not cover or provide any medical services or benefits which are not Medically Necessary for the diagnosis and treatment of the Member. The determination as to which services are Medically Necessary shall be made by AvMed subject to the terms and conditions of this Agreement.

AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.

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

II. INTERPRETATION

In order to provide the advantages of medical and hospital facilities and of the Participating Providers, AvMed operates on a direct service rather than indemnity basis. The interpretation of this Agreement shall be guided by the direct service nature of AvMed's program and the definitions and other provisions contained herein.

III. DEFINITIONS

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

- 3.01 **“AvMed, Inc.”**, otherwise known as “AvMed”, means a private, not-for-profit Florida corporation, state licensed as a health maintenance organization and a third party administrator under Chapters 641 and 626, Florida Statutes, which has contracted with the Employer to provide or arrange for health care services to its Members under the terms and conditions set forth in this Agreement.
- 3.02 **“Agreement”** means this administrative services agreement between the parties and all amendments, addenda, exhibits, supplemental agreements, and schedules which are or may be incorporated in this Agreement from time to time.
- 3.03 **“Contract Year”** means the period of twelve (12) consecutive months commencing on the effective date of this Agreement.
- 3.04 **“Copayment”** means the charge which the Covered Member is required to pay at the time certain health services are provided under the Plan. The Covered Member is responsible for the payment of any Copayment charges directly to the provider of the health services at the time of service.
- 3.05 **“Dependent”** means any member of a Subscriber's family who meets all applicable requirements of the Plan for dependent status, who is enrolled under the Plan and for whom the administrative service fee required by Part III has been received by AvMed.
- 3.06 **“Exclusion”** means any provision of this Agreement or the Plan whereby coverage for a specific injury, service or condition is entirely eliminated.

- 3.07 **“Experimental and/or Investigational”** means a drug, treatment, device, surgery or procedure that AvMed, in its discretion, determines to be experimental and/or investigational if any of the following applies:
- 3.07.01 The Food and Drug Administration (FDA) has not granted approval for general use; or
 - 3.07.02 There are insufficient outcomes data available from controlled, clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 - 3.07.03 There is no consensus among practitioners that the drug, treatment, therapy, procedure or device is safe or effective for the treatment in question or such drug, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or similar condition; or
 - 3.07.04 Such drug, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.
- 3.08 **“Health Professionals”** means physicians, osteopaths, podiatrists, chiropractors, physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health care services who are licensed and practice under an institutional license, individual practice association, or other authority consistent with state law and who are Participating Providers of Health Plan.
- 3.09 **“Home Health Care Services”** means services that are provided for a Member who is unable to receive medical care on an ambulatory outpatient basis and does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under this Agreement or the Plan.
- 3.10 **“Hospital”** means any general acute care facility which is licensed by the state and with which AvMed has contracted or established arrangements for inpatient hospital services and/or emergency services, and shall at times be referred to as “Plan Hospital.”
- 3.11 **“Hospital Services”** (except as expressly limited or excluded by this Agreement or the Plan) means those services for registered bed patients which are:
- 3.11.01 Generally and customarily provided by acute general Hospitals within the Service Area;

- 3.11.02 Performed, prescribed, or directed by Plan Providers; and
- 3.11.03 Medically Necessary for conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.
- 3.12 **“Hospitalist/Admitting Panelist”** means a physician who specializes in treating inpatients and who may coordinate a Member’s health care when the Member has been admitted for a Medically Necessary procedure or treatment at a hospital.
- 3.13 **“Limitation”** means any provision other than an Exclusion which restricts coverage under this Agreement or the Plan.
- 3.14 **“Medically Necessary”** means the use of any appropriate medical treatment, service, equipment, and/or supply as provided by a hospital, skilled nursing facility, physician, or other provider which is necessary for the diagnosis, care, and/or treatment of a Member’s illness or injury, and which is:
 - 3.14.01 Consistent with the symptom, diagnosis, and treatment of the Member’s condition;
 - 3.14.02 The most appropriate level of supply and/or service for the diagnosis and treatment of the Member’s condition;
 - 3.14.03 In accordance with standards of acceptable community practice;
 - 3.14.04 Not primarily intended for the personal comfort or convenience of the Member, the Member’s family, the physician, or health care provider;
 - 3.14.05 Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the Member’s condition;
 - 3.14.06 Prescribed, directed, authorized, and/or rendered by a participating or authorized provider, except in case of an emergency; and
 - 3.14.07 Not experimental or investigational.
- 3.15 **“Medical Office”** means any outpatient facility or Physician’s office in the Service Area utilized by a Participating Provider.
- 3.16 **“Medical Services”** (except as limited or excluded by this Agreement or the Plan) means those professional services of Physicians and other Health Professionals including medical, surgical, diagnostic, therapeutic, and preventative services which are:

- 3.16.01 Generally and customarily provided in the Service Area;
- 3.16.02 Performed, prescribed, or directed by Participating Providers; and
- 3.16.03 Medically Necessary (except for preventative services as stated herein) for the diagnosis and treatment of injury or illness.
- 3.17 **“Member”** means any Subscriber or Dependent, including any individual continuing coverage under The Plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time (“COBRA”), and shall at times be referred herein to as a “Member” or “Plan Member.”
- 3.18 **“Non-Participating Provider”** means any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility with whom Health Plan has neither made arrangements nor contracted to render the professional health services set forth herein, and shall at times be referred to as “Non-Plan Provider.”
- 3.19 **“Other Health Care Facility(ies)”** means any licensed facility, other than Ventilator Dependent Care Units and acute care hospitals, providing inpatient services such as skilled nursing care or rehabilitative services for which AvMed has contracted or established arrangements for providing these services to Members.
- 3.20 **“Participating Provider”** means any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility with whom Health Plan has made arrangements or contracted to render the professional health services set forth herein, and shall at times be referred to as “Plan Provider.”
- 3.21 **“Plan”** means the City of Fort Lauderdale Employee Health Plan, as described in Exhibit A, maintained by the Employer for the benefit of Employer’s eligible Subscribers and their eligible dependents.
- 3.22 **“Physician”** means any participating physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor), 461 (podiatrist), or 457 (acupuncturist) Florida Statutes, and shall at times be referred to as “Plan Physician.” “Attending Physician” means the Participating Provider Physician primarily responsible for the care of a Member with respect to any particular injury or illness.
- 3.23 **“Primary Care Physician”** means a Participating Provider Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, osteopathy, or any specialty physician from time to time designated by Health Plan as “Primary Care Physician” in AvMed’s current list of Physicians and Hospitals.
- 3.24 **“Service Area”** means those counties in the State of Florida where AvMed conducts business, as listed in the summary plan description for the Plan.

- 3.25 **“Specialty Health Care Professional”** means a Health Professional other than the Member’s Chosen Primary Care Physician.
- 3.26 **“Subscriber”** means a person who meets all applicable requirements of the Plan, enrolls in AvMed, and for whom administrative service fee required by Part V has been received by AvMed.
- 3.27 **“Utilization Management Program”** means those procedures adopted by AvMed to assure that the supplies and services provided to Members are Medically Necessary. These include, but are not limited to: (1) Pre-authorization for hospital admissions (except emergencies), outpatient surgery, and specialty referrals to tertiary care providers; (2) concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate; (3) case management for all inpatients who need continued care in an alternate setting (such as homecare or a skilled nursing facility) and for outpatients when deemed appropriate.
- 3.28 **“Ventilator Dependent Care Unit”** means any facility which provides transitional care to patients other than acute hospital care, including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers, and all other like facilities whether maintained in a free standing facility or maintained in a hospital setting. These units specifically do not include facilities known as skilled nursing facilities, rehabilitation facilities, and any other type of facility providing services similar to that of a skilled nursing facility or rehabilitation facility.

IV. ELIGIBILITY AND ENROLLMENT

- 4.01 Employer shall:
- (i) respond to all routine inquiries from Members concerning enrollment in the Plan and its terms, conditions, and operations;
 - (ii) handle all enrollment activity using enrollment forms approved by AvMed, as amended from time to time by AvMed; and
 - (iii) notify Members of their right to apply for benefits and supply them with claim filing instructions, if required.
- 4.02 In determining any person’s right to benefits under the Plan, AvMed shall rely upon eligibility information furnished by the Employer. It is mutually understood that the effective performance of this Agreement by AvMed will require that it be advised on a timely basis by the Employer during the continuance of this Agreement of the identity of individuals eligible for benefits under the Plan. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to AvMed in a form and with such other information as reasonably may be

required by AvMed for the proper administration of the Plan. Employer represents and warrants that its eligibility determinations shall be in accordance with the terms of the Plan. AvMed will assist Employer in screening new entrants for validation of dependent eligibility, including newly acquired dependents and continued monitoring of dependent child eligibility in accordance with the Plan provisions.

- 4.03 Employer acknowledges that its prompt furnishing of complete and accurate eligibility and benefit information is essential to the timely and efficient administration by AvMed of claims for benefits under the Plan. If Employer, or any party designated by Employer, fails to provide AvMed with accurate eligibility information, benefit design requirements, or other agreed-upon data, including but not limited to electronic data, tapes, or software, in an accessible and readable format, and in the time frame and format prescribed by AvMed (“Required Data”), AvMed shall have no liability whatsoever under this Agreement for any act or omission by AvMed, or its employees, affiliates, subcontractors, agents, or representatives, which is directly or indirectly caused by such failure.
- 4.04 Employer shall notify AvMed of the termination of eligibility of any Member immediately but not later than sixty (60) days after the loss of eligibility. Employer shall remain responsible for all fees, charges, and claims with respect to such terminated individual incurred or charged until such time as AvMed has processed such notice of termination. In addition, all authorizations provided prior to such notice of termination will be honored and will remain the responsibility of the Employer if AvMed is unable to recover funds on behalf of Employer in accordance with the Florida Prompt Payment legislation. The Employer has the right to recover funds from the Subscriber on behalf of any payments made on behalf of Subscriber or his Dependent.
- 4.05 The eligibility requirements set forth in the Plan shall at all times control and no coverage contrary thereto shall be effective. Coverage shall not be implied due to clerical or administrative errors if such coverage would be contrary to the terms of the Plan.

V. ADMINISTRATIVE FEES

- 5.01 On or before the first day of each month for which coverage is sought, Employer or its designated agent shall remit to AvMed, on behalf of each Subscriber and his Dependents, the monthly charges set forth in Exhibit B, Part II. Only Members for whom the stipulated payment is actually received by AvMed shall be entitled to the health services covered under this Agreement and then only for the period for which such payment is applicable. Failure of the Employer to pay fees and charges under the Agreement by the first of the month and not later than the end of the grace period (as provided in Section 5.02) shall result in retroactive termination of the Agreement, effective at 12:00 a.m. (midnight) on the last day of the month for which such amounts were paid, unless the payment of amounts due has otherwise been contractually adjusted and specified by the parties in a fully executed addendum to this Agreement. AvMed will charge the Employer a late fee of two (2) percent per month on all payments not received by the

fifteenth of the coverage month. Employer will be responsible for payment of any assessment of tax or deficiency issued by a state or other jurisdiction that is assessed for services provided to Employer. Notwithstanding the foregoing, employer shall not be responsible for any tax or assessment that AvMed would otherwise incur pursuant to its business functions unrelated to its business relationship with Employer under this Agreement, including (i) any real or property related taxes; (ii) any franchise and privilege taxes on Employer's business; (iii) any taxes based on the gross or net income received by Employer; and (iv) any taxes based on the licensing of AvMed, its affiliates or subsidiaries as a third party administrator.

- 5.02 Grace Period. This Agreement has a thirty (30) day grace period. This provision means that if any required fees and charges are not paid on or before the date they are due, they must be paid during the 30-day grace period. During the grace period, the Agreement will stay in force. However, if payment is not received by the last day of the grace period, termination of this Agreement for nonpayment of fees will be retroactive to 12:00 a.m. (midnight) on the last day of the month for which fees were paid. Note: Certain provisions in Section 5.01 may apply if the parties have executed an addendum affecting charges.
- 5.03 Refund of fees paid to AvMed by the Employer for any Member after the date on which that Member's eligibility ceased or the Member was terminated shall be limited to the total excess fees paid up to a maximum of one hundred eighty (180) days from the date of such ineligibility or termination, provided there are no claims incurred subsequent to the effective date of termination. AvMed shall not be liable for any preauthorization of services or supplies or claims paid on behalf of individuals who are retroactively determined to be ineligible for benefits under the Plan, if at the time of such preauthorization or payment, AvMed had reason to believe that such individual was eligible to participate in the Plan. No retroactive terminations of Members will be made beyond 180 days from notification of the terminating event.
- 5.04 In the event of the retroactive termination of an individual Member, AvMed shall not be responsible for expenses incurred by AvMed in providing benefits to the Member under the terms of this Agreement after the effective date of termination (due to the Employer's nonpayment of fees or failure to timely notify AvMed of Person's ineligibility). See Exhibit E for payment recovery options.

VI. TERMINATION

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

This Agreement shall continue in effect for one year from the effective date hereof and may be renewed from year to year thereafter, subject to the following termination provisions. All rights

to benefits under this Agreement shall cease at 12:00 a.m. (midnight) on the effective date of termination.

6.01 Reasons for Termination:

6.01.01 Loss of Eligibility:

- a) Upon a loss of the Subscriber's eligibility as defined under the Plan, including but not limited to the Subscriber's permanent relocation outside Service Area, coverage under the EPN plan shall automatically terminate on the last day of the month for which the monthly administrative fee was paid unless otherwise agreed to by the parties. If the Subscriber relocates and no longer meets the Service Area requirement, the Subscriber may enroll in another benefit plan sponsored by the City of Fort Lauderdale.
- b) Coverage for all Dependents shall automatically terminate on the last day of the month for which the monthly administrative fee was paid upon a loss of the Subscriber's eligibility, as defined under the Plan, unless otherwise agreed to by the parties.

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

6.01.03 Termination of Agreement by Either Party – Employer or AvMed may terminate this Agreement on the anniversary date by giving written notice to the other party sixty (60) days prior to Agreement anniversary date. In such event, benefits hereunder shall terminate for all Participants at 12:00 a.m. (midnight) on Agreement expiration date.

6.01.04 Termination of Agreement by AvMed – AvMed may choose not to renew or discontinue this Agreement based on one or more of the following conditions. In such event, benefits hereunder shall terminate for all Participants at 12:00 a.m. (midnight) on Agreement expiration date as described below.

- a) Employer has failed to pay fees or contributions in accordance with the terms of this Agreement or AvMed has not received timely payments (See Part III, Administrative Fees and Subsection 4.01.02). Termination of coverage will be effective on the last day of the month for which payments were received by AvMed.

- b) Employer has failed to provide funds in accordance with Section II.
- c) Employer had performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Agreement. This will result in immediate termination of the Agreement.
- d) There is no longer any enrollee in connection with the Plan who lives, resides, or works in the Service Area. Termination of coverage will be effective on the last day of the month for which payments were received by AvMed.
- e) AvMed ceases to provide services in the applicable market. Termination will be effective upon one-hundred and eighty (180) days written notice from AvMed to Employer.
- f) The Employer voluntarily or involuntarily files for bankruptcy.

6.01.05

Termination of Membership for Cause – AvMed may terminate any Member immediately upon written notice for the following reasons which lead to a loss of eligibility of the Member:

- a) fraud, material misrepresentation, or omission in applying for membership, benefits, or coverage under the Plan;
- b) misuse of AvMed’s Membership Card furnished to the Member;
- c) furnishing to AvMed incorrect or incomplete information for the purpose of obtaining coverage or benefits under this Agreement or the Plan;
- d) behavior which is disruptive, unruly, abusive, or uncooperative to the extent that the Member’s continuing coverage under this Plan seriously impairs AvMed’s ability to administer this Plan or to arrange for the delivery of health care services to the Member or other Members after AvMed has attempted to resolve the Member’s problem.

At the effective date of such termination, fees received by AvMed on account of such termination shall be refunded on a pro rata basis, and AvMed shall have no further liability or responsibility for the Member(s) under this Agreement or the Plan.

6.02 Notification Requirements:

6.02.01 Loss of Eligibility of Covered Person – It is the responsibility of Employer to notify AvMed in writing within sixty (60) days from the effective date of termination regarding any Covered Person who becomes ineligible to participate in the Plan. Failure of the Employer to provide timely written notice as described above may lead to retroactive termination of the Covered Person. The effective date for such retroactive termination will be the last day of the month for which an administrative fee was paid and during which the Covered Person was eligible for coverage.

6.02.02 Agreement Termination – In the event this Agreement is terminated, the Employer agrees that it shall provide sixty (60) days prior written notification of the date of such termination to Covered Persons who are covered under the Plan.

In no event will any retroactive termination of a Covered Person be made beyond one hundred eighty (180) days from notification of the terminating event.

6.03 Claims Run-Out Upon Agreement Termination

6.03.01 Claims Run-Out – Upon termination of this Agreement, AvMed will continue to process and review claims incurred during the contract period for up to twelve (12) months. Because AvMed will not relinquish the administration of its provider network contracts to a third party, AvMed agrees to receive, process, and review claims from AvMed contracted providers for at least six (6) months and not greater than twelve (12) months following the termination of this Agreement. The Employer is expected to fund the claims presented by AvMed within the same timeframes as agreed to for claims paid during this Agreement period. If this agreement terminates due to non-funding of claims, bankruptcy or other reasons stated in Section 6.01.01, AvMed may notify the healthcare providers as to revised process for obtaining payment. AvMed will not charge an additional claims administration fee for providing this service. If after the above runout period and if the parties mutually agree to have AvMed continue to process any runout claims on behalf of Employer, then AvMed will charge a per claim fee, as found in Exhibit B. AvMed will provide Employer with a listing of all claims adjudicated for the extra month(s). Standard monthly reports will not be generated.

VII. DISCLAIMER OF LIABILITY

7.01 AvMed's health care providers are independent contractors and not the agents or employees of AvMed. Therefore, neither Employer nor its agents, servants or

employees, nor any Member the agent or representative of AvMed, and none of them shall be liable for any acts or omissions of AvMed, its agents or employees or of a Plan Hospital, or a Plan physician, or any other person or organization with which AvMed has made or hereafter shall make arrangements for the performance of services under this Agreement.

- 7.02 Neither AvMed nor its agents, servants or employees, nor any Member is the agent or representative of the Employer, and none of them shall be liable for any acts or omissions of Employer, its agents or employees or any other person representing or acting on behalf of Employer.
- 7.03 AvMed shall not be liable for any negligent act or omission committed by any independent practicing physicians, nurses, or medical personnel, nor any hospital or health care facility, its personnel, other health care professionals or any of their employees or agents who may, from time to time, provide medical services to a Member under the Plan. Furthermore, AvMed shall not be vicariously liable for any negligent act or omission of any of these health care professionals who treat a Member under the Plan.

VIII. CLAIM ADMINISTRATION

- 8.01 AvMed shall, consistent with the general standards in the industry for third party administration and consistent with the terms of the Plan and the Plan administration policies and procedures adopted by Employer and provided to AvMed:
- (i) receive claims for Plan benefits and timely review such claims and requests to determine what amount, if any, is due, payable and/ or allowable with respect thereto in accordance with the terms and conditions of the Plan in accordance with Florida Prompt payment of claims legislation (Florida Statutes 641.3155 and 627.6131).; and
 - (ii) disburse or provide, to the person entitled thereto, benefit payments that it determines to be due in accordance with the provisions of the Plan; and
- 8.02 Employer, acting as fiduciary to The Plan, reserves to itself the authority and responsibility to make a full and fair review of each claim denial and to notify the claimant in writing of its decision on review. Employer acknowledges that this reservation of authority is reflected in the governing document(s) of the Plan and the summary plan description provided to Plan participants.
- 8.03 AvMed will make initial claims determinations pursuant to the Plan terms. The foregoing is subject to Employer's retention of full responsibility, as Plan Administrator and as named fiduciary, for the final review of denied claims appealed in writing by a Plan participant or beneficiary holding a valid assignment of benefits under the Plan. AvMed agrees to cooperate with Employer in establishing a procedure whereby AvMed

notifies Plan participants and beneficiaries of the right to address a final written appeal to the Employer in circumstances where AvMed makes an initial claim denial pursuant to the terms of the Plan. AvMed further agrees to cooperate with Employer by providing, in a timely manner, all information in its possession or control necessary for Employer to review the final appeal of a denied claim.

IX. FUNDING AND PAYMENT OF CLAIMS

- 9.01 AvMed will notify Employer either by facsimile or email of the total dollar amount of claims and/or prescription drug payments to be paid. This notification will be sent to Employer no less than weekly or as often as a “claims and/or prescription drug payments to be funded report” is available. The Employer may authorize AvMed to initiate an ACH (Automated Clearing House) transfer of funds or the Employer may initiate an ACH transfer of funds. The funds must be received by AvMed within two (2) business days of the original notification. If neither of these ACH methods is acceptable, Employer may wire transfer funds into AvMed’s account within the required two (2) business days. If any other funding mechanism is to be used, such as payment by check, additional claim deposits will be required so that the flow of claims and/or prescription drug payments is steady and predictable. In the event a claim exceeds the stop loss deductible amount in a single payment, AvMed and Employer will determine the appropriate manner in which to proceed with such payment.
- 9.02 AvMed, as the provider of the administrative services described in this Agreement, shall issue checks for Plan benefits and Plan-related expenses in the amount AvMed determines to be proper under the Plan and/or under this Agreement. In the event that sufficient funds are not available to pay all Plan benefits and Plan-related expenses when due, then AvMed shall cease to process claims under this Agreement and shall provide notice to the Employer of this action. If the Employer is delinquent in funding the Account, the Employer is immediately required to notify all Participants and all health care providers paid of the delinquency of funding. Such notification shall be in writing and a copy forwarded to AvMed. If the Employer does not provide such notification within five (5) calendar days of such delinquent funding, AvMed has the right, but not the duty, to notify Subscribers and health care providers of the delinquency of funding.
- 9.03 In the event AvMed pays any person less than the amount to which it is entitled under the Plan, AvMed will promptly adjust the underpayment by requesting additional funds through the claims funding process. In the event AvMed overpays any person entitled to benefits under the Plan, or pays benefits to any person not entitled to them, AvMed shall take all reasonable steps to recover the overpayment; however, AvMed shall not be required to initiate court proceedings to recover an overpayment. AvMed shall promptly notify the Employer if it is unsuccessful in recovering any overpayment. AvMed shall

deposit all amounts recovered in the Employer's Account with AvMed. See Exhibit E for payment recovery options. AvMed shall only be liable for overpayments to the extent set forth in Section 11.

9.04 The parties acknowledge that the Employer has paid the sum of \$1,000, which is to be used as follows:

a) A working deposit of \$1,000 for interest payments to providers should they be required under the Florida prompt pay legislation.

If these deposits are used in whole or part AvMed will request the balance as part of the funding request process outlined in Section 9.02. This amount shall be reviewed periodically by AvMed and if it proves insufficient based on an average of three months paid claim data. Employer agrees to increase the deposit accordingly. It is understood that AvMed will not advance its own funds for payment of any medical, interest or pharmacy expenses incurred by the Employer's Members.

X. RECORD RETENTION AND REVIEW

10.01 Employer may perform reasonable audits of AvMed's performance under this Agreement. The audits may be performed by the Employer or its designated agent as determined by the Employer in its discretion. Upon thirty (30) days' advance written request, documents relating to the payment of claims together with any supporting documentation or material necessary in the determination or calculation of all claims and costs charged to the Plan shall be made available to the Employer or its designated agent for its audit or inspection during regular business hours at the place or places of business where it is maintained by AvMed. Any audit shall be conducted pursuant to the Claim Audit Agreement attached as Exhibit C. AvMed shall cooperate fully with any such audit. Any costs or expenses incurred by AvMed or any delegate of AvMed in conforming to the audit or the request for information by Employer or its agent shall be paid by AvMed.

Any release of confidential records or information to the Employer or its designee shall be made subject to the Confidentiality Agreement attached hereto as Exhibit D. Employer agrees that it shall ensure that any designee or other third party who will have access to such confidential records or information executes such documentation required by AvMed to effectuate the purpose of this Section. No information shall be furnished in the absence of such documentation.

Upon termination of this Agreement, claim information shall be furnished to Employer for the standard runout period addressed in the Agreement and to the extent administratively feasible based on the standard reporting package provided to Employer before Agreement was terminated.

- 10.02 Employer shall have no interest in, nor shall AvMed have any obligation to provide to Employer any claim or payment data recorded for or otherwise integrated into AvMed's data processing systems during the ordinary course of business (provided, however, that claim or payment data will be available to Employer pursuant to Section 9), any information which AvMed reasonably deems to be proprietary in nature or any information which AvMed reasonably believes it cannot disclose due to applicable state and/or federal privacy restrictions. Notwithstanding the above, AvMed shall provide any information or data required by Employer in connection with any dispute or litigation regarding a claim for benefits under the Plan or in connection with an audit by Employer or its agent of claims or costs charged to the Plan.
- 10.03 All claims data and records shall be maintained by AvMed for not less than six (6) years and in accordance with the privacy and confidentiality safeguards required by law.
- 10.04 The obligations set forth in this Section shall survive termination of this Agreement.

XI. LIABILITY AND INDEMNITY

- 11.01 In performing its obligations under this Agreement, AvMed neither insures nor underwrites any liability of the Employer under the Plan, but acts only as the provider of the administrative services described in this Agreement.
- 11.02 AvMed shall have no duty or obligation to defend against any action or proceeding brought to recover Plan benefits. AvMed shall, however, make available to the Employer and its counsel, such evidence relevant to such action or proceeding as AvMed may have as a result of its administration of the contested benefit determination.
- 11.03 To the extent permitted by law except as otherwise explicitly provided in this Agreement, the Employer shall accept the tender of defense and retain the liability for all Plan benefit claims and all expenses incident to the Plan and agrees to indemnify AvMed for and hold it, its directors, officers and employees, harmless from all amounts and expenses (including reasonable attorney's fees and court costs) for which AvMed may become liable:
- (i) for any state premium, or similar tax, or similar benefit-or plan-related charge, surcharge or assessment, however denominated, including any penalties and interest payable with respect thereto, assessed against AvMed or the Employer on the basis of and/or measured by the amount of Plan benefits administered by AvMed pursuant to this Agreement;
 - (ii) arising from any legal action or proceeding to recover benefits under the Plan;
 - (iii) arising from any claim, legal action or proceeding, whether made by or on behalf of any Plan participants, any governmental body or bodies, or any other person,

regarding unclaimed or abandoned property, or laws relating thereto, or any escheat obligations, as related to Plan benefits administered pursuant to this Agreement, including any penalties and interest payable with respect thereto; and/or

- (iv) arising from any allegation of a breach of confidentiality arising out of release of confidential information to Employer or a third party or arising out of any improper use of such information by Employer or a third party.

This indemnity shall survive the termination of this Agreement.

11.04 In the event litigation is instituted by a third party against the Employer and/or AvMed concerning any matter under the Plan, including a suit for Plan benefits, each party to this Agreement shall have sole authority to select legal counsel of its choice.

11.05 Each party shall give the other prompt and timely notice of any fact or condition which comes to its attention which may give rise to a claim of indemnity under this Section 11.05.

Each party agrees to indemnify and hold the other harmless with respect to any and all losses, damages, judgments, obligations, expenses (including reasonable attorney's fees) and liabilities of any kind or nature caused by (a) the party's breach of any of its undertakings or agreements set forth in this Agreement, or (b) in the case of AvMed, any negligence in the adjudication of claims, with the exception of any error made on a claim that is a result of the eligibility status of the Subscriber or Dependent.

Nothing in this Agreement shall be construed as a waiver of the limitations of liability set forth in Section 768.28, Florida Statutes, which shall remain in full force and effect.

This indemnity shall survive the termination of the Agreement.

11.06 To avoid misunderstanding by third parties concerning the respective duties and liabilities hereunder, each party agrees not to use the other's name, logo, service marks, trade marks or other identifying information without the prior written approval of the other.

11.07 Employer retains full discretionary authority to settle or compromise any lawsuit based on a claim for Plan benefits. The Employer's defense and/or settlement, as provided herein, shall be at the Employer's direction and expense, except that the Employer can recover the expenses of the defense and/or settlement if the Employer is entitled to indemnification pursuant to this Agreement. In the event litigation or other legal action is

instituted by a third party against Employer and/or AvMed concerning a claim for Plan benefits, the affected party shall give immediate written notice of such litigation or other legal action to the other party. The parties shall cooperate fully to determine the relevant facts within the context of the terms and provisions of this Agreement and the applicable terms of the Plan.

- 11.08 In the event litigation is instituted by a third party against the Employer and/or AvMed concerning any matter under the Plan or this Agreement, other than a claim for Plan benefits over which the Employer maintains control hereunder, each party to this Agreement shall have sole authority to select legal counsel of its choice. Each party is required to give immediate written notice of such litigation to the other party. Notwithstanding the foregoing, the parties shall not assume their interests are adverse without first making a reasonable effort to determine the relevant facts within the context of this Agreement and the terms of the Plan as it applies to the operation of the Plan.
- 11.09 To avoid misunderstanding by third parties concerning their respective duties and liabilities under this Agreement, neither the Employer nor AvMed shall make any representations regarding the other or this Agreement to third parties. The terms of this Agreement are confidential as between the parties and no representation regarding this Agreement as it may or may not affect the other party's liability under this Agreement shall be made to third parties (other than to AvMed's or Employer's legal counsel) unless disclosed in answer to a lawsuit or subject to a subpoena or other valid order of a court of law having jurisdiction over the pertinent legal proceedings.
- 11.10 The Employer may terminate this Agreement for a material default or breach by AvMed in the performance of its duties and responsibilities listed in Exhibit B, thirty (30) days after giving AvMed written notice of its intent to do so, specifying the nature of the material default or breach. If the default is cured to the Employer's satisfaction within the thirty (30) day period, then this Agreement shall remain in full force and effect.

XII. MODIFICATION OF PLAN AND ADMINISTRATIVE DUTIES AND CHARGES

- 12.01 AvMed shall have the right to revise the administration charge Employer on each anniversary of this Agreement, in accordance with the Administrative Fees as described in Exhibit B, except as described in Section 12.02.
- 12.02 Modification or amendment of the Plan as described in Exhibit A shall be communicated in writing by the Employer to AvMed sixty (60) days prior to the effective date of such change. Implementation of the modification or amendment shall be mutually agreed upon by the Employer and AvMed subject to data processing systems changes, retroactive effective dates, payment by Employer of increase in administrative fees and other adjustments and procedure changes necessitated by the modification or amendment. Notwithstanding the above, changes required under Federal law will be implemented on

the date required under that Federal law. The cost of notification to Plan Participants of changes made by the Employer will be the responsibility of the Employer.

- 12.03 The benefit design of the EPN plan, as described in the Summary Plan Description in Exhibit A, is based on AvMed's core benefit packages as offered to AvMed's large group clients. AvMed makes changes to these core offerings from time to time. AvMed will give notice to the Employer no later than sixty (60) days prior to renewal of any change that affects the administration or benefit design of this plan. Implementation of the modification or amendment shall be mutually agreed upon by the Employer and AvMed. Notwithstanding the above, changes required under Federal law will be implemented on the date required under the Federal law. The cost of notification to Plan Participants of changes made by AvMed will be the responsibility of AvMed.
- 12.04 The term "Plan" as used in this Agreement shall include each such modification or amendment as of the implementation date agreed upon by the parties.
- 12.05 Modification of the duties as described in Exhibit B shall be by mutual agreement of the Employer and AvMed. Any such modification (and the revised charge, if any, applicable thereto) shall be evidenced by letter agreement between the parties which, upon execution, shall become a part of this Agreement.

XIII. MODIFICATION OF AGREEMENT

This Agreement constitutes the entire contract between the parties concerning the subject matter hereof. All prior or contemporaneous agreements, promises, negotiations or representations relating to the subject matter of this Agreement not expressly set forth in this Agreement, including its Exhibits, are of no force or effect. No modifications or amendment hereto shall be valid unless in writing and signed by an authorized representative of each of the parties, except that modification of administration charges pursuant to Section XII above may be made by written notice to Employer by AvMed. If Employer pays such revised fees or fails to object to such revision in writing within fifteen days of receipt, the Agreement shall be deemed modified to reflect the fees as communicated by AvMed.

XIV. MISCELLANEOUS

- 14.01 **Summary Plan Description.** AvMed shall make available to the Employer a supply of the Summary Plan Description for distribution. AvMed shall also supply the document in a format to the Employer for posting on the Employer's website.
- 14.02 **Membership Cards.** Cards issued by AvMed to Members pursuant to this Agreement are for purposes of identification only. Possession of an AvMed identification card confers no right to health services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose

behalf all applicable charges under this Agreement have actually been paid and accepted by AvMed.

- 14.03 **Waiver.** A claim which has not been timely filed with AvMed in accordance with the provisions of the applicable governing document shall be considered waived.
- 14.04 **Non-Waiver.** The failure of AvMed to enforce any of the provisions of this Agreement or to exercise any options herein provided or to require timely performance by any Member or Employer of any of the provisions herein, shall not be construed to be a waiver of such provisions nor shall it affect the validity of this Agreement or any part thereof or the right of AvMed to thereafter enforce each and every such provision.
- 14.05 **Plan Administration.** AvMed may from time to time adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Agreement.
- 14.06 **Notice.** Any notice intended for and directed to a party to this Agreement, unless otherwise expressly provided, should be sent by United States mail, postage prepaid, addressed as follows:

If to AvMed, to:

AvMed Health Plan
Senior Vice President of Marketing
9400 South Dadeland Blvd.
Suite 409
Miami, Florida 33156

If to Employer, to:

City of Fort Lauderdale
Risk Manager
100 N. Andrews Avenue
Ft. Lauderdale, FL 33301

- 14.07 **Gender.** Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.
- 14.08 **Clerical Errors.** Clerical error(s) shall neither deprive any individual Member of any benefits or coverage provided under this Agreement nor shall such error(s) act as authorization of benefits or coverage for the Member that is not otherwise validly in force.
- 14.09 **Premium Tax/Surcharge.** If any government entity shall impose a premium tax or surcharge, then the sums due from the Employer under the terms of this Agreement shall be increased by the amount of such premium tax or surcharge.

- 14.10 **Entirety of Agreement.** This Agreement and all applicable Schedules, Exhibits, Riders and any other attachments and endorsements, constitute the entire agreement between the Employer and AvMed. No modification (or oral representation) of this Agreement shall be of any force or effect unless it is in writing and signed by both parties.
- 14.11 **Third Party Beneficiary.** This Agreement is entered into exclusively between the Employer and AvMed. This Agreement is intended only to benefit the Employer and does not confer any rights on any third parties.
- 14.12 **Assignment.** This Agreement, and all rights and benefits related thereto, may not be assigned by the Employer without written consent of AvMed.
- 14.13 **Statute of Limitations.** A claims which has not been timely filed with AvMed shall be considered waived if, on the date notice of it is received by AvMed, that claim would otherwise have been barred by any Florida Statute of Limitations if asserted in civil court.
- 14.14 **Applicability of Law.** The provisions of this Agreement shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with the laws and regulations of the State of Florida and the United States.

IN WITNESS OF THE FOREGOING, the parties have set their hands and seals the day and year first written above.

WITNESSES:

CITY OF FORT LAUDERDALE

By _____
Mayor

Print/type Name

By _____
Acting City Manager

Print/type Name

(CORPORATE SEAL)

ATTEST:

City Clerk

Approved as to form:

City Attorney

WITNESSES:

AvMed, Inc.

Print/type Name

By _____
Name:
Title:

Print/type Name

ATTEST:

(CORPORATE SEAL)

STATE OF _____:
COUNTY OF _____:

The foregoing instrument was acknowledged before me this _____, 2004,
by _____ and _____, as
_____ and _____, respectively, of AvMed, Inc., a Florida
corporation, on behalf of the corporation. He/she/they is/are personally known to me or have
produced _____ as identification.

(SEAL)

Notary Public, State of Florida
(Signature of Notary taking
Acknowledgment)

Name of Notary Typed, Printed
Or Stamped

My Commission Expires:

Commission Number

EXHIBIT A

PLAN DOCUMENT

Plan No. CITYFORT

[Attach Plan Document and Summary Plan Description]

Summary Plan Description
of the
EPN Option
for the
City of Fort Lauderdale Employee Health Plan

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**Addendum to
Summary Plan Description
Of
The City of Fort Lauderdale Employee Health Plan**

Introduction

This document is an addendum to the Summary Plan Description (SPD) for the Exclusive Provider Network Plan (EPN) component of The City of Fort Lauderdale Employee Health Plan. This Plan provides benefits through an Exclusive Provider Network Plan administered by AvMed, Inc. d/b/a AvMed Health Plans.

This document and the attached documents together comprise the SPD for EPN Option of The City of Fort Lauderdale Employee Health Plan.

General Information About The Plan

| | |
|---|---|
| Plan Name: | The City of Fort Lauderdale Employee Health Plan |
| Type of Plan: | Self-insured welfare plan providing medical, vision, and prescription drug benefits administered through agreements with various third party administrators. |
| Plan Year: | 2004 |
| Effective Date: | March 1, 2004 for the EPN Plan |
| Date of the End of the Plan Year: | December 31 |
| Funding of Plan: | The Plan is funded from employer and employee contributions. The EPN component of the Plan is self-insured through an administrative services agreement with AvMed, Inc. d/b/a AvMed Health Plans. The Plan Sponsor has purchased individual excess loss insurance. |
| Plan Sponsor: | The City of Fort Lauderdale 100 North Andrews Avenue Fort Lauderdale, FL 33301 Phone: (954) 828-5177 Fax: (954) 828-5439 |
| Plan Sponsor's Employer Identification Number: | 59-6000319 |

Plan Number: CITYFORT

Plan Administrator: The City of Fort Lauderdale
100 North Andrews Avenue
Fort Lauderdale, FL 33301
Phone: (954) 828-5177
Fax: (954) 828-5439

Claims and Appeals Administrator: The Claims Administrator for the EPN component of the Plan is:

AvMed, Inc. d/b/a
AvMed Health Plans
P.O. Box 749
Gainesville, FL 32602-0749
1-800-346-0231

The Claims Administrator of the Prescription Drug Component of the Plan is:

Eckerd Health Services
620 Epsilon Drive,
Pittsburgh, PA 15238
412-967-2300
Fax: 412-967-2335

The Appeals Administrator for the Plan is the Plan Administrator.

Title of Person(s) Authorized To Amend or Terminate The Plan: City Manager/City Commission

AvMed CORPORATE OFFICE
9400 S. DADELAND BLVD.
P.O. BOX 569004
MIAMI, FL 33156-9004

SERVICE AREAS

MIAMI

9400 South Dadeland Boulevard
Post Office Box 569004
Miami, Florida 33156-9004

(305) 671-5437
(800) 432-6676

Miami-Dade

FT. LAUDERDALE

13450 W. Sunrise Boulevard
Suite 370
Sunrise, Florida 33323-2947

(954) 462-2520
(800) 368-9189

Broward
Palm Beach

JACKSONVILLE

1300 Riverplace Boulevard
Suite 200
Jacksonville, Florida 32207

(904) 858-1300
(800) 227-4184

Baker
Clay
Duval
Nassau
St. Johns

GAINESVILLE

4300 N.W. 89th Boulevard
Post Office Box 749
Gainesville, Florida 32606-0749

(352) 372-8400
(800) 346-0231

Alachua
Bradford
Citrus
Columbia
Dixie
Gilchrist
Hamilton
Levy
Marion
Suwannee
Union

ORLANDO

541 South Orlando Avenue
Suite 205
Maitland, Florida 32751

(407) 539-0007
(800) 227-4848

Orange
Osceola
Seminole

**TAMPA BAY/ SOUTHWEST
FLORIDA**

1511 North Westshore Boulevard
Suite 700
Tampa, Florida 33607

(813) 281-5650
(800) 257-2273

Hernando
Hillsborough
Lee
Pasco
Pinellas
Polk
Sarasota

ALL AREAS

1-800-88 AvMed
(1-800-882-8633)

I. INTRODUCTION

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

This document, together with the attached Addendum, is a Summary Plan Description (“SPD”) of the medical benefits provided to you by **City of Fort Lauderdale** (the “Company”) under the **City of Fort Lauderdale** Employee Health Plan (hereinafter, the Plan). Unless otherwise noted in this document, if any conflict between the terms of this document and the terms of the Plan conflict, the Plan document shall control.

The Company may designate any other third-party administrators or claims administrators to carry out certain Plan duties and responsibilities. The Company is responsible for formulating and carrying out all rules and regulations necessary to administer the Plan. To the extent not delegated to another third party, the company has the discretionary authority to make decisions regarding the interpretation or application of Plan provisions and the discretionary authority to determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan and to review claims under the Plan.

The Plan may be amended at any time. Such amendments, for example, may (a) increase or otherwise change the cost to you for coverage, (b) change the type of benefits provided under the Plan, the conditions of participation, and any other terms of the Plan, (c) require additional contributions from Participants, or (d) terminate the Plan in whole or in part at any time.

The Plan is not intended to and does not cover or provide any Medical Services or benefits which are not Medically Necessary for the diagnosis and treatment of the Participants.

Notwithstanding any references for definitional purposes to the contrary, this Plan is not an HMO product and is not subject to § 641 of the Florida Statutes, nor is a Participant of the Plan afforded any individual rights under § 641, Florida Statutes. This is an employer-sponsored self-insured welfare plan.

II. DEFINITIONS

As used in this Summary Plan Description, each of the following terms shall have the meaning indicated:

2.01 **“Adverse Benefit Determination”** means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant’s eligibility to participate in the Plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) of, a

benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary.

- 2.02 **“Claim”** means a request for benefits under the Plan made by a Participant in accordance with the Plan’s procedures for filing benefit claims, including Pre-Service Claims and Post-Service Claims.
- 2.03 **“Claimant”** means a Participant or an authorized representative acting on behalf of the Participant. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of the Participant. If the Claim is an Urgent Care or Pre-Service Claim, a Health Care Professional, with knowledge of the Participant’s medical condition, shall be authorized to act as the Participant’s authorized representative and will be notified of all approvals on the Claimant’s behalf. In the event of an adverse benefit determination, AvMed will notify both the Participant and the Health Professional.
- 2.04 **“Concurrent Care”** means an ongoing course of treatment to be provided over a period of time or number of treatments that AvMed previously approved.
- 2.05 **“Company”** means **City of Fort Lauderdale**.
- 2.06 **“Copayment”** means the charge which the Participant is required to pay at the time certain health services are provided. The Copayment may be a specific dollar amount or a percentage of the cost. The covered Participant is responsible for the payment of any Copayment charges directly to the provider of the health services at the time of service.
- 2.07 **“Covered Dependent”** means any Participant of a Covered Employee’s family who meets all applicable requirements of the Plan and is enrolled in the Plan.
- 2.08 **“Covered Employee”** means an employee of the Company who meets all of the applicable requirements of the Plan and is enrolled in the Plan.
- 2.09 **“Custodial Care”** means services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking, and taking oral medicines. “Custodial Care” also means services and supplies that can be safely and adequately provided by persons other than licensed health care professionals, such as dressing changes and catheter care or that ambulatory patients customarily provide for themselves, such as ostomy care, measuring and recording urine and blood sugar levels, and administering insulin.
- 2.10 **“Dental Care”** means dental x-rays, examinations and treatment of the teeth or structures directly supporting the teeth that are customarily provided by dentists, including orthodontics, reconstructive jaw surgery, casts, splints, and services for dental malocclusion.

2.11 **“Durable Medical Equipment (DME), Orthotics, and/or Prosthetics”** Coverage for DME, Orthotics and Prosthetics is limited as outlined in Part VIII subject to specific Exclusions as listed in Part X. The determination of whether a covered item will be paid under the DME, Orthotic or Prosthetics benefit will be based upon its classification as defined by the Center for Medicare and Medicaid Services (CMS).

2.12 **“Emergency Medical Condition”** means:

2.12.01 A medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- a) Serious jeopardy to the health of a patient, including a pregnant woman or fetus.
- b) Serious impairment to bodily functions.
- c) Serious dysfunction of any bodily organ or part.

2.12.02 With respect to a pregnant woman:

- a) That there is inadequate time to effect safe transfer to another Hospital prior to delivery;
- b) That a transfer may pose a threat to the health and safety of the patient or fetus; or
- c) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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

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

2.13.01 In-Area Emergency does not include elective or routine care, care of minor illness, or care that can reasonably be sought and obtained from the Participant’s Primary Care Physician. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and

may be made retrospectively based upon all information known at the time patient was present for treatment.

- 2.13.02 Out-of-Area Emergency does not include care for conditions for which a Participant could reasonably have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time patient was present for treatment.
- 2.14 **“Exclusion”** means any provision of this Plan whereby coverage for a specific hazard or condition is entirely eliminated.
- 2.15 **“Experimental and/or Investigational”** means a drug, treatment, device, surgery or procedure that AvMed, in its discretion, determines to be experimental and/or investigational if any of the following applies:
- 2.15.01 The Food and Drug Administration (FDA) has not granted the approval for general use; or
- 2.15.02 There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- 2.15.03 There is no consensus among practitioners that the drug, treatment, therapy, procedure or device is safe or effective for the treatment in question or such drug, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or similar condition; or
- 2.15.04 Such drug, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.
- 2.16 **“Full-Time Student”** means one who is attending a recognized and/or accredited college, university, vocational, or secondary school and is carrying sufficient credits to qualify as a Full-Time Student in accordance with the requirements of the school. For this purpose, school vacations, prior to graduation, will be considered a part of full-time school attendance. If a child leaves school during a school term because of illness or injury, he will be considered a Full-Time Student until the earlier of the end of the school term or the date he ceases to be disabled due to said illness or injury.

- 2.17 **“Group Health Insurance”** (for purposes of part XI) means that form of health insurance covering groups of persons under a master Group Health Insurance policy issued to any one of the groups listed in Sections 627.552 (employee groups), 627.553 (debtor groups), 627.554 (labor union and association groups) and 627.5565 (additional groups), Florida Statutes.
- 2.17.01 The terms “amount of insurance” and “insurance” include the benefits provided under a plan of self-insurance;
- 2.17.02 The term “insurer” includes any person, entity or governmental unit providing a plan of self-insurance; and
- 2.17.03 The term “policy,” “insurance policy,” health insurance policy,” and “Group Health Insurance policy” include plans of self-insurance providing health insurance benefits.
- 2.18 **“Health Professional”** means Physicians, osteopaths, podiatrists, chiropractors, Physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health care services who are licensed and practice under an institutional license, individual practice association, or other authority consistent with state law and who are Participating Providers of AvMed.
- 2.19 **“Home Health Care Services”** means services that are provided for a Participant who is homebound and is unable to receive medical care on an ambulatory outpatient basis and does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under the Plan.
- 2.20 **“Hospice”** means a public agency or private organization which is duly licensed by the State to provide Hospice services and with whom AvMed has a current provider agreement. Such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill Participants.
- 2.21 **“Hospital”** means any general acute care facility which is licensed by the state and with which AvMed has contracted or established arrangements for inpatient Hospital Services and/or emergency services, and shall at times be referred to as “Participating Hospital.”
- 2.22 **“Hospital Services”** (except as expressly limited or excluded by the Plan) means those services for registered bed patients which are:
- 2.22.01 Generally and customarily provided by acute care general Hospitals within the Service Area;
- 2.22.02 Performed, prescribed, or directed by Participating Providers; and

- 2.22.03 Medically Necessary for conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.
- 2.23 **“Hospitalist/Admitting Panelist”** means a Physician who specializes in treating inpatients and who may coordinate a Participant’s health care when the Participant has been admitted for a Medically Necessary procedure or treatment at a Hospital.
- 2.24 **“Limitation”** means any provision other than an Exclusion which restricts coverage under the Plan.
- 2.25 **“Medically Necessary”** means the use of any appropriate medical treatment, service, equipment, and/or supply as provided by a Hospital, skilled nursing facility, Physician, or other provider which is necessary for the diagnosis, care, and/or treatment of a Participant’s illness or injury, and which is:
- 2.25.01 Consistent with the symptom, diagnosis, and treatment of the Participant’s condition;
 - 2.25.02 The most appropriate level of supply and/or service for the diagnosis and treatment of the Participant’s condition;
 - 2.25.03 In accordance with standards of acceptable community practice;
 - 2.25.04 Not primarily intended for the personal comfort or convenience of the Participant, the Participant’s family, the Physician, or other health care provider;
 - 2.25.05 Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the Participant’s condition;
 - 2.25.06 Prescribed, directed, authorized, and/or rendered by a participating or authorized provider, except in the case of an emergency; and
 - 2.25.07 Not Experimental and/or Investigational.
- 2.26 **“Medical Office”** means any outpatient facility or Physician’s office in the Service Area utilized by a Participating Provider.
- 2.27 **“Medical Services”** (except as limited or excluded by the Plan) means those professional services of Physicians and other Health Professionals including medical, surgical, diagnostic, therapeutic, and preventive services which are:
- 2.27.01 Generally and customarily provided in the Service Area;

- 2.27.02 Performed, prescribed, or directed by Participating Providers; and
- 2.27.03 Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness.
- 2.28 **“Non-Participating Provider”** means any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility with whom AvMed has neither made arrangements nor contracted to render the professional health services set forth herein.
- 2.29 **“Other Health Care Facility(ies)”** means any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, providing inpatient services such as skilled nursing care or rehabilitative services for which AvMed has contracted or established arrangements for providing these services to Participants.
- 2.30 **“Participant”** means any Covered Employee.
- 2.31 **“Participating Provider”** means any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility with whom AvMed has made arrangements or contracted to render the professional health services set forth herein.
- 2.32 **“Participating Physician”** means any participating Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), Florida Statutes with whom AvMed has made arrangements or contracted with to render professional health services, as set forth herein. **“Attending Physician”** means the Participating Physician primarily responsible for the care of a Participant with respect to any particular injury or illness.
- 2.33 **“Plan”** means the **City of Fort Lauderdale** Employee Health Plan sponsored by the Company to provide covered Medical Services to Participants and their Covered Dependents.
- 2.34 **“Plan Administrator”** means **City of Fort Lauderdale**.
- 2.35 **“Post-Service Claim”** means any Claim for benefits under the Plan that is not a Pre-Service Claim.
- 3.36 **“Pre-Service Claim”** means any Claim for benefits under the Plan with respect to which, in whole or in part, a Participant must obtain authorization from AvMed in advance of such services being provided to or received by the Participant.
- 2.37 **“Primary Care Physician”** means a Participating Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, osteopathy, or any specialty

Physician from time to time designated by AvMed as “Primary Care Physician” in AvMed’s current list of Physicians and Hospitals.

- 2.38 **“Relevant Document”** means any documentation that:
- 2.38.01 Was relied upon in making the benefit determination;
 - 2.38.02 Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the determination.
 - 2.38.03 Demonstrated compliance with the administrative process; and
 - 2.38.04 Constitutes a statement of policy or guidance with respect to the Plan concerning the Adverse Benefit Determination for the Claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.
- 2.39 **“Service Area”** means those counties in the State of Florida where AvMed has been approved to conduct business by the Florida Department of Financial Services.
- 2.40 **“Specialty Health Care Professional”** means any Participating physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), Florida Statutes, other than the Participant’s chosen Primary Care Physician.
- 2.41 **“Total Disability”** means a totally disabling condition resulting from an illness or injury which prevents the Participant from engaging in any employment or occupation for which he may otherwise become qualified by reason of education, training, or experience, and for which the Participant is under the regular care of a Physician.
- 2.42 **“Urgent Care Claim”** means any Claim for medical care or treatment that could seriously jeopardize the Participant’s life or health or the Participant’s ability to regain maximum function or, in the opinion of a Physician with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment requested. Generally, the determination of whether a Claim is an Urgent Care Claim shall be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Participant’s medical condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.
- 2.43 **“Urgent Care/Immediate Care”** means medical screening, examination, and evaluation received in an Urgent Care Center or Immediate Care Center or rendered in your Primary Care Physician’s office after-hours and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

- 2.44 **“Utilization Management Program”** means those procedures adopted by AvMed to assure that the supplies and services provided to Participants are Medically Necessary. These include, but are not limited to: (1) pre-authorization for specialty referrals, Hospital admissions (except emergencies), outpatient surgery, and certain outpatient diagnostic tests and procedures; (2) concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate; (3) case management for all inpatients who need continued care in an alternative setting (such as homecare or a skilled nursing facility) and for outpatients when deemed appropriate.
- 2.45 **“Ventilator Dependent Care Unit”** means care received in any facility which provides services to ventilator dependent patients other than acute Hospital care, including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers, and all other like facilities whether maintained in a free standing facility or maintained in a Hospital or skilled nursing facility setting. Coverage is limited to 100 days lifetime maximum.

III. ELIGIBILITY

- 3.01 To be eligible to enroll as a Participant, a person must be:
- 3.01.01 An employee of the Company who works 40 hours per week. The employee must either work or reside in the Service Area. **Except as provided for emergency services, the covered services and benefits are available only from Participating Providers.** An employee is eligible to enroll on the first day of the month following date of hire.
 - 3.01.02 Entitled on his own behalf to participate in the medical and Hospital care benefits arranged by the Company under the Plan; or
 - 3.01.03 A Retiree meeting the Employer’s definition of Retired Employee; or
 - 3.01.04 A Participant as designated by The City of Fort Lauderdale and its city commission.
- 3.02 To be eligible to enroll as a Dependent, a person must be:
- 3.02.01 the spouse of the Covered Employee; a new spouse must be enrolled within thirty-one (31) days after marriage in order to be covered; or
 - 3.02.02 a child of the Covered Employee, or a child of a Covered Dependent of the Covered Employee, provided that the following conditions apply:
 - a) The child is the natural child or stepchild of the Covered Employee; a legally adopted child in the custody of the Covered Employee from the

time of placement in the home (written evidence of adoption must be furnished to AvMed upon request); a child for whom the Covered Employee is permanent legal guardian; or a newborn child of a Covered Dependent of the Covered Employee (such coverage terminates 18 months after the birth of the newborn child);

- b) The child resides with the Covered Employee (except for "f" and "h" below);
- c) The child is under the age of 19 (except for "f" and "g" below);
- d) The child is principally dependent upon the Covered Employee for maintenance and support and is not regularly employed by one or more employers for a total of thirty (30) hours or more per week;
- e) The child is not married;
- f) The child is age 19 or over, but under the age of 25, and meets all of the following:
 - 1. The child is dependent upon the Covered Employee for support; and;
 - 2. The child is living in the household of the Covered Employee, or the child is a Full-Time or Part-Time Student;

In such cases, the child will be covered until the end of the calendar year in which the child reaches age 25. Covered Employee is responsible for notifying AvMed when full-time or part-time attendance commences or terminates, or when the child moves in or out of the Covered Employee's household or becomes dependent or is no longer dependent upon the Covered Employee. Coverage shall commence or terminate upon such notification.

- g) The child is age 19 or over and is wholly dependent on the Covered Employee due to mental retardation or physical handicap. (See below);
- h) In the event an eligible dependent child does not reside with the Covered Employee, coverage will be extended where the Covered Employee is obligated to provide medical care by Qualified Medical Child Support Order provided the eligible Dependent resides within the Service Area. You (or your beneficiaries) may obtain, without charge, copies of the Plan's procedures governing Qualified Medical Child Support Orders and a sample Qualified Medical Child Support Order by contacting the Plan Administrator.

- i) In the case of a newborn child, AvMed should be notified in writing prior to the scheduled delivery date of the Covered Employee's intention to enroll the newborn child, but such notice shall not be later than thirty-one (31) days after the birth. If notice is not provided within 60 days of the birth, the child may not be enrolled until the next open enrollment period of the Company.

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

Coverage for the newborn child of a Covered Dependent of the Covered Employee (other than the spouse of the Covered Employee) shall terminate eighteen (18) months after the birth of the newborn child.

- 3.03 No person is eligible to enroll hereunder who has had his coverage previously terminated under Part VII, "Termination of Participation for Cause," except with the written approval of AvMed.
- 3.04 Attainment of the limiting age by a dependent child shall not operate to exclude from or terminate the coverage of such child nor shall coverage prevent the enrollment of a child while such child is and continues to be both:
 - 3.04.01 Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
 - 3.04.02 Chiefly dependent upon the Covered Employee for support and maintenance, provided proof of such incapacity and dependency is furnished to AvMed by the Company within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by AvMed, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
- 3.05 During the plan year, no changes in the Company's eligibility or requirements shall be permitted to affect eligibility or enrollment under the Plan, unless such change is agreed to by AvMed.
- 3.06 If both husband and wife are Eligible Employees, then their children may be covered as Dependents of either the mother or father, but not of both.

- 3.07 If a person covered under this plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.
- 3.08 The Plan Administrator or AvMed has the right to request proof of marriage, birth, financial dependency including proof of the Employee declaring the dependent child as an income tax deduction, and other written proof deemed necessary to confirm eligibility requirements are met. Failure to provide documentation upon request will be treated as though eligibility is not met.

IV. ENROLLMENT

- 4.01 Prior to the effective date of the Plan and at a proper time prior to each anniversary thereof, the Company may allow an open enrollment period of thirty (30) days, in which any eligible Covered Employee on behalf of himself and his Dependents may elect to enroll in the Plan.
- 4.02 Except as provided for newborns, eligible Employees and Dependents who meet the requirements of Part III must enroll within thirty-one (31) days after becoming eligible by submitting application forms acceptable to or provided by AvMed; otherwise, the eligible Employees and Dependents may not enroll until the next open enrollment period of the Company or a Special Enrollment Period.
- 4.03 Special Enrollment Periods. An Eligible Employee or Dependent may request to enroll in the Plan outside of the initial enrollment and Annual Open Enrollment Periods if that individual, within the immediately preceding thirty-one (31) days, was covered under another employer health benefit plan as an employee or dependent at the time he was initially eligible to enroll for coverage under the Plan, and:
- 4.03.01 Demonstrates that he or his Dependent has experienced one of the following status change events, including:
- a) marriage;
 - b) birth, adoption or placement for adoption;
 - c) legal separation, divorce or annulment;
 - d) change in legal custody or legal guardianship;
 - e) death;
 - f) relocation into or out of a Service Area;

- g) termination/commencement of employment;
- h) reduction in the number of hours of employment;
- i) commencement of or return from leave of absence;
- j) change in employment status;
- k) change in worksite;
- l) strike or lockout;
- m) termination of coverage due to the termination of employer contributions toward such coverage; and

4.03.02 Requests enrollment within thirty-one (31) days after the termination of coverage under another employer health benefit plan; and

4.03.03 Provides proof of continuous coverage under the other employer health benefit plan.

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

V. EFFECTIVE DATE OF COVERAGE

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

5.01 Eligible Employees and Dependents who enroll during the open enrollment period will become Participants as of the effective date of this Plan or subsequent anniversary thereof.

5.02 If a Covered Employee acquires an eligible Dependent through birth, adoption, placement for adoption or marriage, such Dependent shall be treated as immediately covered under the Plan if, within thirty-one (31) days (or as otherwise provided for newborns in Part III) of acquiring the new dependent, you complete and submit an enrollment form on behalf of such dependent. If received by the Plan within the thirty-one (31) day time period (or 60-days as permitted for newborns), the enrollment for such Dependent shall become effective on the date of the birth, adoption or placement for adoption, or for marriage, the first day of the month following the date you enroll your new spouse. During this period, you and your eligible spouse may also enroll for medical coverage under the Plan, if not already covered. However, if an enrollment is not

received by the Plan within the required timeframe, you and your eligible Dependents will be required to wait until the next open enrollment period to apply for coverage.

- 5.03 If you or your Dependents originally declined medical coverage under the Plan due to other health coverage, and that coverage is subsequently terminated as a result of either a loss of eligibility for such coverage or the termination of any employer contributions for such coverage, you and your Dependents will be eligible to enroll in the Plan. To enroll, you must properly complete an enrollment form within thirty-one (31) days of the loss of such other coverage or termination of employer contributions. The effective date of any coverage provided under the Plan will be the first day of the month following the date you enroll. If you fail to enroll within thirty-one (31) days after the loss of other coverage, you must wait until the next open enrollment period to apply for coverage.

VI. MONTHLY PAYMENTS AND COPAYMENTS

- 6.01 **Maximum Copayments.** Total annual Copayments are limited as described in your Schedule of Copayments. The Copayment limits apply to Copayments made for all core benefits contained in this Contract, and do not apply to services provided under the Prescription Drug, Mental Health, Substance Abuse, Vision and other supplemental amendments. It is the responsibility of the Covered Employee to retain receipts and to notify and document to the satisfaction of AvMed when either of the Copayment limits has been reached.
- 6.02 No retroactive termination of a Participant will be made beyond 180 days from notification of the terminating event.
- 6.03 In the event of the retroactive termination of an individual Participant, the Plan shall not be responsible for medical expenses incurred by the Plan in providing benefits to the Participant under the terms of the Plan after the effective date of termination.

VII. TERMINATION OF PARTICIPATION

- 7.01 **Reasons for Termination:**

7.01.01 Loss of Eligibility:

- a) Upon a loss of the Covered Participant's eligibility, as defined in Part III, including but not limited to the permanent relocation outside the AvMed Service Area, coverage shall automatically terminate on the last day of the month for which the monthly administrative fee was paid and during which the Participant was eligible for coverage.
- b) Coverage for all Dependents shall automatically terminate on the last day of the month for which the monthly administrative fee was paid upon a

loss of the Covered Employee's or Dependent's eligibility, as defined in Part III, unless otherwise agreed to by the parties.

- 7.01.02 Failure to Pay Copayments and Fees – Upon failure of the Company to make payment of the monthly administrative fee within thirty (30) days following the due date specified by AvMed, benefits under the Plan shall terminate for all Participants for whom such payment has not been received at 12:00 a.m. (midnight) on the last day of the month for which the monthly administrative fee was paid.

Upon failure of the Covered Employee to make payment of any contributions or applicable supplemental charges required under Section VI, coverage shall automatically terminate for the Covered Employee and all Dependents on the tenth day after written notice from AvMed or the Plan.

- 7.01.03 Termination of Participation for Cause – AvMed may terminate or cease to provide services to any Participant immediately upon written notice for the following reasons which lead to a loss of eligibility of the Participant:

- a) fraud, material misrepresentation, or omission in applying for benefits, or coverage under the Plan;
- b) misuse of the Identification Card furnished by AvMed to the Participant;
- c) furnishing to the Plan incorrect or incomplete information for the purpose of obtaining coverage or benefits under the Plan;
- d) behavior which is disruptive, unruly, abusive, or uncooperative to the extent that the Participant's continuing coverage under the Plan seriously impairs AvMed's ability to administer the Plan or to arrange for the delivery of health care services to the Participant or other Participants after AvMed has attempted to resolve the Participant's problem.

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

7.02 Notification Requirements:

- 7.02.01 Loss of Eligibility of Covered Employee - It is the responsibility of the Company to notify AvMed in writing as soon as possible but no later than sixty (60) days from the effective date of termination regarding any Covered Employee and/or Dependent who becomes ineligible to participate in the Plan. Failure of the Company to provide timely written notice as described above may lead to retroactive termination of the Covered Employee and/or

Dependent. The effective date for such retroactive termination will be the last day of the month for which the administrative service fee was paid and during which the Covered Employee and/or Dependent was eligible for coverage.

7.02.02 Loss of Eligibility of Dependent - When a Dependent becomes ineligible for Dependent coverage due to age, student status, etc., the Covered Employee is required to notify AvMed in writing within thirty (30) days of the Dependent becoming ineligible.

7.03 **Certificates of Creditable Coverage.** Upon termination of a Participant's coverage under the Plan, including termination of any COBRA continuation coverage, the Participant has the right to receive within a reasonable period of time, a certificate of creditable coverage, which shows the continuous amount of coverage the Participant had under the Plan. The Participant may also request a certificate during the time he or she is covered under the Plan and any time within 24 months after the Participant ceases to be covered under the Plan.

7.04 **COBRA Continuation Coverage.** A federal law (the Consolidated Omnibus Budget Reconciliation Act, commonly known as COBRA) requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This section of the SPD is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this section carefully.

7.04.01 **Eligibility.** You or your Covered Dependents will become eligible for continuation coverage under the Consolidated Omnibus Reconciliation Act of 1986, as amended (COBRA), after any of the following qualifying events result in the loss of plan coverage:

- a) loss of benefits due to a reduction in your hours of employment;
- b) termination of your employment, including retirement but excluding termination for gross misconduct;
- c) termination of employment following FMLA leave, in which case the qualifying event will occur on the earlier of the date you indicated you were not returning to work or the last day of the FMLA leave; or
- d) you or a dependent first become entitled to Medicare or covered under another group health plan prior to your loss of coverage due to termination of employment or reduction in hours.

7.04.02 In addition, your enrolled dependents will become eligible for COBRA continuation coverage after any of the following qualifying events occur to cause a loss of plan coverage:

- a) your death;
- b) your divorce or legal separation;
- c) you first become entitled to Medicare after your loss of coverage due to termination of employment or reduction in hours; or
- d) your dependent child no longer qualifies as a dependent under the plan.

A child who is born to or placed for adoption with a covered former employee during the continuation coverage period has the same continuation coverage rights as a dependent child described above.

7.04.03 Notification. If a qualifying event other than divorce, legal separation, loss of dependent status or entitlement to Medicare occurs, the plan administrator will be notified of the qualifying event by your employer and will send you an election form. To continue plan coverage, you must return the election form within 60 days from the later of the date you received the form, or the date your coverage ends due to a qualifying event.

If divorce, legal separation, loss of dependent status or entitlement to Medicare under the plan occurs, you or your Covered Dependent must notify the plan administrator that a qualifying event has occurred. This notification must be received by the plan administrator within 60 days after the later of the date of such event, or the date you or your eligible dependent would lose coverage on account of such event. Failure to promptly notify the plan administrator of these events will result in loss of the right to continue coverage for you and your dependents.

After receiving this notice, the plan administrator will send you an election form within 14 days. If you or your dependents wish to elect continuation coverage, the election form must be returned to the plan administrator within 60 days from the later of the date you received the form, or the date your coverage ends due to the qualifying event.

7.04.04 Cost. If you elect to continue coverage, you must pay the entire cost of coverage (the employer's contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation coverage.

If you or your dependent is Social Security disabled (Social Security disability status must occur as defined by Title II or Title XVI of the Social Security

Act), you may elect to continue coverage for the disabled person only or for some or all of COBRA eligible family members for up to 29 months if your employment is terminated or your hours are reduced. You must pay 102% of the cost of coverage for the first 18 months of COBRA continuation coverage and 150% of the cost of coverage for the 19th through the 29th months of coverage. The Social Security disability date must occur within the first 60 days of loss of coverage due to your termination of employment or reduction in hours.

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

7.04.05 Duration. COBRA Continuation Coverage can be extended for:

- a) 18 months if coverage ended due to a reduction in your work hours or termination of your employment and you or one of your covered dependent(s) is not Social Security disabled within 60 days of the date you lose coverage due to termination of employment or reduction in hours, the Medicare entitled person may elect up to 18 months of COBRA. If you are that Medicare entitled person, your dependents may elect COBRA for the longer of 36 months from your prior Medicare entitlement date, or 18 months from the date of your termination or reduction in hours.
- b) 36 months for your dependents, if your dependents lose eligibility for medical coverage due to your death, your divorce or legal separation, your entitlement to Medicare after your termination or reduction in hours, or your dependent child ceasing to qualify as a dependent under the plan.
- c) 29 months if you lose coverage due to a termination of employment or reduction in hours and you or a dependent is disabled, as defined by Title II or Title XVI of the Social Security Act, within 60 days of the original qualifying event. In this case, you may continue coverage for an additional 11 months after the original 18-month period either for the disabled person only or for one or all of your covered family members.

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

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

- a) first becomes covered under another group health plan after the loss of coverage due to your termination or reduction in hours, unless the new group coverage is limited due to a pre-existing condition exclusion; this plan will be primary for the pre-existing condition and secondary for all other eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;
- b) fails to make required contributions when due;
- c) first becomes entitled to Medicare benefits after the initial COBRA qualifying event; or
- d) is extending the 18-month coverage period because of disability and is no longer disabled as defined by the Social Security Act.

7.05 Continuation Coverage During Leaves of Absence.

7.05.01 Family and Medical Leaves of Absence (FMLA). Under the Family and Medical Leave Act of 1993, you may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each calendar year for the following:

- a) the birth of your child, to care for your newborn child, or for placement of a child in your home for adoption or foster care;
- b) to care for your spouse, child or parent with a serious health condition; or
- c) for your own serious health condition.

If your FMLA leave is a paid leave, your pay will be reduced by your before-tax contributions as usual for the coverage level in effect on the date your FMLA leave begins. If your FMLA leave is unpaid, you will be required to pay your contributions directly to the employer until you return to active pay status.

If you notify your employer that you are terminating employment during your FMLA leave, your coverage will end on the date of your notification. If you do not return to work on your expected FMLA return date, and you do not notify your employer of your

intent either to terminate your employment or to extend the period of leave, your Plan coverage will end on the date you were expected to return.

You may not change your Plan elections during your FMLA leave unless an open enrollment occurs, or unless you are on a paid FMLA leave and you have a change in status event or a special enrollment event under HIPAA.

7.05.02 Military Leaves of Absence. If you are absent from work due to military service, you may elect to continue coverage under the Plan (including coverage for enrolled dependents) for up to 18 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”). Your contributions for continued coverage will be the same as for similarly situated active Participants in the Plan.

Whether or not you continue coverage during military service, you may reinstate coverage under the Plan option you elected on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that you had not fully completed any required waiting period prior to the start of the military service.

VIII. SCHEDULE OF BASIC BENEFITS

The professional judgment of a Physician concerning the proper course of treatment of a Participant shall not be subject to modification by AvMed or its Board of Directors, Officers, or Administrators. However, this subsection is not intended to and shall not restrict any Utilization Management Program established by AvMed.

All covered services and benefits shall be provided in conformity with the terms of the Plan. It is the Participant’s responsibility when seeking benefits under the Plan to identify himself as a Plan Participant and to assure that the services received by the Participant are being rendered by Participating Providers.

Participants should remember that services that are provided or received without having been authorized in advance by AvMed's Medical Department, or if the service is beyond the scope of practice authorized for that Provider under state law, except in instances of Emergency Services and Care, are not covered unless such services otherwise have been expressly authorized under the terms of the Plan. Except for Emergency Services and Care, all services must be received from Participating Providers on referral from AvMed. If a Participant does not follow the access rules, he risks having services and supplies received not covered under the Plan. In such a circumstance, the Participant will be responsible for reimbursing AvMed for the reasonable cost of the services and supplies received.

Also, Participants must understand that services will not be covered if they are not Medically Necessary. Any and all decisions made by AvMed in administering the provisions of this Contract, including without limitation, the provisions of Part VIII (Schedule of Basic Benefits), Part IX (Limitations of Basic Benefits), and Part X (Exclusions from Basic Benefits), are made only to determine whether payment for any benefits will be made by the Plan. Any and all decisions that pertain to the medical need for, or desirability of the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Participant and his Physician, in accordance with the normal patient/physician relationship for purposes of determining what is in the best interest of the Participant. AvMed does not have the right of control over the medical decisions made by the Participant's Physician or health care providers. The ordering of a service by a Physician, whether Participating or Non-Participating, does not in itself make such service Medically Necessary.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS WHICH MUST BE PAID TO HEALTH CARE PROVIDERS FOR CERTAIN SERVICES, AT THE TIME SERVICES ARE RENDERED, AS SET FORTH IN THE SCHEDULE OF COPAYMENTS.

- 8.01 The names and addresses of Participating Providers and Hospitals are set forth in a separate booklet which is incorporated herein by reference. The list of Participating Providers, which may change from time to time, will be provided to the Company. The list of Participating Providers may also be accessed from the AvMed website at www.AvMed.org. Notwithstanding the printed booklet, the names and addresses of Participating Providers on file with AvMed at any given time shall constitute the official and controlling list of Participating Providers.
- 8.02 Within the Service Area, Participants are entitled to receive the covered services and benefits only as herein specified and appropriately prescribed or directed by Participating Physicians. The covered services and benefits are available only from Participating Providers within the Service Area and, except for Emergency Medical Services and Care, the Plan shall have no liability or obligation whatsoever on account of services or benefits sought or received by any Participant from any Non-Participating Physician, Health Professional, Hospital or Other Health Care Facility, or other person, institution or organization, unless prior arrangements have been made for the Participant and confirmed by written referral or authorization from AvMed.
- 8.03 Each Participant shall select one Primary Care Physician upon enrollment. If you do not select a Primary Care Physician upon enrollment, AvMed will assign one for you. You must notify and receive approval from AvMed **prior** to changing your Primary Care Physician. Such change will become effective on the first day of the month after you notify AvMed. You cannot change your Primary Care Physician selection more than once per month. Health Professionals may from time to time cease their affiliation with AvMed. In such cases, you will be required to receive services from another Participating Health Professional.

8.04 Any Participant requiring medical, Hospital, or ambulance services for Emergency Medical Services and Care, either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive the Emergency benefits as specified under the Plan.

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

Pre-authorization is also required for inpatient Hospital Services for mental health and substance abuse, and these services are subject to the conditions set forth in the optional coverage selected. (Also see Section IX.)

8.06 Physician Care: Inpatient. All Medical Services rendered by Participating Physicians and other Health Professionals when requested or directed by the Attending Physician, including surgical procedures, anesthesia, consultation and treatment by specialists, laboratory and diagnostic imaging services, and physical therapy are provided while the Participant is admitted to a Participating Hospital as a registered bed patient. When available and requested by the Participant, the Plan covers the services of a certified nurse anesthetist.

8.07 Physician Care: Outpatient

8.07.01 Diagnosis and Treatment. All Medical Services rendered by Participating Physicians and other Health Professionals, as requested or directed by the Primary Care Physician, are covered when provided at Medical Offices, including surgical procedures, routine hearing examinations and vision examinations for glasses for children under age 18 (such examinations may be provided by optometrists licensed pursuant to Chapter 463, Florida Statutes or by ophthalmologists licensed pursuant to Chapter 458 or 459, Florida Statutes), and consultation and treatment by Specialty Health Care Physicians. Also included are non-reusable materials and surgical supplies. These services and materials are subject to the Limitations outlined in Part IX (Limitations of Basic Benefits). See Part X for Exclusions.

8.07.02 Preventive and Health Maintenance Services. The services of the Participant's Primary Care Physician for illness prevention and health maintenance, including Child Health supervision services, immunizations provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics and/or the Advisory Committee on Immunization

Practices, sterilization (See Schedule of Copayments), periodic health assessment, physical examinations, and voluntary family planning services are also covered. These services are subject to Limitations as outlined in Part IX (Limitations of Basic Benefits). See Part X for Exclusions.

- 8.07.03 Outpatient Mental Health Services. These services are covered only for diagnostic evaluation and crisis intervention. Each visit requires a Copayment. (See Schedule of Copayments)
- 8.08 Physical, Occupational or Speech Therapy. Physical, Occupational, Respiratory or Speech Therapy provided in the Outpatient or Home Care setting is covered for acute conditions for which therapy applied for a consecutive two (2) month period can be expected to result in significant improvement. Rehabilitation services for the acute phase of a chronic condition are covered only if, in the judgment of AvMed, such services are Medically Necessary and will result in significant improvement of a Participant's condition through short-term therapy. Long-term physical therapy, occupational therapy, respiratory therapy, speech therapy, rehabilitation, or other treatment of chronic conditions is not covered.
- 8.09 Cardiac Rehabilitation. Cardiac rehabilitation is covered for the following conditions: acute myocardial infarction, percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), repair or replacement of heart valve(s) or heart transplant. Coverage is limited to a maximum of eighteen (18) visits per calendar year. See Schedule of Copayments for detailed information regarding copayments and limitations.
- 8.10 Obstetrical and Gynecological Care. Obstetrical care benefits as specified herein are covered and include hospital care, anesthesia, diagnostic imaging, and laboratory services for conditions related to pregnancy unless such pregnancy is the result of a preplanned adoption arrangement, more commonly known as surrogacy. Newborn child care is covered as provided in Part III and below. An annual gynecological examination and Medically Necessary follow-up care detected at that visit are available without the need for a prior referral from the Primary Care Physician.
- 8.11 Maternity Services. Medical care and treatment due to pregnancy are paid in the same way as any other eligible medical expense for the Covered Employee and Covered Dependents. Any Hospital length of stay for childbirth for the newborn or mother may not be less than 48 hours following normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).
- 8.12 Newborn Care. All services applicable for children under the Plan are covered for an enrolled newborn child of the Covered Employee or the enrolled newborn child of a

Covered Dependent of the Covered Employee or the newborn adopted child of the Covered Employee (Part III), from the moment of birth, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, and transportation costs to the nearest facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is Medically Necessary. Circumcisions are provided for up to one year from date of birth provided that newborn was continuously covered by the Plan from date of birth.

- 8.13 **Emergency Services.** All necessary Physician and Hospital Services will be covered by the Plan for Emergency Medical Services and Care. In the event that Hospital inpatient services are provided following emergency services, AvMed should be notified within 24 hours or as soon as the Participant is lucid and able to notify AvMed of the inpatient admission. The Plan will pay the usual, reasonable, and customary charges to a Non-Participating Physician or facility only for those services rendered before a Participant's condition permits him to be reasonably able to travel to a Participating facility. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within ninety (90) days after the emergency or as soon as reasonably possible but not later than one (1) year unless the claimant was legally incapacitated.
- 8.14 **Urgent Care Services.** All necessary and covered services received in Urgent Care or Immediate Care Centers or rendered in your Primary Care Physician's office after-hours for conditions as described in Section II will be covered by the Plan. See Schedule of Copayments for details. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within ninety (90) days after the emergency or as soon as reasonably possible but not later than one (1) year unless the claimant was legally incapacitated.
- 8.15 **Ambulance Service.** For an emergency or when pre-authorized by AvMed, ambulance service to the nearest Hospital appropriately staffed and equipped to treat the condition will be covered.
- 8.16 **Other Health Care Facility(ies).** All routine services of Other Health Care Facilities, including Physician visits, physiotherapy, diagnostic imaging and laboratory work, are covered when a Participant is admitted to such a facility, following discharge from a Hospital, for a condition that cannot be adequately treated with Home Health Care Services or on an ambulatory basis.
- 8.17 **Diagnostic Imaging and Laboratory.** All prescribed diagnostic imaging and laboratory tests and services including diagnostic imaging, fluoroscopy, electrocardiograms, blood and urine and other laboratory tests, and diagnostic clinical isotope services are covered when Medically Necessary and ordered by a Participating Physician as part of the diagnosis and/or treatment of a covered illness or injury or as preventive health care services.

- 8.18 Home Health Care Services. With prior authorization by AvMed, Home Health Care Services are covered when ordered by and under the direction of the Participant's Attending Physician. Physical, Occupational or Speech Therapy services provided in the home are limited as noted in Section 8.08. Homemaker or other Custodial Care services are not covered.
- 8.19 Hospice Services. With prior authorization by AvMed, services are available from an AvMed affiliated Hospice organization for a Participant whose Participating Physician has determined the Participant's illness will result in a remaining life span of six (6) months or less.
- 8.20 Second Medical Opinions. The Participant is entitled to a second medical opinion when he: 1) disputes the appropriateness or necessity of a surgical procedure; or 2) is subject to a serious injury or illness.

With prior notice to AvMed, the Participant may obtain the second medical opinion from any Participating or Non-Participating Physician, chosen by the Participant, who is within AvMed's Service Area. If a Participating Physician is chosen, there is no cost to the Participant other than any applicable Copayment. If the Participant chooses a Non-Participating Physician, the Participant will be responsible for 40% of the amount of reasonable and customary charges for the second medical opinion.

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

The Plan may limit second medical opinions in connection with a particular diagnosis or treatment to three (3) per Contract Year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Participant.

- 8.21 Durable Medical Equipment and Orthotic Appliances.
- 8.21.01 Durable Medical Equipment. The Plan provides benefits, when Medically Necessary, for the purchase or rental of such Durable Medical Equipment that:
- a) Can withstand repeated use (i.e. could normally be rented and used by successive patients);
 - b) Is primarily and customarily used to serve a medical purpose;
 - c) Generally is not useful to a person in the absence of illness or injury; and
 - d) Is appropriate for use in a patient's home.

Some examples of Durable Medical Equipment are: hospital beds, crutches, canes, walkers, wheelchairs, respiratory equipment, apnea monitors and insulin pumps. In accordance with Florida Statutes, coverage of insulin pumps for the treatment of diabetes will apply toward the annual maximum limitation but shall not be subject to the limitation. It does not include hearing aids or corrective lenses, including the professional fee for fitting same. It also does not include medical supplies and devices, such as a corset, which do not require prescriptions. The option of purchasing or renting the equipment will be determined based on cost. AvMed will require that the most economical option be selected. Repair and/or replacement is not covered. See Schedule of Copayments for any Copayments or Limitations. See Part X for Exclusions.

- 8.21.02 Orthotic Appliances. Coverage for Orthotic appliances is limited to leg, arm, back, and neck custom-made braces when related to a surgical procedure or when used in an attempt to avoid surgery and are necessary to carry out normal activities of daily living, excluding sports activities. Coverage is limited to the first such item; repair and/or replacement is not covered. All other Orthotic appliances are not covered. See Schedule of Copayments for any Copayments or Limitations. See Part X for Exclusions.
- 8.22 Prosthetic Devices. The Plan provides benefits, when Medically Necessary, for Prosthetic devices. Coverage for Prosthetic devices is limited to artificial limbs, artificial joints, and ocular prostheses. Coverage includes the initial purchase, fitting, or adjustment. Replacement is covered only when Medically Necessary due to a change in bodily configuration. The initial Prosthetic device following a covered mastectomy is also covered. Replacement of cataract lenses is covered only if there is a change in prescription which cannot be accommodated by eyeglasses. All other Prosthetic devices are not covered. See Schedule of Copayments for any Copayments or Limitations. See Part X for Exclusions.
- 8.23 Payment to Non-Participating Providers. When, in the professional judgment of AvMed's Medical Director, a Participant needs covered medical or Hospital Services which require skills or facilities not available from Participating Providers and it is in the best interest of the Participant to obtain the needed care from a Non-Participating Provider, upon authorization by the Medical Director, payment not to exceed usual, customary and reasonable charges for such covered services rendered by a Non-Participating Provider will be made by the Plan. Charges for Non-Participating Hospital Services will be reimbursed in accordance with the covered benefits the Participant would be entitled to receive in a Participating Hospital.
- 8.24 Prescription Drug Benefits. Allergy serums and chemotherapy for cancer patients are covered. Coverage for insulin and other diabetic supplies is described below in Section 8.27. Other prescription drugs are a covered benefit under a separate prescription drug plan (see Addendum for Prescription Drug Card Program and Mail Order Program).

- 8.25 Ventilator Dependent Care. With prior authorization by AvMed, Ventilator Dependent Care is covered up to a total of 100 days lifetime maximum benefit.
- 8.26 Major Organ Transplants at a facility deemed appropriate and authorized by AvMed, as well as associated immunosuppressant drugs are covered except those deemed Experimental and/or Investigational. (See Section X.)
- 8.27 Diabetes Treatment for all Medically Necessary equipment, supplies, and services to treat diabetes. This includes outpatient self-management training and educational services, if the Participant's Primary Care Physician, or the Physician to whom the Participant has been referred who specializes in diabetes treatment, certifies the equipment, supplies, or services are Medically Necessary. Insulin pumps are covered under the provisions for Durable Medical Equipment above. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board certified endocrinologist under contract with AvMed.

Insulin, insulin syringes, lancets, and test strips are covered under the Prescription Drug Addendum, if any. In the event that the Company does not contract for a supplemental Prescription Drug coverage, insulin, insulin syringes, lancets, and test strips are covered subject to a \$30 Copayment per item for a 30-day supply.

- 8.28 Mammograms: one baseline mammogram is covered for female Participants between the ages of 35 and 39; a mammogram is available every two years for female Participants between the ages of 40 and 49; and a mammogram is available every year for female Participants aged 50 and older.

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

- 8.29 Osteoporosis Diagnosis and Treatment when Medically Necessary for high-risk individuals, e.g. estrogen-deficient individuals, individuals with vertebral abnormalities, individuals on long-term glucocorticoid (steroid) therapy, individuals with primary hyperparathyroidism, and individuals with a family history of osteoporosis.
- 8.30 Dermatological Services. The Plan will cover up to five (5) office visits per calendar year to a Participating Dermatologist for Medically Necessary covered services. No prior referral is required for these services.
- 8.31 Mastectomy Surgery when performed for breast cancer. Coverage for Post-Mastectomy Reconstructive Surgery shall include: 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction on the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications during all stages of mastectomy including lymphedemas. The length of stay will not be less than

that determined by the treating Physician to be Medically Necessary in accordance with prevailing medical standards and after consultation with the covered patient. Coverage is subject to any applicable copayments and will require pre-authorization of services as applicable to other surgical procedures or hospitalizations under the Plan.

- 8.32 General Anesthesia and Hospitalization Services to a Covered Dependent who is under 8 years of age and is determined by a licensed dentist and the Covered Dependent's Physician to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or if the Covered Dependent has one or more medical conditions that would create significant or undue medical risk for the Covered Dependent in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center. Pre-authorization by AvMed is required. There is no coverage for diagnosis or treatment of dental disease.
- 8.33 Coverage for Cleft Lip and Cleft Palate for Covered Dependents under 18 years of age. The coverage provided by this section is subject to the terms and conditions applicable to other benefits.
- 8.34 Acupuncture. Subject to specialist copayment.
- 8.35 Special supplies as follows, if prescribed by the attending physician: JOBST stockings; catheters; colostomy bags, tape, rings and belts; flotation pads; needles and syringes; splints; trusses; initial cataract lenses following cataract surgery.
- 8.36 Dental Services required because of treatment rendered within 12 months of accidental injury to natural teeth sustained while covered under this Plan.

IX. LIMITATIONS OF BASIC BENEFITS

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

- 9.01 Periodic physical examinations are limited to those which in the judgment of the Participant's Primary Care Physician are essential to the maintenance of the Participant's good health.
- 9.02 A Participant shall select one Primary Care Physician upon enrollment. If the Participant does not select a Primary Care Physician upon enrollment, a Primary Care Physician will be assigned by AvMed for the Participant. The Participant may obtain assistance in making a selection by contacting AvMed.
- 9.03 Substance Abuse - Hospital Limitation. Inpatient services for alcohol and drug abuse shall be provided but only for acute detoxification and the treatment of other medical

conditions of such abuse. Inpatient alcohol or drug rehabilitation services are not covered.

- 9.04 Visits to Licensed Dietitians/Nutritionists for the treatment of diabetes, renal disease or obesity control shall be limited to three (3) outpatient visits per calendar year and each visit requires a Copayment. (See Schedule of Copayments and Section X)
- 9.05 Spinal manipulations will be covered only when Medically Necessary and prescribed by a Participating Physician or by self-referral to a Participating Physician.
- 9.06 The total benefit for Ventilator Dependent Care is limited to 100 calendar days lifetime maximum.
- 9.07 Inpatient Hospital care for a medical "Emergency," in-area or out-of-area, will only be covered when authorized by AvMed, after the Participant or the Hospital notifies AvMed within 24 hours of admission or as soon as the Participant is lucid and able to notify AvMed of the admission following emergency care and services.
- 9.08 Other Health Care Facility (ies). All routine services of Other Health Care Facilities including Physician visits, physiotherapy, diagnostic imaging and laboratory work, are provided for a maximum of one hundred (100) days per contract year when a Participant is admitted to such a facility, following discharge from a Hospital, for a condition that cannot be adequately treated with Home Health Care Services or on an ambulatory basis.
- 9.09 Physical, Occupational or Speech therapies shall be limited as explained above.
- 9.10 Surgical or non-surgical procedures which are undertaken to improve or otherwise modify the Participant's external appearance shall be limited to reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect or initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast.
- 9.11 Hyperbaric Oxygen Treatments are limited to forty (40) treatments per condition as appropriate pursuant to the Centers for Medicare and Medicaid Services (CMS) guidelines subject to applicable Copayments as listed for Physical, Speech and Occupational Therapies.
- 9.12 Pre-Existing Conditions – Covered Employees and their enrolled Dependents will not be entitled to benefit payments for covered medical expenses that are incurred as a result of an injury or sickness for which advice, diagnosis, care or treatment was recommended or received or which was present within the six-month period immediately prior to the effective date of coverage.

This limitation will no longer apply after the expiration of a period of:

- a) twelve (12) consecutive months during which the Participant was continuously at work and covered under this Plan; or
- b) eighteen (18) consecutive months during which a Late Enrollee was continuously at work and/or covered under this Plan.

This Plan will credit periods of previous coverage toward a pre-existing condition period. Prior creditable coverage includes coverage under a group plan, individual health insurance coverage, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefit Program, a public health plan as defined in the regulations and any health benefit plan of the Peace Corps Act.

The individual must not experience a break in coverage of more than 63 days to avoid imposition of a pre-existing condition. A waiting period for the new plan is not considered a break in coverage for purposes of calculating the 63-day maximum.

Supplemental policies are not covered by the portability rules. Such policies include accident or disability policies, auto, liability, workers compensation, credit or other coverage that is secondary or incidental to other benefits. In addition, certain benefits are not covered by portability provisions if the benefits are offered separately. These benefits include dental, vision, long-term care and home health care.

- 9.13 Self-injectable Drugs are covered under the pharmacy benefits administered by Eckerd Health Services (see Addendum for Prescription Drug Card Program and Mail Order Program).

X. EXCLUSIONS FROM BASIC BENEFITS

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

10.01 Treatment of a condition resulting from:

- a) War or any act of war, whether declared or undeclared;
- b) Participation in a riot or rebellion;
- c) Engagement in an illegal occupation;
- d) Commission of or attempted commission of an assault; commission or attempted commission of a crime punishable as a felony;

10.02 Cosmetic, surgical or non-surgical procedures which are undertaken primarily to improve or otherwise modify the Participant's external appearance. Also excluded are surgical

excision or reformation of any sagging skin of any part of the body, including, but not limited to: the eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to: the face, lips, jaw, chin, nose, ears, breasts, or genitals (including circumcision, except newborns for up to one year from date of birth); hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; removal of tattooing; or any other surgical or non-surgical procedures which are primarily for cosmetic purposes or to create body symmetry. Non-medically necessary removal of warts, moles, skin tags, lipomas, keloids, scars, and other benign lesions is not covered. Additionally, all medical complications as a result of cosmetic, surgical or non-surgical procedures are excluded.

- 10.03 Medical care or surgery not authorized by a Participating Provider, except for Emergency Services, or not within the benefits covered by the Plan.
- 10.04 Dental Care for any condition except:
 - 10.04.01 When such services are for the treatment of trauma related fractures of the jaw or facial bones or for the treatment of tumors;
 - 10.04.02 Reconstructive jaw surgery for the treatment of deformities that are **present** and **apparent** at birth, provided the Covered Dependent was continuously covered by AvMed from date of birth to date of surgery; or
 - 10.04.03 Full mouth extraction when required before radiation therapy.
 - 10.04.04 Treatment resulting from a covered injury to sound natural teeth and rendered within 12 months from date of accident.
- 10.05 Services related to the diagnosis/treatment of temporomandibular joint (TMJ) dysfunction except when Medically Necessary; all dental treatment for TMJ.
- 10.06 Mandibular and maxillary osteotomies except when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.
- 10.07 Medical supplies when not prescribed by a Physician.
- 10.08 Home monitoring devices and measuring devices (other than apnea monitors) and any other equipment or devices for use outside the Hospital.
- 10.09 Surgically implanted devices and any associated external devices, except for cardiac pacemakers, intraocular lenses, artificial joints and orthopedic hardware, and vascular grafts. Dental appliances, other corrective lenses and hearing aids, including the professional fee for fitting them are not covered.

- 10.10 Over-the-counter medications, all contraceptives (including drugs and devices), hypodermic needles and syringes, and self-administered injectable drugs except for chemotherapy for cancer patients, insulin and insulin syringes, allergy serums.
- 10.11 Travel expenses including expenses for ambulance services to and from a Physician or Hospital except in accordance with Section VIII.
- 10.12 Treatment for chronic alcoholism and chronic drug addiction, except those services offered as a basic health service (See Section IX).
- 10.13 Treatment for armed forces service-connected medical care (for both sickness and injury).
- 10.14 Custodial Care.
- 10.15 Experimental and/or Investigational procedures unless approved by AvMed. For the purposes of this Contract, a drug, treatment, device, surgery or procedure may be determined to be experimental and/or investigational if any of the following applies:
- a) the Food and Drug Administration (FDA) has not granted the approval for general use; or
 - b) there are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 - c) there is no consensus among practicing physicians that the drug, treatment, therapy, procedure or device is safe or effective for the treatment in question or such drug, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or similar condition; or
 - d) such drug, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.
- 10.16 Personal comfort items not Medically Necessary for proper medical care as part of the therapeutic plan to treat or arrest the progression of an illness or injury. This Exclusion includes, but is not limited to: wigs (including partial hair pieces, weaves, and toupees); personal care kits; guest meals and accommodations; maid service; television/radio; telephone charges; photographs; complimentary meals; birth announcements; take home supplies; travel expenses other than Medically Necessary ambulance services that are provided for in the covered benefits section; air conditioners; humidifiers; dehumidifiers; and air purifiers or filters.

- 10.17 Physical examinations or tests, such as premarital blood tests or tests for continuing employment, education, licensing, or insurance or that are otherwise required by a third party.
- 10.18 Eye care including:
- a) Training or orthoptics, including eye exercises; or
 - b) Radial Keratotomy, refractory keratoplasty, Lasik surgery or any other corneal surgical procedure to correct refractive error.
- 10.19 Hearing examinations for Plan Participants 18 years of age or older for the purpose of determining the need for hearing correction.
- 10.20 Cosmetics, dietary supplements, nutritional formulae, health or beauty aids.
- 10.21 Care and treatment of obesity (with the exception of morbid obesity), weight loss or dietary control whether or not it is, in any case, part of the treatment plan for another illness.
- 10.22 Gender reassignment surgery as well as any service, supply, or medical care associated with gender reassignment or gender identity disorders.
- 10.23 All drugs, devices, and other forms of treatment related to a diagnosis of sexual dysfunction.
- 10.24 Infertility diagnosis, treatment, and supplies, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures. Also excluded are obstetrical benefits when such pregnancy is the subject of a Preplanned Adoption Arrangement or Surrogacy as defined under Chapter 63, Florida Statutes. Drugs for the treatment of infertility are not covered.
- 10.25 Reversal of sterilization procedures.
- 10.26 Immunizations and medications for the purpose of foreign travel or employment.
- 10.27 Biofeedback, hypnotherapy, massage therapy, sleep therapy, sex therapy, behavioral training, cognitive therapy, and vocational rehabilitation.
- 10.28 Foot supports are not covered. These include orthopedic or specialty shoes, shoe build-ups, shoe orthotics, shoe braces, and shoe supports. Also excluded is routine foot care, including trimming of corns, calluses, and nails.

- 10.29 The Medical and Hospital Services for a donor or prospective donor who is a Participant when the recipient of an organ transplant is not a Participant. Coverage is provided for costs associated with the bone marrow donor-patients to the same extent as the insured recipient. The reasonable costs of searching for the bone marrow donor is limited to immediate family and the National Bone Marrow Donor Program.
- 10.30 Diagnostic testing and treatment related to mental retardation or deficiency, learning disabilities, behavioral problems, developmental delays or Autism Spectrum Disorder. Expenses for remedial or special education, counseling, or therapy including evaluation and treatment of the above-listed conditions or behavioral training whether or not associated with manifest mental disorders or other disturbances.
- 10.31 Emergency room services for non-emergency purposes.
- 10.32 Hospital Services that are associated with excluded surgery or Dental Care.
- 10.33 Any treatment received by a Participant from a Non-Participating Provider, except in the case of an Emergency or when specifically pre-authorized by AvMed.
- 10.34 Physical, speech, occupational, and all other therapies for chronic conditions. Speech therapy for delayed or abnormal speech pathology is not covered.
- 10.35 Alcohol or substance abuse rehabilitation, vocational rehabilitation, pulmonary rehabilitation, long term rehabilitation, or any other rehabilitation program, except as specifically provided for in Section IX.
- 10.36 Surgery for the reduction or augmentation of the size of the breasts except as required for the comprehensive treatment of breast cancer or unless meets the “medically necessary” definition in 2.26.
- 10.37 Termination of pregnancy (other than when a live birth is not possible), unless the life of the mother is endangered by the continued Pregnancy, the fetus is deemed to have the potential for a congenital disorder, or the Pregnancy is the result of rape or incest.
- 10.38 Hospital Exclusion. If a Participant elects to receive Hospital care from a Non-Participating attending Physician or a Non-Participating Hospital, then coverage is excluded for the entire episode of care, except when the admission was due to an Emergency or with prior written authorization of AvMed.
- 10.39 Ventilator Dependent Care, except as provided in Part VIII (Schedule of Basic Benefits) for 100 days lifetime maximum benefit.
- 10.40 Private duty nursing services.

- 10.41 Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment.
- 10.42 Complications of any non-covered service, including the evaluation or treatment of any condition which arises as a complication of a non-covered service.
- 10.43 Any service or supply to eliminate or reduce dependency on or addiction to tobacco, including but not limited to: nicotine withdrawal programs, facilities, and supplies (e.g. transdermal patches, Nicorette gum).
- 10.44 Services associated with autopsy or postmortem examinations, including the autopsy.
- 10.45 Exercise programs, gym memberships, or exercise equipment of any kind, including, but not limited to: exercise bicycles; treadmills; stairmasters, rowing machines; free weights or resistance equipment. Also excluded are massage devices; portable whirlpool pumps, hot tubs, jacuzzis, sauna baths and similar equipment.

XI. COORDINATION OF BENEFITS

- 11.01 The services and benefits provided under the Plan are not intended and do not duplicate any benefit to which Participants are entitled under any other Group Health Insurance, HMO, Personal Injury Protection and Medical Payments under the Automobile Insurance Laws of this or any other jurisdiction, governmental organization, agency, or any other entity providing health or accident benefits to a Participant, including but not limited to: Medicare, Public Health Service, Champus, Maritime Health Benefits, or similar state programs as permitted by contract, policy, or law. Plan coverage will be primary to Medicaid benefits.
- 11.02 If any covered person is eligible for services or benefits under two or more plans as set forth above, the coverage under those plans will be coordinated so that up to but not more than 100% of any eligible expense will be paid for or provided by all such plans combined. The Participant shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Plan. Failure to do so will result in nonpayment of claims. Requested information should be provided to AvMed within thirty (30) days of request or Participant will be responsible for payment of claim. Information received after one (1) year from date of service will not be considered.
- 11.03 The standards governing the coordination of benefits are the following:
 - 11.03.01 The benefits of a policy or plan which covers the person as a Covered Employee or Participant, other than as a Dependent, are determined before those of the policy or plan which covers the person as a Dependent.

- 11.03.02 Except as stated below, when two or more policies or plans cover the same child as a Dependent of different parents:
- a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but
 - b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.
- 11.03.03 If two or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- a) First, the policy or plan of the parent with custody of the child;
 - b) Second, the policy or plan of the spouse of the parent with custody of the child; and
 - c) Third, the policy or plan of the parent not having custody of the child.
- However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.
- 11.03.04 The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this Subsection shall not apply.
- 11.03.05 If none of the above rules determine the order of benefits, the benefits of the policy or plan which covered the Participant for a longer period of time are determined before those of the policy or plan which covered that person for the shorter period of time.
- 11.03.06 Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in Section 627.635, Florida

Statutes, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

- 11.03.07 If an individual is covered under a COBRA continuation plan as a result of the purchase of continuation coverage as provided under COBRA, and also under another group plan, the following order of benefits applies:
- a) First, the plan covering the person as an employee, or as the employee's dependent.
 - b) Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.
- 11.04 For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of this agreement, AvMed may, without the consent of or notice to any person, release to or obtain from any other insurance Company, organizations or person, any information, with respect to any Participant, which AvMed deems to be necessary for such purposes.
- 11.05 Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts the Plan shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be Benefits paid under this Plan.
- 11.06 All treatments must be Medically Necessary and comply with all terms, conditions, Limitations, and Exclusions of this Plan even if the Plan is secondary to other coverage and the treatment is covered under the other coverage.
- 11.07 Persons Eligible for Medicare
- 11.07.01 Medicare shall be considered the secondary plan and this Plan shall be considered the primary plan with respect to the following covered persons entitled to Medicare:
- a) For Medicare entitlement due to age, active employees and their spouses;
 - b) For Medicare entitlement due to disability, employees under this Plan due to current employment status and their family participants;
 - c) For Medicare entitlement due to end-stage renal disease, all covered persons during the first 30 months of Medicare entitlement.
- 11.07.02 For all other covered persons entitled to Medicare, this Plan shall be secondary plan. When this Plan is secondary to Medicare, the amount payable

under this Plan shall be reduced by the amount payable under Medicare, if any, regardless of whether the covered person has enrolled in Medicare.

XII. REIMBURSEMENT

In the event that the Plan provides medical benefits or payments to a Participant who suffers injury, disease, or illness by virtue of a negligent act or omission by a third party, the Plan is entitled to reimbursement from the Participant.

Participant may be asked to provide a written assignment to the Plan of Participant's rights to all claims, demands, and rights to recovery that Participant may have against the third party. The Plan may take any action it deems necessary to protect its rights to recover the amount of any payments made by the Plan, including the right to bring suit in Participant's name. Participant shall execute and deliver any and all instruments and papers as may be required by the Plan and do whatever else is necessary to secure such recovery rights of the Plan.

Participant shall hold such proceeds in trust for the benefit of the Plan and pay them to the Plan upon demand if the proceeds have been paid directly to the Participant.

XIII. DISCLAIMER OF LIABILITY

- 13.01 Neither the Plan nor AvMed directly employs any practicing Physicians nor any Hospital personnel or Physicians. These health care providers are independent contractors and are not the agents or employees of the Plan. Therefore, neither AvMed, nor the Plan shall be liable for any negligent act or omission committed by any independent practicing Physicians, nurses, or medical personnel, nor any Hospital or health care facility, its personnel, other health care professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Participant of the Plan. Furthermore, neither AvMed nor the Plan shall be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat Plan Participants.
- 13.02 Certain Participants may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians. Participating Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the Physician/patient relationship and as obstructing the provision of proper medical care. If a Participant refuses to accept the medical treatment or procedure recommended by the Participating Physician and if, in the judgment of the Participating Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Participating Physician, the Participant shall be so advised. If a Participant continues to refuse the recommended treatment or procedure, the Plan may terminate the Participant's coverage under the Plan as set forth in Part VII.

XIV. GRIEVANCE PROCEDURE

Participants are entitled to have any complaint regarding the services or benefits covered under the Plan reviewed in accordance with the procedures set forth below. The Company has delegated the discretionary authority to interpret the Plan and to make initial claim determinations to AvMed. The Company retains the discretionary authority to make final claim review decisions on appeal and to determine whether you and your dependents are eligible to enroll for or continue coverage under the Plan. If your claim for Plan benefits is denied, AvMed will give you written notice of the specific reason for the denial, specific references to the Plan provisions on which your denial is based, a description of any additional information necessary to perfect your claim and an explanation of the Plan's appeal procedures.

14.01 Grievances Relating to Plan Services:

AvMed encourages the informal resolution of complaints relating to Plan services (e.g. quality of service, office waiting times, physician behavior or other concerns). However, if a Covered Person's complaint cannot be resolved in this manner (i.e. over the telephone), the Covered Person may submit his or her grievance in writing to the AvMed Member Services Department. AvMed shall acknowledge the written grievance and investigate the grievance. A written response regarding the disposition of the complaint shall be provided within 60 days after receipt of the written grievance.

You may submit a grievance in writing to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
1-800-882-8633

AvMed Member Services - South
P.O. Box 569008
Miami, Fl 33256-9906
1-800-882-8633

14.02 Urgent Care Claims.

14.02.01 Initial Claim. An Urgent Care Claim shall be deemed to be filed on the date received by AvMed on behalf of the Plan. AvMed shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical urgency, but not later than 72 hours after AvMed receives, either orally or in writing, the Urgent Care Claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If such information is not provided, AvMed shall notify the Claimant as soon as possible, but not later than 24 hours after AvMed receives the Claim, of the specified information necessary to complete the Claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. AvMed shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- a) AvMed's receipt of the specified information; or
- b) The end of the period afforded the Claimant to provide the specified additional information.

If the Claimant fails to supply the requested information within the 48-hour period, the Claim shall be denied. AvMed may notify the Claimant of its benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification, meeting the requirements of Section 14.06 shall be provided to the Claimant no later than 3 days after the oral notification.

14.02.02 Appeal. If you would like AvMed to review the denial prior to filing an appeal, you may do so by calling AvMed Member Services Department at 1-800-882-8633 or by submitting the request in writing to this address:

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

You may provide additional information to clarify or support your claim. Persons who were not involved in the initial determination shall conduct an internal review. A decision will be made within 30 working days and written notification will be provided to the Covered Person. However, this process in no way extends the 180 day period in which you are required to contact the Company.

A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within 180 days of receiving the Adverse Benefit Determination. The Plan shall notify the Claimant, in accordance with Section 14.08, of the Plan's benefit determination on review as soon as possible, taking into account the medical urgency, but not later than 72 hours after the Plan receives the Claimant's request for review of an Adverse Benefit Determination.

You may submit an appeal to:

Personal and Confidential
Employee Benefits Coordinator
City of Fort Lauderdale
Risk Management Department
100 North Andrews Avenue
Fort Lauderdale, Florida 33301
(954) 828-5436

14.03 Pre-Service Claims.

- 14.03.01 Initial Claim – A Pre-Service Claim shall be deemed to be filed on the date received by AvMed on behalf of the Plan. AvMed shall notify the Claimant of the Plan’s benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after AvMed receives the Pre-Service Claim. AvMed may extend this period one time for up to 15 days, provided that AvMed determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which AvMed expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In the case of a failure by a Claimant to follow the Plan’s procedures for filing a Pre-Service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits not later than five (5) days following such failure. The Plan’s period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim shall be denied.
- 14.03.02 Appeal – If you would like AvMed to review the denial prior to filing an appeal, you may do so by calling AvMed Member Services Department at 1-800-882-8633 or by submitting the request in writing to this address:

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

You may provide additional information to clarify or support your claim. Persons who were not involved in the initial determination shall conduct an internal review. A decision will be made within 30 working days and written notification will be provided to the Covered Person. However, this process in no way extends the 180 day period in which you are required to contact the Company.

A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving the Adverse Benefit Determination. The Plan shall notify the Claimant, in accordance with Section 14.08, of the Plan’s determination on review within a reasonable period of time. Such notification shall be provided not later than 30 days after the Plan receives the Claimant’s request for review of the Adverse Benefit Determination.

You may submit an appeal to:

Personal and Confidential
Employee Benefits Coordinator
City of Fort Lauderdale
Risk Management Department
100 North Andrews Avenue
Ft. Lauderdale, Florida 33301
(954) 828-5436

14.04 Post-Service Claims.

14.04.01 Initial Claim – A Post-Service Claim shall be deemed to be filed on the date received by AvMed on behalf of the Plan. AvMed shall notify the Claimant, in accordance with Section 14.06 of the Plan’s Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after AvMed receives the Post-Service Claim. AvMed may extend this period one time for up to 15 days, provided that AvMed determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which AvMed expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The Plan’s period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim shall be denied.

14.04.02 Appeal – If you would like AvMed to review the denial prior to filing an appeal, you may do so by calling AvMed Member Services Department at 1-800-882-8633 or by submitting the request in writing to this address:

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

You may provide additional information to clarify or support your claim. Persons who were not involved in the initial determination shall conduct an internal review. A decision will be made within 30 working days and written notification will be provided to the Covered Person. However, this process in

no way extends the 180 day period in which you are required to contact the Company.

A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within 180 days of receiving the adverse Benefit Determination. The Plan shall notify the Claimant, in accordance with Section 14.08, of the Plan's determination of review within a reasonable period of time. Such notification shall be provided not later than 60 days after the Plan receives the Claimant's request for review of the Adverse Benefit Determination.

You may submit an appeal to:
Personal and Confidential
Employee Benefits Coordinator
City of Fort Lauderdale
Risk Management Department
100 North Andrews Avenue
Ft. Lauderdale, Florida 33301
(954) 828-5436

14.05 Concurrent Care Claims

14.05.01 Any reduction or termination by AvMed of Concurrent Care (other than by plan amendment or termination) before the end of an approved period of time or number of treatments, shall constitute an Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with Section 14.06, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

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

14.06 Manner and Content of Initial Claims Determination Notification. AvMed shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant, the following:

- 14.06.01 The specific reason(s) for the Adverse Benefit Determination.
 - 14.06.02 Reference to the specific Plan provisions on which the determination is based.
 - 14.06.03 A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.
 - 14.06.04 A description of the Plan's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on final review.
 - 14.06.05 If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Averse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.
 - 14.06.06 If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.
 - 14.06.07 In the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim.
- 14.07 Review Procedure Upon Appeal. The Plan's appeal procedures shall include the following substantive procedures and safeguards:
- 14.07.01 Claimant may submit written comments, documents, records, and other information relating to the claim.
 - 14.07.02 Upon request and free of charge, the Claimant shall have reasonable access to and copies of any Relevant Document.
 - 14.07.03 The appeal shall take into account all comments, documents, records, and other information the claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
 - 14.07.04 The appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit

Determination nor the subordinate of such individual. Such person shall not defer to the initial Adverse Benefit Determination.

- 14.07.05 In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- 14.07.06 The appeal shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
- 14.07.07 The appeal shall provide that the Health Care Professional engaged for purposes of a consultation in Subsection 14.07.05 shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- 14.07.08 In the case of an Urgent Care Claim, there shall be an expedited review process pursuant to which:
 - a) a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and
 - b) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious methods.
- 14.08 Manner and Content of Appeal Notification. The Plan shall provide a Claimant with written or electronic notification of the Plan's benefit determination upon review.
 - 14.08.01 In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant, all of the following, as appropriate:
 - a) The specific reason(s) for the Adverse Benefit Determination.
 - b) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based.
 - c) A statement that the Claimant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of any Relevant Document.

- d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.
- e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.
- f) If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

XV. MISCELLANEOUS

- 15.01 **Individual Information.** Participants or other individuals shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. If Participant or other individual fails to provide accurate information which the Plan deems material to providing coverage for such individual, upon ten (10) days written notice, the Plan may deny coverage and/or participation in the Plan to such individual.
- 15.02 **Identification Cards.** Cards issued by AvMed to Participants pursuant to the Plan are for purposes of identification only. Possession of an identification card confers no right to health services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable charges under the Plan have actually been paid and accepted by the Plan.
- 15.03 **Waiver.** A claim which has not been timely filed with the Plan within one (1) year of date of service, shall be considered waived.
- 15.04 **Plan Administration.** The Company may from time to time adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the Plan.
- 15.05 **Gender.** Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.
- 15.06 **Clerical Errors.** Clerical error(s) shall neither deprive any individual Participant of any benefits or coverage provided under the Plan nor shall such error(s) act as authorization of benefits or coverage for the Participant that is not otherwise validly in force.

Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a 60 day period from the date of notification. Refunds of administrative service fees are done for up to a 60 day period from the date of notification. Refunds of administrative service fees are limited to a total of 60 days from the date of notification of the event, provided there are no claims incurred subsequent to the effective date of such event.

XVI. PRIVACY PRACTICES – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan, the Plan is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan Administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices, which may be obtained from your Plan Sponsor.

BENEFIT SUMMARY

OPTION 1

EFFECTIVE JANUARY 1, 2004

Benefit Summary

| BASIC OPTION/35 250-ADMIT | SCHEDULE OF COPAYMENTS | COST TO PARTICIPANT |
|--|--|--|
| OUT-OF-POCKET MAXIMUM | | \$1,500 INDIVIDUAL \$3,000 FAMILY |
| AVMED PRIMARY CARE PHYSICIAN | <p>Services at participating doctors' offices include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ ROUTINE OFFICE VISITS / ANNUAL GYN VISIT WHEN PERFORMED BY PRIMARY CARE PHYSICIAN ▪ MATERNITY-OUTPATIENT VISITS ▪ PEDIATRIC CARE & WELL-BABY CARE ▪ PERIODIC HEALTH EVALUATION & IMMUNIZATIONS ▪ DIAGNOSTIC IMAGING, LABORATORY OR OTHER DIAGNOSTIC SERVICES ▪ MINOR SURGICAL PROCEDURES ▪ VISION & HEARING EXAMINATIONS FOR CHILDREN UNDER 18 | \$15 PER VISIT |
| AVMED SPECIALIST'S SERVICES | <ul style="list-style-type: none"> ▪ OFFICE VISITS ▪ ANNUAL GYN EXAMINATION WHEN PERFORMED BY PARTICIPATING SPECIALIST | \$35 PER VISIT |
| HOSPITAL | <p>Inpatient care at participating hospitals includes:</p> <ul style="list-style-type: none"> ▪ ROOM & BOARD - UNLIMITED DAYS (SEMI-PRIVATE) ▪ PHYSICIAN'S, SPECIALIST'S & SURGEON'S SERVICES ▪ ANESTHESIA, USE OF OPERATING & RECOVERY ROOMS, OXYGEN, DRUGS & MEDICATION ▪ INTENSIVE CARE UNIT & OTHER SPECIAL UNITS, GENERAL & SPECIAL DUTY NURSING ▪ LABORATORY & DIAGNOSTIC IMAGING ▪ REQUIRED SPECIAL DIETS ▪ RADIATION & INHALATION THERAPIES | \$250 PER ADMISSION; 100% COVERAGE THEREAFTER |
| OUTPATIENT SURGERY | <ul style="list-style-type: none"> ▪ OUTPATIENT SURGERIES, INCLUDING CARDIAC CATHETERIZATIONS AND ANGIOPLASTY | \$250 COPAYMENT |
| OUTPATIENT DIAGNOSTIC TESTS | <ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ OTHER DIAGNOSTIC IMAGING TESTS | \$25 PER TEST \$10 PER TEST |
| EMERGENCY SERVICES | <p>An emergency is the sudden & unexpected onset of a condition requiring immediate medical or surgical care. (Copayment waived if admitted.)</p> <ul style="list-style-type: none"> ▪ EMERGENCY ROOM AT PARTICIPATING HOSPITALS ▪ EMERGENCY SERVICES - NON-PARTICIPATING HOSPITALS, FACILITIES, &/OR PHYSICIANS | \$100 COPAYMENT \$100 COPAYMENT |
| <p>AVMED MUST BE NOTIFIED WITHIN 24 HOURS OF INPATIENT ADMISSION FOLLOWING EMERGENCY SERVICES OR AS SOON AS REASONABLY POSSIBLE.</p> | | |
| URGENT/IMMEDIATE CARE | <ul style="list-style-type: none"> ▪ MEDICAL SERVICES AT A PARTICIPATING URGENT/IMMEDIATE CARE FACILITY OR SERVICES RENDERED AFTER HOURS IN YOUR PRIMARY CARE PHYSICIAN'S OFFICE ▪ MEDICAL SERVICES AT A NON-PARTICIPATING URGENT/IMMEDIATE CARE FACILITY | \$40 COPAYMENT \$60 COPAYMENT |

Benefit Summary, continued

| | | |
|--|--|---|
| MENTAL HEALTH | <ul style="list-style-type: none"> ▪ 20 OUTPATIENT VISITS | \$25 PER VISIT |
| FAMILY PLANNING | <ul style="list-style-type: none"> ▪ VOLUNTARY FAMILY PLANNING SERVICES ▪ STERILIZATION | \$15 PER VISIT \$250 COPAYMENT |
| ALLERGY TREATMENTS | <ul style="list-style-type: none"> ▪ INJECTIONS ▪ SKIN TESTING | \$10 PER VISIT \$50 PER COURSE OF TESTING |
| AMBULANCE | <ul style="list-style-type: none"> ▪ WHEN PRE-AUTHORIZED OR IN THE CASE OF EMERGENCY | NO CHARGE |
| PHYSICAL, SPEECH, & OCCUPATIONAL THERAPIES | <ul style="list-style-type: none"> ▪ SHORT-TERM PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY FOR ACUTE CONDITIONS ▪ COVERAGE IS LIMITED TO 24 VISITS PER CALENDAR YEAR FOR ALL SERVICES COMBINED <p>REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR SPECIFIC EXCLUSIONS & LIMITATIONS.</p> | \$20 PER VISIT |
| SKILLED NURSING FACILITIES & REHABILITATION CENTERS | <ul style="list-style-type: none"> ▪ UP TO 20 DAYS PER CONTRACT YEAR POST-HOSPITALIZATION CARE WHEN PRESCRIBED BY PHYSICIAN & AUTHORIZED BY AVMED | \$50 PER DAY |
| CARDIAC REHABILITATION | <p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ ACUTE MYOCARDIAL INFARCTION ▪ PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) ▪ REPAIR OR REPLACEMENT OF HEART VALVE(S) ▪ CORONARY ARTERY BYPASS GRAFT (CABG), or ▪ HEART TRANSPLANT <p>COVERAGE IS LIMITED TO 18 VISITS PER YEAR</p> | \$20 PER VISIT BENEFITS LIMITED TO \$1,500 PER CONTRACT YEAR. |
| HOME HEALTH CARE | <ul style="list-style-type: none"> ▪ PER OCCURRENCE | NO CHARGE |
| DURABLE MEDICAL EQUIPMENT & ORTHOTIC APPLIANCES | <p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ HOSPITAL BEDS ▪ WALKERS ▪ CRUTCHES ▪ WHEELCHAIRS <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ LEG, ARM, BACK, AND NECK CUSTOM-MADE BRACES <p>REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR SPECIFIC EXCLUSIONS & LIMITATIONS.</p> | \$50 PER EPISODE OF ILLNESS. BENEFITS LIMITED TO \$500 PER CONTRACT YEAR. |
| PROSTHETIC DEVICES | <p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ ARTIFICIAL LIMBS ▪ ARTIFICIAL JOINTS ▪ OCULAR PROSTHESES <p>REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR SPECIFIC EXCLUSIONS & LIMITATIONS.</p> | NO CHARGE |

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

THIS SCHEDULE OF COPAYMENTS IS NOT A CONTRACT.
FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS & LIMITATIONS, PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION. (SPD)

SELECT - OPEN ACCESS TO SPECIALTY HEALTH CARE PHYSICIANS

As of the Effective Date, the following Section of the Summary Plan Description is amended to read:

8.03 Each Participant shall select one Primary Care Physician (PCP) upon enrollment. If you do not select a Primary Care Physician upon enrollment, AvMed will assign one for you. You must notify and receive approval by AvMed **prior** to changing your Primary Care Physician. Such change will become effective on the first day of the month after you notify AvMed. You cannot change your PCP selection more than once per month.

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Addendum to SPD

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As of the effective date, the following Inpatient Mental Health Benefit has been added.

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As of the effective date, the following Substance Abuse Benefits have been added.

INPATIENT Inpatient treatment of alcohol and drug abuse is not provided except for acute detoxification.

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Addendum to SPD

Durable Medical Equipment

If selected, the following coverage is hereby modified:

DURABLE MEDICAL EQUIPMENT

- Benefits are limited to a maximum of \$4,000 per contract year.

All other coverage provisions, including copayment, limitations and exclusions remain as stated in the Summary Plan Description or Schedule of Co-Payments.

*In the treatment of diabetes, coverage for an infusion pump will apply toward the annual maximum limitation but shall not be subject to the durable medical equipment benefit limitation.



Addendum to SPD

Vision Benefits

As of the effective date, the following Vision Benefits have been added.

The following vision rider applies to ANY Licensed Vision Care Provider

EYE EXAMINATIONS

One (1) refractive eye examination per calendar year:

PLAN WILL PAY 100% UP TO:

| | |
|---|----------|
| Eyeglasses | \$ 39.00 |
| Contact Lenses (including fitting for regular daily wear, extended wear and disposable lenses, three months of follow-up care and starter kit.) | \$ 69.00 |

EYEGLASSES

One (1) pair of eyeglasses (frames and lenses) per calendar year:

PLAN WILL PAY 100% UP TO:

Frames

| | |
|-----------|---------|
| Any frame | \$69.00 |
|-----------|---------|

Plastic Ophthalmic Lenses

| | |
|--|----------|
| Single Vision | |
| Bifocal (FT 25-35 or Executive Lenses) | \$ 39.00 |
| Trifocal (FT 25-35 or Executive Lenses) | \$ 59.00 |
| Progressive "No Line" Bifocals and Trifocals | \$ 69.00 |
| Lenticular | \$105.00 |
| | \$105.00 |

In addition to the benefits shown above, the following lens options are available:

PLAN WILL PAY 100% UP TO:

| | |
|-------------------------|----------|
| High index Plastic | |
| Polycarbonate | \$ 50.00 |
| Glass | \$ 30.00 |
| Photochromatic | \$ 10.00 |
| Tints | \$ 20.00 |
| UV Coating | \$ 10.00 |
| Scratch Coating | \$ 12.00 |
| Transition | \$ 15.00 |
| Polarized | \$ 70.00 |
| Anti-Reflective Coating | \$ 45.00 |
| | \$ 36.00 |

Addendum to SPD, continued

CONTACT LENSES

PLAN WILL PAY 100% UP TO:

| | |
|---|-------------------|
| Daily Wear | |
| Daily Wear Replacement Lenses | \$ 35.00 per pair |
| Extended Wear | \$ 20.00 per lens |
| Extended Wear Replacement Lenses | \$ 39.00 per pair |
| Disposable Lenses (box of 6 lenses) | \$ 25.00 per lens |
| Daily Disposable Lenses (1 – 3 boxes of 30 one day wear lenses) | \$ 19.00 per box |
| (4 or more boxes of 30 one day wear lenses) | \$ 28.50 per box |
| | \$ 23.50 per box |

DEFINITIONS

All terms used in this Addendum shall have the respective meanings specified in the Summary Plan Description unless the context otherwise requires.

CONDITIONS

- The benefits and services covered by this Addendum are limited to the benefits and services set forth herein which are Medically Necessary.
- The benefits and services covered by this Addendum are part of the City of Fort Lauderdale's Employee Health Plan and do not require an additional or separate contribution by the Participant.
- With the exception of waiving the pre-existing condition limitation for vision care benefits described in this Addendum, nothing herein contained shall be held to vary, alter, waive, supplement, or extend any of the terms, conditions, provisions, agreement or limitations of the Summary Plan Description to which this Addendum is attached.
- Coverage under this Addendum shall commence and terminate in accordance with the terms of the Summary Plan Description.

Prescription Drug Program

When you enroll for coverage under the City of Fort Lauderdale’s prescription program, your drug coverage is administered through Eckerd Health Services (EHS).

TWO WAYS TO PURCHASE PRESCRIPTION DRUGS

You may purchase prescription drugs:

- From retail pharmacies that participate in the EHS network (in-network);
- By mail through Express Pharmacy Services (EPS).

SUMMARY OF COVERAGE

| | GENERIC DRUGS | BRAND DRUGS | <u>NON-FORMULARY</u> |
|--|----------------------|--------------------|-----------------------------|
| RETAIL COPAYS (up to a 30 days supply) | \$10 | \$20 | <u>\$35</u> |
| MAIL COPAYS (up to a 90 days supply) | \$20 | \$40 | <u>\$70</u> |

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

Your Prescription Drug Program ID Card

After enrolling in the City of Fort Lauderdale’s prescription program, you will receive an EHS (EPN plan) or BMC (PPO plan) ID card. Always show your EHS or BMC ID card when filling a prescription.

Prescription Drug Categories

With the Prescription Drug Program, there are three categories of prescription drugs:

- Generic
- Brand
- **Non-formulary**

Generic – Most generic drugs are covered under the Prescription Drug Program, unless they are plan exclusions. For purchases of generic drugs, you pay the lowest **copay** available under the program. A generic drug has the same chemical compound as its brand-name counterpart. The use of generic drugs offers a simple and safe alternative to help reduce prescription drug costs for you and the City.

Your pharmacist will substitute generic medications whenever possible, based upon availability, legal requirements and your physician's approval. But you can help ensure that you'll receive the generic product when it is available by asking your physician to write your prescription by the generic or chemical name.

Retail Pharmacy Purchases

Most associates live in an EHS network area. In addition to Eckerd Drug Stores, the EHS network includes many other pharmacy, grocery, and retail stores.

Network Pharmacies – Prescriptions for up to a 30-day supply can be filled at a network pharmacy. **Network pharmacies are those participating in the EHS national network of retail drug stores.** To find out if your pharmacy is in the network, call EHS or [create a login at www.ehs.com](http://www.ehs.com) and check the pharmacy locator.

You must present your EHS or BMC ID card at the time of purchase and pay your share of the cost. If you do not present your card when you purchase your prescriptions, you will be reimbursed at the non-network pharmacy level as outlined below.

Mail Service Purchases

Prescription for maintenance drugs – those that you take regularly over an extended period – can be filled by mail service through Express Pharmacy Services (EPS). You may purchase up to a 90-day supply of most of these drugs, such as insulin, heart or high-blood-pressure medication. Certain “controlled” (Schedule II) substances are limited to a 30-day supply with no refills. If you are taking maintenance drugs, call EHS and request a Mail Service enrollment form/envelope.

Follow these steps to use the Mail Service service:

- ⇒ When your physician prescribes a maintenance drug, ask for two written prescriptions – one for your immediate needs and one up to 90-day supply.
- ∕ Fill the prescription for a short-term supply (30 days or less) at a retail pharmacy.
- ⊂ Send the prescription for your long-term supply, your mail service form, and your check or credit card number to EPS. If you do not know which copayment applies, call EHS for assistance. Be sure to use the EPS Mail Service envelope, available through EHS.

EPS mails your prescription within two or three weeks after it is received by EPS. If your prescription includes refills, you may order them by calling EHS, mailing the prescription refill order form, or on the website at www.ehs.com.

Prior Authorization

There are certain prescription medications that, while not plan exclusions, may initially be denied because they require prior authorization. These situations require a closer review before EHS can approve the reimbursement. The prior authorization process is in place to make sure medications are being dispensed for the appropriate reason, in the appropriate quantities, at the appropriate time.

Listed below are the major reasons a prescription would require prior authorization:

- Refill too soon;
- Vacation supply;
- Increased dosage;
- Lost medication;
- Interim supply;
- Newly FDA approved drugs; or
- Medical necessity

For most of the reasons listed above, you need to call EHS and provide additional information.

Medical necessity and newly FDA approved drugs prior authorizations require a closer review to support their benefit(s) to the patient.

A medical necessity review is performed on a limited number of prescriptions. This medical necessity prior authorization requires a medical diagnosis from the prescribing physician. Some medications may require more information, in addition to the medical diagnosis. Your

pharmacist may supply EHS with the necessary information if it is provided on the actual prescription or your physician can call or fax the appropriate medical documentation to EHS. After receiving the documentation (from your pharmacist or physician), pharmacists at EHS will determine if the condition falls within the appropriate medical guidelines based on both medical judgment and current medical literature. In addition, some drugs may be subject to quantity limitations due to safety and cost concerns.

In most cases, you will not experience a delay in obtaining your medicine. You may experience a delay, however, if the appropriate documentation cannot be obtained from your physician or pharmacist immediately.

Drugs typically selected to be included in the prior authorization process are new drugs, drugs that have off-label (not approved by the FDA) uses, drugs that have the potential to be used inappropriately or drugs that are extremely expensive.

The need for prior authorization affects only a small number of medications. As new drugs become available, prior authorization may be required.

PRESCRIPTION DRUGS THAT ARE NOT COVERED

The Prescription Drug Program does not cover expenses for the following:

- Prescription refills in excess of the number specified by the physician, or any refill dispensed after one year from the date of the prescription;
- Prescription which are not medically necessary as determined by EHS;
- OTC products or over-the-counter equivalents and state restricted drugs;
- Implantable time-released medication (i.e., Norplant);
- Experimental or investigation drugs; or drugs prescribed for experimental (non-FDA approved/unlabeled) indications (i.e., progesterone suppositories, Yocon);
- Drugs FDA approved for cosmetic use only (i.e., Renova, Rogaine, Propecia, Vaniqua);
- Extemporaneously prepared combination of raw chemicals or combination of federal legend drugs in a non-FDA approved dosage form (i.e., capsules made from progesterone an estrogen powder);
- Fertility drugs (i.e., Lutrepulse Kit, Metrodin, Pergonal, Profasi, Pregnyl);
- Oral fertility drugs (i.e., Clomid, Serophene);
- Smoking Cessation Agents (i.e., Nicorette, Habitrol, Nicoderm, Nicotrol, ProStep);
- Immune Response Modifiers (Rebetron);
- Testosterone (patches, gel, injectables).

The Plan reserves the right to temporarily or permanently limit, restrict, or deny coverage for newly approved drugs and/or newly emergent therapeutic classes pending the completion of a comprehensive pharmaco-economic impact analysis by Eckerd Health Services.

PREScription DRUGS WITH RESTRICTIONS OR REQUIRE PRIOR AUTHORIZATION

| Therapeutic Class | Drug Name(s) and/or Description | Coverage |
|--|---|---|
| Anabolic steroids | Anadrol, Oxandrin, Winstrol | Covered with medical necessity |
| Antibiotics (Oxazolidinones) | Zyvox | Cover with Prior Authorization |
| Antimigraine agents: | Treatment of migraine headache attacks (e.g., Imitrex, Zomig, Amerge, Maxalt) | Cover with following restrictions: Imitrex – (18) tablets/month (9) 100mg tablets/month Zomig - (12) 2.5 tabs or (6) 5mg tabs/month Amerge - (18) 1 mg tabs or (9) 2.5 mg tabs /month Maxalt - (12) tablets per month Frova- (12) tablets per month |
| Cosmetic agents | Retin-A, Differin, Avita | Cover through age 25, then prior authorization |
| Cosmetic/Antineoplastic agent with alternate use | Proscar | Diagnosis required. Covered as an antineoplastic agent only; not for hair growth. |
| Emergency Contraceptive | Preven, Plan B | Maximum 1 Kit per 6 month at Retail only |
| Impotence Drugs | Viagra | Cover with quantity limits, 4 per month |
| Miscellaneous | Thalomid | Covered with medical necessity |
| Narcolepsy Drug | Xyrem | Cover with prior authorization and quantity limitations; 3 bottles per 30 days |
| Neuraminidase inhibitors | Relenza Diskhaler, Tamiflu caps | Relenza: Cover one diskhaler per year. Tamiflu: Cover 10 capsules per year. Cover 75mg solution per year. |
| Nutritional Supplements | Phenyl-Free & others used in PKU | Cover for PKU only. |
| Oral fertility drugs | Crinone | Cover with prior authorization for amenorrhea only. |

| | | |
|---|---|--|
| Osteoporosis Drugs | Actonel | Cover quantity limitations; 4 tablets per 30 days retail. |
| Pain Management | Toradol | Cover for 5 consecutive days only at FDA approved maximum dose; tablets limited to 40mg/day, injectable limited to 120mg/day |
| Pain Management | Stadol NS | Limit to 2 spray units for 30 calendar days |
| PMDD (premenstrual dysphoric disorder) Drugs | Sarafem | Limit coverage to females with Prior Authorization |
| Antidepressant agent with alternate use | Wellbutrin-SR | Diagnosis required |
| Sympathomimetic amines: (common uses: Attention Deficit Hyperactivity Disorder, Narcolepsy) | Ritalin, Metadate, Concerta, Cylert, Adderal, Dexedrine, Desoxyn, Provigil | Ritalin/ Metadate covered with 60mg/day as maximum daily dose. Concerta cover with 54mg/day as maximum daily dose. |
| Weight loss medications | All other drugs in this class (Meridia, Xenical and other drugs prescribed for weight loss) | Covered with medical necessity. |
| VITAMINS: | | |
| Legend vitamins (except Prenatal) | **Many brands** | Cover for medical necessity only, not for supplementation |
| Prenatal vitamins | **Many brands** | Cover for women only up to age 50. Cover for all members > 50 years for medical necessity. |
| Single entity Legend Vitamins/Minerals | Vitamin B3 (Niacin), Oil Soluble & Water Soluble (A, D, K) | Cover for medical necessity only, not for supplementation |
| | | |
| Antibiotics | <u>Zyvox</u> (Oxazolidinones) | Cover with Prior Authorization |
| Anticoagulants: Heparin and Lovenox | prevention and treatment of blood clots | Prior Authorization required for Lovenox only, which is used after certain surgeries. |
| Antimigraine agents: Imitrex | Treatment of migraine headache attacks. | Cover maximum 6 kits (12 syringes) per month, or 18 tabs per month, or 12 bottles nasal spray per month |
| Antineoplastic agents - (i.e., 5-fluorouracil, Lupron, Taxol, Zoladex & Methotrexate) | Treatment of cancer. | Cover Lupron with valid DX (not covered for fertility unless plan covers that category) |

| | | |
|--------------------------------------|--|--|
| Anti-Rheumatic Drugs - | Enbrel | Prior auth required; maximum 8 vials/30 days |
| Biologicals – Immune Globulins | Provides passive immunization to infectious diseases (e.g. Gammar, Gammimune, Sandoglobulin) | Prior Authorization Required |
| Crohn's Disease treatment | Remicade | Prior Authorization required – see Appendix |
| Growth hormones | e.g., Humatrope, Nutropin, Protropin | Prior authorization required |
| Impotence drugs | Used for treatment of impotence (e.g., Caverject, Muse, Edex) | Cover with quantity limitations; Caverject-6 vials/30 days Muse-1 carton/30 days Edex-6 vials or 4 kits per 30 days Viagra – 4 per 30 days |
| Insomnia Drugs | Ambien, Sonata | Cover with quantity limitations; 14 tablets per 32 days retail, 42 tablets per 90 days mail order. |
| Irritable Bowel Syndrome (IBS) Drugs | Lotronex, Zelnorm | Cover with prior authorization and quantity limit; 60 tablets per 30 days, 180 tablets per 90 days |
| Osteoarthritis agent | Synvisc, Hyalgan | Cover with Prior Authorization |
| RSV agent | Synagis | Cover with Prior Authorization |
| Miscellaneous | Botox, Myobloc | Cover with Prior Authorization |
| Insulin Delivery Devices | Implantable insulin pumps | Prior authorization required. |
| Insulin Delivery Devices | Ancillary pump products (i.e. Minimed tubing, needles, syringes) | Prior authorization required. |
| Narcotic Analgesics | <u>Allow a 60 days supply per year – allow 3 tablets per day</u> | <u>Then Prior authorization required.</u> |

BENEFIT SUMMARY

OPTION 2

EFFECTIVE JANUARY 1, 2004

Benefit Summary

SCHEDULE OF COPAYMENTS

COST TO PARTICIPANT

LARGE GROUP
\$30/\$750/20%

| CASH DEDUCTIBLE | INDIVIDUAL/FAMILY | \$750/\$2,250 annually |
|--|---|--|
| COINSURANCE OUT-OF-POCKET MAXIMUM | INDIVIDUAL/FAMILY | \$5,000/10,000 annually |
| AVMED PRIMARY CARE PHYSICIAN | Services at participating doctors' offices include, but are not limited to: <ul style="list-style-type: none"> ▪ ROUTINE OFFICE VISITS/ANNUAL GYN VISIT WHEN PERFORMED BY PRIMARY CARE PHYSICIAN ▪ MATERNITY-OUTPATIENT VISITS ▪ PEDIATRIC CARE & WELL-CHILD CARE ▪ PERIODIC HEALTH EVALUATION & IMMUNIZATIONS ▪ DIAGNOSTIC IMAGING, LABORATORY OR OTHER DIAGNOSTIC SERVICES ▪ MINOR SURGICAL PROCEDURES ▪ VISION & HEARING EXAMINATIONS FOR CHILDREN UNDER 18 | \$30 PER VISIT |
| AVMED SPECIALIST'S SERVICES | <ul style="list-style-type: none"> ▪ OFFICE VISITS ▪ ANNUAL GYN EXAMINATION WHEN PERFORMED BY PARTICIPATING SPECIALIST | \$60 PER VISIT |
| HOSPITAL | Inpatient care at hospitals includes: <ul style="list-style-type: none"> ▪ ROOM & BOARD – UNLIMITED DAYS (SEMI-PRIVATE) ▪ PHYSICIAN'S, SPECIALIST'S & SURGEON'S SERVICES ▪ ANESTHESIA, USE OF OPERATING & RECOVERY ROOMS, OXYGEN, DRUGS & MEDICATION ▪ INTENSIVE CARE UNIT & OTHER SPECIAL UNITS, GENERAL & SPECIAL DUTY NURSING ▪ LABORATORY & DIAGNOSTIC IMAGING ▪ REQUIRED SPECIAL DIETS ▪ RADIATION & INHALATION THERAPIES | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE |
| OUTPATIENT SURGERY | <ul style="list-style-type: none"> ▪ OUTPATIENT SURGERIES, INCLUDING CARDIAC CATHETERIZATIONS AND ANGIOPLASTY | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE |
| OUTPATIENT DIAGNOSTIC TESTS | <ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ OTHER DIAGNOSTIC IMAGING TESTS | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE |
| EMERGENCY SERVICES | An emergency is the sudden & unexpected onset of a condition requiring immediate medical or surgical care. (Copayment waived if admitted.) <ul style="list-style-type: none"> ▪ EMERGENCY ROOM AT PARTICIPATING HOSPITALS ▪ EMERGENCY SERVICES – NON-PARTICIPATING HOSPITALS, FACILITIES, &/OR PHYSICIANS <p>AVMED MUST BE NOTIFIED WITHIN 24 HOURS OF INPATIENT ADMISSION FOLLOWING EMERGENCY SERVICES OR AS SOON AS REASONABLY POSSIBLE.</p> | \$100 COPAYMENT \$100 COPAYMENT |
| URGENT/IMMEDIATE CARE | <ul style="list-style-type: none"> ▪ MEDICAL SERVICES AT A PARTICIPATING URGENT/IMMEDIATE CARE FACILITY OR SERVICES RENDERED AFTER HOURS IN YOUR PRIMARY CARE PHYSICIAN'S OFFICE ▪ MEDICAL SERVICES AT A NON-PARTICIPATING URGENT/IMMEDIATE CARE FACILITY | \$40 COPAYMENT \$60 COPAYMENT |
| FAMILY PLANNING | <ul style="list-style-type: none"> ▪ VOLUNTARY FAMILY PLANNING SERVICES ▪ STERILIZATION | \$30 PER VISIT \$250 COPAYMENT |

Benefit Summary, continued

| | | |
|--|--|---|
| MENTAL HEALTH | <ul style="list-style-type: none"> ▪ 20 OUTPATIENT VISITS | \$60 PER VISIT |
| ALLERGY TREATMENTS | <ul style="list-style-type: none"> ▪ INJECTIONS ▪ SKIN TESTING | \$30 PER VISIT \$50 PER COURSE OF TESTING |
| AMBULANCE | <ul style="list-style-type: none"> ▪ WHEN PRE-AUTHORIZED OR IN THE CASE OF EMERGENCY | \$100 COPAYMENT |
| PHYSICAL, SPEECH, & OCCUPATIONAL THERAPIES | <ul style="list-style-type: none"> ▪ SHORT-TERM PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY FOR ACUTE CONDITIONS ▪ COVERAGE IS LIMITED TO 24 VISITS PER CALENDAR YEAR FOR ALL SERVICES COMBINED. <p style="text-align: center;">REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR SPECIFIC EXCLUSIONS & LIMITATIONS.</p> | \$30 PER VISIT |
| SKILLED NURSING FACILITIES & REHABILITATION CENTERS | <ul style="list-style-type: none"> ▪ UP TO 20 DAYS PER CONTRACT YEAR POST-HOSPITALIZATION CARE WHEN PRESCRIBED BY PHYSICIAN & AUTHORIZED BY AVMED | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE |
| CARDIAC REHABILITATION | <p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ ACUTE MYOCARDIAL INFARCTION ▪ PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) ▪ REPAIR OR REPLACEMENT OF HEART VALVE(S) ▪ CORONARY ARTERY BYPASS GRAFT (CABG), or ▪ HEART TRANSPLANT <p style="text-align: center;">COVERAGE IS LIMITED TO 18 VISITS PER YEAR</p> | \$30 PER VISIT BENEFITS LIMITED TO \$1,500 PER CONTRACT YEAR. |
| HOME HEALTH CARE | <ul style="list-style-type: none"> ▪ PER OCCURRENCE | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE |
| DURABLE MEDICAL EQUIPMENT & ORTHOTIC APPLIANCES | <p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ HOSPITAL BEDS ▪ WALKERS ▪ CRUTCHES ▪ WHEELCHAIRS <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ LEG, ARM, BACK, AND NECK CUSTOM-MADE BRACES <p style="text-align: center;">REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR SPECIFIC EXCLUSIONS & LIMITATIONS.</p> | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE BENEFITS LIMITED TO \$2,000 PER CONTRACT YEAR. |
| PROSTHETIC DEVICES | <p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ ARTIFICIAL LIMBS ▪ ARTIFICIAL JOINTS ▪ OCULAR PROSTHESES <p style="text-align: center;">REFER TO YOUR SUMMARY PLAN DESCRIPTION FOR SPECIFIC EXCLUSIONS & LIMITATIONS.</p> | 20% OF THE CONTRACTED RATE AFTER DEDUCTIBLE |

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

THIS SCHEDULE OF COPAYMENTS IS NOT A CONTRACT. FOR SPECIFIC INFORMATION ON BENEFITS, EXCLUSIONS AND LIMITATIONS, PLEASE CONSULT YOUR SUMMARY PLAN DESCRIPTION. (SPD)

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As a Select Participant, you are entitled to see most participating Specialty Health Care Physicians without a referral from your Primary Care Physician. However, there are certain services provided by Specialty Health Care Physicians that require prior authorization, including some services performed in the office. In addition, self-referral is not permitted to participating Specialty Health Care Physicians designated as “Requires Special Consultation between your Doctor and the AvMed Medical Director” in the written or electronic Provider Directories at the time of service.

Health Professionals may from time to time cease their affiliation with AvMed. In such cases, you will be required to receive services from another Participating Health Professional.

Addendum to SPD

Inpatient Mental Health Benefits

As of the effective date, the following Inpatient Mental Health Benefit has been added.

- Inpatient treatment of mental/nervous disorders for up to 30 days per patient, subject to a Participant copayment of \$250 per day for the first 5 days of each admission, shall be provided when a Participant is admitted to an AvMed Participating Facility as a registered bed patient.

Addendum to SPD

Substance Abuse Benefits

As of the effective date, the following Substance Abuse Benefits have been added.

INPATIENT Inpatient treatment of alcohol and drug abuse is not provided except for acute detoxification.

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Addendum to SPD

Durable Medical Equipment

If selected, the following coverage is hereby modified:

DURABLE MEDICAL EQUIPMENT

- Benefits are limited to a maximum of \$4,000 per contract year.

All other coverage provisions, including copayment, limitations and exclusions remain as stated in the Summary Plan Description or Schedule of Co-Payments.

*In the treatment of diabetes, coverage for an infusion pump will apply toward the annual maximum limitation but shall not be subject to the durable medical equipment benefit limitation.



Addendum to SPD

Vision Benefits

As of the effective date, the following Vision Benefits have been added.

The following vision rider applies to ANY Licensed Vision Care Provider

EYE EXAMINATIONS

One (1) refractive eye examination per calendar year:

PLAN WILL PAY 100% UP TO:

| | |
|---|----------|
| Eyeglasses | \$ 39.00 |
| Contact Lenses (including fitting for regular daily wear, extended wear and disposable lenses, three months of follow-up care and starter kit.) | \$ 69.00 |

EYEGASSES

One (1) pair of eyeglasses (frames and lenses) per calendar year:

PLAN WILL PAY 100% UP TO:

Frames

| | |
|-----------|---------|
| Any frame | \$69.00 |
|-----------|---------|

Plastic Ophthalmic Lenses

| | |
|--|----------|
| Single Vision | |
| Bifocal (FT 25-35 or Executive Lenses) | \$ 39.00 |
| Trifocal (FT 25-35 or Executive Lenses) | \$ 59.00 |
| Progressive "No Line" Bifocals and Trifocals | \$ 69.00 |
| Lenticular | \$105.00 |
| | \$105.00 |

In addition to the benefits shown above, the following lens options are available:

PLAN WILL PAY 100% UP TO:

| | |
|-------------------------|----------|
| High index Plastic | |
| Polycarbonate | \$ 50.00 |
| Glass | \$ 30.00 |
| Photochromatic | \$ 10.00 |
| Tints | \$ 20.00 |
| UV Coating | \$ 10.00 |
| Scratch Coating | \$ 12.00 |
| Transition | \$ 15.00 |
| Polarized | \$ 70.00 |
| Anti-Reflective Coating | \$ 45.00 |
| | \$ 36.00 |

Addendum to SPD, continued

CONTACT LENSES

PLAN WILL PAY 100% UP TO:

| | |
|---|-------------------|
| Daily Wear | |
| Daily Wear Replacement Lenses | \$ 35.00 per pair |
| Extended Wear | \$ 20.00 per lens |
| Extended Wear Replacement Lenses | \$ 39.00 per pair |
| Disposable Lenses (box of 6 lenses) | \$ 25.00 per lens |
| Daily Disposable Lenses (1 – 3 boxes of 30 one day wear lenses) | \$ 19.00 per box |
| (4 or more boxes of 30 one day wear lenses) | \$ 28.50 per box |
| | \$ 23.50 per box |

DEFINITIONS

All terms used in this Addendum shall have the respective meanings specified in the Summary Plan Description unless the context otherwise requires.

CONDITIONS

- The benefits and services covered by this Addendum are limited to the benefits and services set forth herein which are Medically Necessary.
- The benefits and services covered by this Addendum are part of the City of Fort Lauderdale's Employee Health Plan and do not require an additional or separate contribution by the Participant.
- With the exception of waiving the pre-existing condition limitation for vision care benefits described in this Addendum, nothing herein contained shall be held to vary, alter, waive, supplement, or extend any of the terms, conditions, provisions, agreement or limitations of the Summary Plan Description to which this Addendum is attached.
- Coverage under this Addendum shall commence and terminate in accordance with the terms of the Summary Plan Description.

Prescription Drug Program

When you enroll for coverage under the City of Fort Lauderdale’s prescription program, your drug coverage is administered through Eckerd Health Services (EHS).

TWO WAYS TO PURCHASE PRESCRIPTION DRUGS

You may purchase prescription drugs:

- From retail pharmacies that participate in the EHS network (in-network);
- By mail through Express Pharmacy Services (EPS).

SUMMARY OF COVERAGE

| | GENERIC DRUGS | BRAND DRUGS | <u>NON-FORMULARY</u> |
|--|----------------------|--------------------|-----------------------------|
| RETAIL COPAYS (up to a 30 days supply) | \$10 | \$20 | <u>\$35</u> |
| MAIL COPAYS (up to a 90 days supply) | \$20 | \$40 | <u>\$70</u> |

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

Your Prescription Drug Program ID Card

After enrolling in the City of Fort Lauderdale’s prescription program, you will receive an EHS (EPN plan) or BMC (PPO plan) ID card. Always show your EHS or BMC ID card when filling a prescription.

Prescription Drug Categories

With the Prescription Drug Program, there are three categories of prescription drugs:

- Generic
- Brand
- **Non-formulary**

Generic – Most generic drugs are covered under the Prescription Drug Program, unless they are plan exclusions. For purchases of generic drugs, you pay the lowest **copay** available under the program. A generic drug has the same chemical compound as its brand-name counterpart. The use of generic drugs offers a simple and safe alternative to help reduce prescription drug costs for you and the City.

Your pharmacist will substitute generic medications whenever possible, based upon availability, legal requirements and your physician's approval. But you can help ensure that you'll receive the generic product when it is available by asking your physician to write your prescription by the generic or chemical name.

Retail Pharmacy Purchases

Most associates live in an EHS network area. In addition to Eckerd Drug Stores, the EHS network includes many other pharmacy, grocery, and retail stores.

Network Pharmacies – Prescriptions for up to a 30-day supply can be filled at a network pharmacy. **Network pharmacies are those participating in the EHS national network of retail drug stores.** To find out if your pharmacy is in the network, call EHS or [create a login at www.ehs.com](http://www.ehs.com) and check the pharmacy locator.

You must present your EHS or BMC ID card at the time of purchase and pay your share of the cost. If you do not present your card when you purchase your prescriptions, you will be reimbursed at the non-network pharmacy level as outlined below.

Mail Service Purchases

Prescription for maintenance drugs – those that you take regularly over an extended period – can be filled by mail service through Express Pharmacy Services (EPS). You may purchase up to a 90-day supply of most of these drugs, such as insulin, heart or high-blood-pressure medication. Certain “controlled” (Schedule II) substances are limited to a 30-day supply with no refills. If you are taking maintenance drugs, call EHS and request a Mail Service enrollment form/envelope.

Follow these steps to use the Mail Service service:

- ⇒ When your physician prescribes a maintenance drug, ask for two written prescriptions – one for your immediate needs and one up to 90-day supply.
- ∄ Fill the prescription for a short-term supply (30 days or less) at a retail pharmacy.
- ⊂ Send the prescription for your long-term supply, your mail service form, and your check or credit card number to EPS. If you do not know which copayment applies, call EHS for assistance. Be sure to use the EPS Mail Service envelope, available through EHS.

EPS mails your prescription within two or three weeks after it is received by EPS. If your prescription includes refills, you may order them by calling EHS, mailing the prescription refill order form, or on the website at www.ehs.com.

Prior Authorization

There are certain prescription medications that, while not plan exclusions, may initially be denied because they require prior authorization. These situations require a closer review before EHS can approve the reimbursement. The prior authorization process is in place to make sure medications are being dispensed for the appropriate reason, in the appropriate quantities, at the appropriate time.

Listed below are the major reasons a prescription would require prior authorization:

- Refill too soon;
- Vacation supply;
- Increased dosage;
- Lost medication;
- Interim supply;
- Newly FDA approved drugs; or
- Medical necessity

For most of the reasons listed above, you need to call EHS and provide additional information.

Medical necessity and newly FDA approved drugs prior authorizations require a closer review to support their benefit(s) to the patient.

A medical necessity review is performed on a limited number of prescriptions. This medical necessity prior authorization requires a medical diagnosis from the prescribing physician. Some medications may require more information, in addition to the medical diagnosis. Your

pharmacist may supply EHS with the necessary information if it is provided on the actual prescription or your physician can call or fax the appropriate medical documentation to EHS. After receiving the documentation (from your pharmacist or physician), pharmacists at EHS will determine if the condition falls within the appropriate medical guidelines based on both medical judgment and current medical literature. In addition, some drugs may be subject to quantity limitations due to safety and cost concerns.

In most cases, you will not experience a delay in obtaining your medicine. You may experience a delay, however, if the appropriate documentation cannot be obtained from your physician or pharmacist immediately.

Drugs typically selected to be included in the prior authorization process are new drugs, drugs that have off-label (not approved by the FDA) uses, drugs that have the potential to be used inappropriately or drugs that are extremely expensive.

The need for prior authorization affects only a small number of medications. As new drugs become available, prior authorization may be required.

PRESCRIPTION DRUGS THAT ARE NOT COVERED

The Prescription Drug Program does not cover expenses for the following:

- Prescription refills in excess of the number specified by the physician, or any refill dispensed after one year from the date of the prescription;
- Prescription which are not medically necessary as determined by EHS;
- OTC products or over-the-counter equivalents and state restricted drugs;
- Implantable time-released medication (i.e., Norplant);
- Experimental or investigation drugs; or drugs prescribed for experimental (non-FDA approved/unlabeled) indications (i.e., progesterone suppositories, Yocon);
- Drugs FDA approved for cosmetic use only (i.e., Renova, Rogaine, Propecia, Vaniqua);
- Extemporaneously prepared combination of raw chemicals or combination of federal legend drugs in a non-FDA approved dosage form (i.e., capsules made from progesterone an estrogen powder);
- Fertility drugs (i.e., Lutrepulse Kit, Metrodin, Pergonal, Profasi, Pregnyl);
- Oral fertility drugs (i.e., Clomid, Serophene);
- Smoking Cessation Agents (i.e., Nicorette, Habitrol, Nicoderm, Nicotrol, ProStep);
- Immune Response Modifiers (Rebetron);
- Testosterone (patches, gel, injectables).

The Plan reserves the right to temporarily or permanently limit, restrict, or deny coverage for newly approved drugs and/or newly emergent therapeutic classes pending the completion of a comprehensive pharmaco-economic impact analysis by Eckerd Health Services.

PREScription DRUGS WITH RESTRICTIONS OR REQUIRE PRIOR AUTHORIZATION

| Therapeutic Class | Drug Name(s) and/or Description | Coverage |
|--|---|---|
| Anabolic steroids | Anadrol, Oxandrin, Winstrol | Covered with medical necessity |
| Antibiotics (Oxazolidinones) | Zyvox | Cover with Prior Authorization |
| Antimigraine agents: | Treatment of migraine headache attacks (e.g., Imitrex, Zomig, Amerge, Maxalt) | Cover with following restrictions: Imitrex – (18) tablets/month (9) 100mg tablets/month Zomig - (12) 2.5 tabs or (6) 5mg tabs/month Amerge - (18) 1 mg tabs or (9) 2.5 mg tabs /month Maxalt - (12) tablets per month Frova- (12) tablets per month |
| Cosmetic agents | Retin-A, Differin, Avita | Cover through age 25, then prior authorization |
| Cosmetic/Antineoplastic agent with alternate use | Proscar | Diagnosis required. Covered as an antineoplastic agent only; not for hair growth. |
| Emergency Contraceptive | Preven, Plan B | Maximum 1 Kit per 6 month at Retail only |
| Impotence Drugs | Viagra | Cover with quantity limits, 4 per month |
| Miscellaneous | Thalomid | Covered with medical necessity |
| Narcolepsy Drug | Xyrem | Cover with prior authorization and quantity limitations; 3 bottles per 30 days |
| Neuraminidase inhibitors | Relenza Diskhaler, Tamiflu caps | Relenza: Cover one diskhaler per year. Tamiflu: Cover 10 capsules per year. Cover 75mg solution per year. |
| Nutritional Supplements | Phenyl-Free & others used in PKU | Cover for PKU only. |
| Oral fertility drugs | Crinone | Cover with prior authorization for amenorrhea only. |

| | | |
|---|---|--|
| Osteoporosis Drugs | Actonel | Cover quantity limitations; 4 tablets per 30 days retail. |
| Pain Management | Toradol | Cover for 5 consecutive days only at FDA approved maximum dose; tablets limited to 40mg/day, injectable limited to 120mg/day |
| Pain Management | Stadol NS | Limit to 2 spray units for 30 calendar days |
| PMDD (premenstrual dysphoric disorder) Drugs | Sarafem | Limit coverage to females with Prior Authorization |
| Antidepressant agent with alternate use | Wellbutrin-SR | Diagnosis required |
| Sympathomimetic amines: (common uses: Attention Deficit Hyperactivity Disorder, Narcolepsy) | Ritalin, Metadate, Concerta, Cylert, Adderal, Dexedrine, Desoxyn, Provigil | Ritalin/ Metadate covered with 60mg/day as maximum daily dose. Concerta cover with 54mg/day as maximum daily dose. |
| Weight loss medications | All other drugs in this class (Meridia, Xenical and other drugs prescribed for weight loss) | Covered with medical necessity. |
| VITAMINS: | | |
| Legend vitamins (except Prenatal) | **Many brands** | Cover for medical necessity only, not for supplementation |
| Prenatal vitamins | **Many brands** | Cover for women only up to age 50. Cover for all members > 50 years for medical necessity. |
| Single entity Legend Vitamins/Minerals | Vitamin B3 (Niacin), Oil Soluble & Water Soluble (A, D, K) | Cover for medical necessity only, not for supplementation |
| Antibiotics | | |
| Antibiotics | <u>Zyvox</u> (Oxazolidinones) | Cover with Prior Authorization |
| Anticoagulants: Heparin and Lovenox | prevention and treatment of blood clots | Prior Authorization required for Lovenox only, which is used after certain surgeries. |
| Antimigraine agents: Imitrex | Treatment of migraine headache attacks. | Cover maximum 6 kits (12 syringes) per month, or 18 tabs per month, or 12 bottles nasal spray per month |
| Antineoplastic agents - (i.e., 5-fluorouracil, Lupron, Taxol, Zoladex & Methotrexate) | Treatment of cancer. | Cover Lupron with valid DX (not covered for fertility unless plan covers that category) |

| | | |
|--------------------------------------|--|--|
| Anti-Rheumatic Drugs - | Enbrel | Prior auth required; maximum 8 vials/30 days |
| Biologicals – Immune Globulins | Provides passive immunization to infectious diseases (e.g. Gammar, Gammimune, Sandoglobulin) | Prior Authorization Required |
| Crohn's Disease treatment | Remicade | Prior Authorization required – see Appendix |
| Growth hormones | e.g., Humatrope, Nutropin, Protropin | Prior authorization required |
| Impotence drugs | Used for treatment of impotence (e.g., Caverject, Muse, Edex) | Cover with quantity limitations; Caverject-6 vials/30 days Muse-1 carton/30 days Edex-6 vials or 4 kits per 30 days Viagra – 4 per 30 days |
| Insomnia Drugs | Ambien, Sonata | Cover with quantity limitations; 14 tablets per 32 days retail, 42 tablets per 90 days mail order. |
| Irritable Bowel Syndrome (IBS) Drugs | Lotronex, Zelnorm | Cover with prior authorization and quantity limit; 60 tablets per 30 days, 180 tablets per 90 days |
| Osteoarthritis agent | Synvisc, Hyalgan | Cover with Prior Authorization |
| RSV agent | Synagis | Cover with Prior Authorization |
| Miscellaneous | Botox, Myobloc | Cover with Prior Authorization |
| Insulin Delivery Devices | Implantable insulin pumps | Prior authorization required. |
| Insulin Delivery Devices | Ancillary pump products (i.e. Minimed tubing, needles, syringes) | Prior authorization required. |
| Narcotic Analgesics | <u>Allow a 60 days supply per year – allow 3 tablets per day</u> | <u>Then Prior authorization required.</u> |

EXHIBIT B

BASIC ADMINISTRATIVE SERVICES AND CHARGES

PART I. BASIC ADMINISTRATIVE SERVICES

A. CLAIM ADMINISTRATION

1. Preparation and delivery of standard claim forms to the Employer for issuance to eligible Employees under the Plan (if necessary);
2. Make initial claim determinations;
3. Investigation of claims, as necessary;
4. Discussion of claims, where appropriate, with providers of health services;
5. Performance of internal audits of claim payments on a random sample basis;
6. Application of claim control procedures necessary to the effective implementation of the basic principles of the Plan;
7. Claim Department consultation, as necessary, with its health care and legal consultants in handling claims. (The Employer will be responsible for seeking its own advice if more specific consultative services are required in a particular case);
8. Calculation of benefits, check preparation, and issuance;
9. Notification to claimants of denied claims for which Member is responsible for payment, and the reason for the denial;
10. Notification to providers of denied claims, if provider submitted claim directly to Plan for payment, along with the reason for the denial and whether or not the Member is responsible for payment;
11. Each AvMed Participating Provider in the EPN network has agreed to accept contractual and negotiated rates as payment in full for services rendered to Employer's members who are covered under the terms of the Employer's benefit plan, provided claims are funded by Employer as soon as presented for payment. Subscribers and Covered Dependents are expected to pay the required copayments, as outlined in the Schedule of Benefits, to the Providers at the time the service is rendered.
12. Issue certificates of creditable coverage pursuant to the requirements of the Health Insurance Portability and Accountability Act ("HIPAA");

13. Coordination with stop loss carrier on aggregate and/or specific stop loss, if purchased;
14. Standard Claims and Experience Reporting by the 20th of the following month for both monthly and quarterly reports;
15. Subrogation Claims Payment (terms described in Part III of this Exhibit).

B. FINANCIAL

1. Provision of a monthly invoice for services, fees, and premiums;
2. Disbursement of monthly payments for insurance premiums, fees, etc... to enable continuous of services and insurance coverages;
3. Provision of annual year-end accounting consisting of a summary of the amount of paid claims at the coverage level and a summary of charges paid.

C. BANKING AND ADMINISTRATION

1. Furnishing of bank account activity data (to the extent administratively reasonable) to Employer on a mutually agreed upon frequency; and
2. Preparation for Employer of information reports required in connection with claim payments under the Plan to providers of health care services pursuant to Section 6041 of the Internal Revenue Code (Form 1099).
3. Provision of data maintained by AvMed for Employer's preparation of required governmental filings, upon request.

D. NETWORK ACCESS

1. Access to the AvMed Exclusive Provider Network (EPN), which may change from time to time.
2. Provide Employer a listing of Participating Providers. Such listing shall include the names, specialties, addresses, and phone numbers of such providers. An updated listing shall be posted on AvMed's website at www.avmed.org, which is updated weekly.
3. Access to the Transplant Network available for AvMed's self-funded clients.

4. Provide Employer with a Provider Directory for each eligible Subscriber at the initial enrollment and provide Employer a reasonable supply of Provider Directories upon each reprint (twice yearly) for distribution to new enrollees in the EPN.
5. Employer understands that AvMed may not contract for all services offered by a participating provider. Employer and enrollee should verify with the provider and AvMed that the services to be provided are covered under AvMed's contract with the provider and by the Employer's Plan Document.
6. Network Management Services which include credentialing and recredentialing of providers, contract negotiations and provider servicing.
7. Provide one ID card for each covered Member upon enrollment and subsequently if there is a material change in benefits. AvMed reserves the right to charge the Plan for reissuing cards at other times. (Refer to Exhibit B Part II for fees).

E. MEDICAL MANAGEMENT

1. AvMed will provide to Employer's Covered Employees and Covered Dependents Utilization Review programs to include: (1) Preauthorization of all inpatient and certain outpatient and office procedures, (2) Concurrent Review of inpatient stays, (either on-site or telephonically), and (3) Service Plus program which provides nurses and other medical staff available to all providers 24 hours a day, 7 days a week.
2. AvMed will provide to Employer's Covered Employees and Covered Dependents other coordinated medical services: (1) certain Disease Management Programs, (2) Nurse On Call, which is staffed 24 hours a day, 7 days a week to provide immediate information to the member either by talking to a nurse or by listening to a pre-recorded informational health topic, (3) Complex Case Management, when appropriate.
3. AvMed will provide Transplant coordination and management to Employer's PPO Plan enrollees, upon notice.

F. COMPREHENSIVE ACCOUNT AND MEMBER SERVICE

1. Enrollment and case installation
2. Designated Account Service Team

3. 24 hour Member Service Staff available via shared toll free telephone number

AvMed Service Standards are:

Call Completion Rate: 96%
Average Speed of Answer: 45 seconds

4. Distribution of participant notices from time to time to improve plan administration or as required by law. Notices specific to City of Fort Lauderdale will be submitted to the Employer for review prior to distribution to participants.
5. Creation and printing of language for SPD.

G. ELIGIBILITY

1. Screen new entrants for dependent eligibility, according to the plan document provisions. This may include verification of dependent eligibility by requests for documentation supporting student status or financial dependency, requesting a copy of a marriage license, adoption papers, birth certificates, etc.
2. Periodically screen for continued dependent child eligibility.
3. Transmit EPN eligibility to the City's Pharmacy Benefit Manager, Eckerd Health Systems (EHS), on a regular basis, as agreed to by EHS and AvMed.

PART II.

**CHARGES FOR BASIC ADMINISTRATIVE SERVICES PROVIDED BY AVMED OR
A SUBCONTRACTOR**

BASIC ADMINISTRATIVE SERVICES.

AvMed Health Plan

Year 1 03/01/03 – 02/29/04

\$39.00 Medical per Subscriber per month.

\$.86 Vision per Subscriber per month.

Year 2 03/01/04 – 02/28/05

Medical not to exceed 5% over year 1.

Vision not to exceed 5% over year 1.

Year 3 03/01/05 – 02/28/06

Medical not to exceed 5% over year 2.

Vision not to exceed 5% over year 2.

Claims Runout

If Employer and AvMed mutually agree AvMed should continue runout beyond the original runout period, then AvMed will charge a fee to the Employer as follows:

\$22.00 per adjudicated claim (including claims that are payable, adjusted, denied, or acknowledged as a duplicate submission previously paid or denied).

Reissue of Member ID Cards at Employer's Request

\$.50 per ID Card

Reinsurance Underwriting Fee Billed by AvMed on Behalf of CMB & Associates for Combined Insurance

\$.50 per Subscriber per month.

Capitation Fee(s) Billed by AvMed on Behalf of Provider Vendors

In lieu of medical claims, fixed expenses will include outpatient Laboratory Capitation of \$2.65 per Subscriber per month, as per the terms of the AvMed HMO/POS contracts with these service providers. Capitation vendors, services, and rates may change throughout the contract year based on AvMed's Commercial block of business. The rate is subject to change as AvMed's rate

is adjusted throughout the year. AvMed shall give Employer a thirty (30) day notice before changing rates or adding or deleting any capitated vendor or service.

PART II.- ADDENDUM

**CHARGES FOR BASIC ADMINISTRATIVE SERVICES PROVIDED BY AVMED OR
A SUBCONTRACTOR**

BASIC ADMINISTRATIVE SERVICES.

AvMed Health Plan

Year 2 03/01/04 – 2/28/05

\$40.95 Medical per Subscriber per month.

\$.90 Vision per Subscriber per month.

Reinsurance Underwriting Fee Billed by AvMed on Behalf of CMB & Associates for Combined
Insurance

Year 2 01/01/04 – 12/31/04

\$.65 per Subscriber per month.

PART III.

CONDITIONAL CLAIM/SUBROGATION RECOVERY SERVICES

A. All conditional claim payment and/or subrogation recoveries under the Plan will be handled by the entity checked below;

X Employer

___ An independent recovery vendor whose name and address follow:

___ AvMed and its subcontractor(s)

B. If Employer has designated AvMed and its subcontractors to act as its recovery agent in paragraph A. above, then:

1. Employer hereby confers upon AvMed and its subcontractors discretionary authority to reduce recovery amounts by as much as ___ (Select 50%, 75%, or 100%) of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts.

2. In the event a settlement offer represents a reduction greater than the selected percentage identified above, AvMed and its subcontractors should seek settlement advice from:

Name: _____

Title: _____

Address: _____

Telephone: _____

3. All amounts reimbursed to Employer's benefit payment Account shall be net of AvMed's and its subcontractors' subrogation administration fee. AvMed's and its subcontractors' subrogation administration fee on cases where AvMed and its subcontractors' have retained legal counsel shall be five percent (5%) of any recovery amount allocable to reimburse the Plan, to a maximum of \$10,000.00, plus any fees paid or payable to such counsel. Where no counsel has been retained by AvMed and its subcontractors, AvMed's and its subcontractors' subrogation administration fee shall be twenty-five percent (25%) of any recovery

amount allocable to reimburse the Plan, to a maximum of \$10,000.00. For the purposes of such fee calculations, the use of counsel to perform ministerial acts such as filing of appearances or defenses in states which require plaintiffs to name employee benefit plans as party defendants and in similar circumstances shall not constitute the retention of counsel.

- C. In accordance with state law restrictions, AvMed and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement, but shall make available to Employer and/or Employer's legal counsel such information relevant to such action or proceeding as AvMed and its subcontractors may have as a result of its handling of any matter under this Agreement.

EXHIBIT C

CLAIM AUDIT AGREEMENT

- A. WHEREAS, AvMed, Inc. d/b/a AvMed Health Plan (“AvMed”) desires to cooperate with requests by City of Fort Lauderdale (“Employer”) to permit an audit for the purposes set forth below; and
- B. WHEREAS, [To Be Determined]_____ (“the Auditor”) has been retained by Employer for the purpose of performing an audit (“Audit”) of claims administered by AvMed.
- C. WHEREAS, the Auditor and the Employer recognize AvMed’s legitimate interests in maintaining the confidentiality of its claim information, protecting its business reputation, avoiding unnecessary disruption of its claim administration, and protecting itself from legal liability;

NOW THEREFORE, IN CONSIDERATION of the premises and the mutual promises contained herein, AvMed, the Employer and the Auditor hereby agree as follows:

1. Audit Specifications

The Auditor will specify to AvMed in writing at least thirty (30) days prior to the commencement of the Audit the following “Audit Specifications”:

- a. the name, title and professional qualifications of individual Auditors;
- b. the Claim Office locations, if any, to be audited;
- c. the Audit objectives;
- d. the scope of the Audit (time period and number of claims);
- e. the process by which claims will be selected for audit;
- f. the records/information required by the Auditor for purposes of the Audit; and
- g. the length of time contemplated as necessary to complete the Audit.

2. Review of Specifications

AvMed will have the right to review the Audit Specifications and to require any changes in, or conditions on, the Audit Specifications which may be necessary to protect AvMed’s legal and business interests identified in paragraph C above.

3. Access to Information

AvMed will make the records/information called for in the Audit Specifications available to the Auditor at a mutually acceptable time and place.

4. Audit Report

The Auditor will provide AvMed with a true copy of the audit's findings, as well as of the Audit Report, if any, that is submitted to the Employer. Such copies will be provided to AvMed at the same time that the audit findings and the Audit Report are submitted to the Employer.

5. Comment on Audit Report

AvMed reserves the right to provide the Auditor and the Employer with its comments on the findings and, if applicable, the Audit Report.

6. Confidentiality

The Auditor understands that AvMed is permitting the Auditor to review the claim records/information solely for purposes of the Audit. Accordingly, the Auditor will ensure that all information pertaining to individual claimants will be kept confidential in accordance with all applicable laws and/or regulations. Without limiting the generality of the foregoing, the Auditor specifically agrees to adhere to the following conditions:

- a. The Auditor shall not make photocopies or remove any of the claim records/information without the express written consent of AvMed;
- b. The Auditor agrees that its Audit Report or any other summary prepared in connection with the Audit shall contain no individually identifiable information.

7. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from AvMed during the Audit with the same degree and standard of confidentiality owed by the Auditor to its clients in accordance with all applicable legal and professional standards. The Auditor shall not, without the express written consent of AvMed executed by an officer of AvMed, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by applicable law. The Employer and Auditor agree to indemnify and to hold harmless AvMed for any and all claims, costs, expenses and damages which may result from any breaches of the Auditor's obligations under paragraphs 6 and 7 of this Agreement or from AvMed's provision of information to the Auditor.

8. Expenses Incurred

Expenses incurred in performing the audit will be the responsibility of the Employer.

9. Termination

AvMed may terminate this agreement with prior written notice. The obligations set forth in Sections 4 through 7 shall survive termination of the Agreement.

Date

AvMed, Inc.

By: _____
Its: _____

Date

Auditor: _____

By: _____
Its: _____

Date

Employer: _____

By: _____
Its: _____

EXHIBIT D

CONFIDENTIALITY AGREEMENT

This Agreement effective the first day of March, 2003 is by and between the City of Fort Lauderdale ("Employer") and AvMed, Inc. d/b/a AvMed Health Plan, for itself and its affiliated companies ("AvMed").

WHEREAS, AvMed and Employer have entered into an Administrative Services Agreement pursuant to which AvMed administers claims for benefits under Employer's self-funded welfare benefit plan ("Plan"); and

WHEREAS, in its role as claim administrator for the Employer, AvMed has come into possession of certain individually identifiable records and other information including, but not limited to, information relating to claims for benefits under the Plan (collectively "Information"); and

WHEREAS, Employer desires that Information in the possession of AvMed be made available to it and to certain designated third parties ("Designated Third Parties") who assist it in administering the Plan. Such parties may include, but are not limited to, third-party administrators, consultants, brokers, auditors, successor administrators or insurers, and stop-loss carriers.

WHEREAS, AvMed desires, to the extent allowable by law, to accommodate Employer's request;

WHEREAS, Employer recognizes the confidential nature of Information that it has requested; and

WHEREAS, Employer recognizes AvMed's legitimate interest in maintaining the confidentiality of Information and in protecting itself from any and all legal liability with respect thereto;

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, AvMed and Employer hereby agree as follows:

1. AvMed will provide to Employer Information requested in writing by a person designated in writing by Employer to receive Information. Information will be used by Employer for the purpose of administration of the Plan, and will be handled and maintained in accordance with all obligations owed by Employer to participants in the Plan.
2. Upon Employer's written request, AvMed will provide to Designated Third Parties Information requested in writing by a person designated in writing by Employer to receive such Information. Information will be used by Designated Third-Parties for the sole purpose of assisting Employer in satisfying its responsibilities with respect to administration of the Plan, and will be handled and maintained in accordance with all obligations owed by Employer to Covered Persons in the Plan.
3. Employer acknowledges that AvMed is providing Information to Employer or to Designated Third Parties solely for the purposes stated in paragraphs 1 and 2 above.

4. Employer will not provide access to Information to any employee, agent or other designee other than an employee, agent or designee on a need-to-know basis who is designated by Employer to participate in the activities described in paragraph 1 above and who has the requisite expertise and responsibility to engage in such activities.
5. Employer will maintain and adhere to a written policy and procedure designed to protect the confidentiality of Information.
6. Employer agrees to keep all Information that pertains to individual Plan participants confidential in accordance with all applicable state and federal laws and regulations.
7. Employer will defend, indemnify and hold AvMed harmless from and against any and all claims, suits, expenses (including reasonable attorney's fees and court costs), liabilities or damages (whether resulting from settlement, judgment, arbitration or otherwise) arising directly or indirectly from AvMed's provision of Information to Employer or to Designated Third-Parties, or relating directly or indirectly to the use of Information by the Employer or Designated Third Parties, their officers, agents, directors, employees or designees.
8. This Confidentiality Agreement shall remain in force until it is terminated upon sixty (60) days prior written notice by either party. However, termination shall not in any way affect the parties' obligations with respect to information released under this Agreement prior to termination nor shall it affect the indemnification provision set forth above in paragraph 7, which also shall survive the termination of this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers.

City of Fort Lauderdale

AvMed, Inc.

By: _____

By: _____

Title: _____

Title: _____

Date: _____

Date: _____

EXHIBIT E

CLAIM PAYMENT OR OVERPAYMENT RECOVERY

If a claim is paid and it becomes necessary to re-claim all or part of the funds from the Participant, AvMed will contact the Participant in writing to request reimbursement of these funds. If there is no response within 30 days AvMed will notify the Employer who will then either handle the recovery themselves OR allow AvMed to use its contracted collection agency to try to recover funds on their behalf. The cost of this collection agency is approximately 25% of collected funds and is the responsibility of the Employer.

Employer should indicate which method of collection is required:

- A) Employer handles recovery in all cases
- B) AvMed refers all cases to collection
- C) Employer determines whether to use A) or B) on case-by-case basis.

WITNESSES:

AvMed, Inc.

Trudy Tappan

TRUDY TAPPAN
Print/type Name

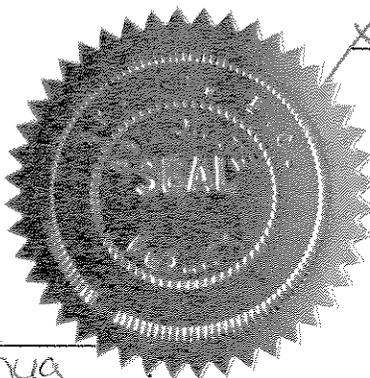
By R. Hudson
Name: Robert C. Hudson
Title: Chief Executive

B. Skinner

BRENDA K SKINNER
Print/type Name

ATTEST:

Stephen J. Demontrollin

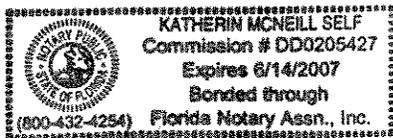


(CORPORATE SEAL)

STATE OF Florida
COUNTY OF Alachua

The foregoing instrument was acknowledged before me this 8/02, 2004, by Robert C. Hudson and Stephen J. Demontrollin, as Chief Executive and Assistant Secretary, respectively, of AvMed, Inc., a Florida corporation, on behalf of the corporation. He/she/they is/are personally known to me or have produced _____ as identification.

(SEAL)



Katherin M. Self
Notary Public, State of Florida
(Signature of Notary taking
Acknowledgment)

Katherin M. Self
Name of Notary Typed, Printed
Or Stamped

My Commission Expires: 6-14-2007

DD0205427
Commission Number