BlueCare
for Large Groups

MEMBER HANDBOOK

This Member Handbook contains a Pre-existing Condition Limitation

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Thank you for choosing Health Options, Inc.

Health Options, Inc. ("HOI") is a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida, Inc., a leader in health care financing solutions for over 50 years. HOI is a Florida-based Health Maintenance Organization ("HMO") providing comprehensive HMO-type coverage for both groups and individuals. This Member Handbook will evidence the existence of the Group Plan and describe the rights and obligations which the Member and HOI have with respect to the coverage and/or benefits to be provided by HOI.

Health Options, Inc.

ROBERT I. LUFRANO, M.D.
PRESIDENT

SECTION 1: GLOSSARY

For purposes of this Member Handbook and any attachments, amendments, and endorsements, the following terms shall have the meanings set forth below:

Accidental Dental Injury means an injury to sound natural teeth (not previously compromised by decay), caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Allowance means the maximum amount HOI will pay to Non-Contracting Providers for Covered Services other than Emergency Services and Care. This amount is determined solely by HOI and is based upon many factors, including but not limited to: the cost of providing the Covered Services; the charge(s) of the provider; the charge(s) of similar providers within a particular geographic area; various pre-negotiated payment amounts and HOI's pre-established fee schedules. In no event, will the Allowance be greater than the amount the provider actually charge(s). The Allowance may be modified by HOI at any time without the consent or notice to the Group or any Member.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the *Florida Statutes*, or other states' applicable laws, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.

Anniversary Date means the date one year after the Effective Date stated on the Group Application, and subsequent annual anniversaries of that date.

Artificial Insemination **(AI)** means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care provider for the purpose of producing a pregnancy.

Birth Center means any facility, institution, or place, licensed pursuant to Chapter 383 of the *Florida Statutes*, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy. A Birth Center is not an Ambulatory Surgical Center or a Hospital.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "bone

marrow transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all hospital, physician or other health care provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

Calendar Year begins January 1st and ends December 31st in any given calendar year.

Certified Nurse Midwife means a person who is licensed pursuant to Chapter 467 of the *Florida Statutes*, or other states' applicable laws, as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the *Florida Statutes*, or other states' applicable laws.

Condition means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Member.

Contracting Provider means any health care institution, facility, pharmacy, Physician, or other health care provider who has entered into a contract with HOI for the provision of health care services.

Copayment means the dollar amount established solely by HOI which is required to be paid to a health care provider by a Member at the time certain Covered Services are rendered by that provider. While this amount may vary depending on, among other things, the contracting status of the health care provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Schedule of Copayments for the service. Except as otherwise established solely by HOI, if more than one Covered Service is rendered by a health care provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Copayments for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.

Covered Services means those Medically Necessary health care services and/or supplies described in the Covered Services sections. The terms "health care services" and "services" include treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals and chemical compounds.

Creditable Coverage means health care coverage which is continuous to a date within 63 days of the Member's Enrollment Date. Such health care coverage may include any of the following:

1. A group health plan;
2. Individual health insurance;
3. Part A and Part B Medicare;
4. Medicaid;
5. Benefits to members and certain former members of the uniformed services and their dependents;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of Title 5, United States Code;
9. A public health plan; or
10. A health benefit plan of the Peace Corps.

Crisis Intervention means acute inpatient psychiatric care which is required for evaluation of an acute psychosis or crisis situation in which the patient presents as a danger to self or others. The acute or crisis situation may be an exacerbation of a history of mental illness or the sudden onset of a psychiatric disorder. The crisis or acute period normally extends 48 to 72 hours, but may be of greater duration depending upon the response to therapy.

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Dependent means a person who meets and continues to meet all of the applicable eligibility requirements set forth in the *Eligibility Requirements for Dependents* subsection, is properly enrolled hereunder through submission of an Individual Application for Group Insurance/Membership or Member Status Change Request form, as applicable, by his or her Subscriber, and for whom, or on whose behalf, Premium has been received by HOI.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent Member is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the Member at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or

other states' applicable law, to supervise diabetes outpatient self-management training and educational services.

Durable Medical Equipment means equipment furnished by a supplier or a home health agency that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) not for comfort or convenience; (4) generally is not useful to an individual in the absence of a Condition; and (5) is appropriate for use in the home.

Effective Date with respect to the Group and to Members properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the Group Application; and with respect to Members subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section.

Eligible Dependent means an individual who meets all of the eligibility requirements set forth in the *Eligibility Requirements for Dependents* subsection and is eligible to enroll as a Dependent.

Eligible Employee means an individual who meets all of the eligibility requirements set forth in the *Eligibility Requirements for Subscribers* subsection and is eligible to enroll as a Subscriber.

Emergency Medical Condition, as indicated in the Member's chart by a Physician or, to the extent permitted by law, by other appropriate licensed professional Hospital personnel under the supervision of a Hospital Physician, means

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

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

2. With respect to a pregnant woman:

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

Emergency Services and Care means Medically Necessary 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 by a Physician necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital.

Enrollment Date means the date of enrollment of the individual in this Group Plan or, if earlier, the first day of the Waiting Period of such enrollment.

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by HOI:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to the Member;

2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;

3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;

4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or 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;

5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or

8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by HOI):

1. records maintained by physicians or hospitals rendering care or treatment to the Member or other patients with the same or similar Condition;

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

3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

4. the written protocol or protocols relied upon by the treating physician or institution or the protocols of another physician or institution studying substantially the same evaluation, treatment, therapy, or device;

5. the written informed consent used by the treating physician or institution or by another physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

NOTE: Services or supplies which are determined by HOI to be Experimental or Investigational are excluded (see Exclusions and Limitations Section). In making benefit determinations, HOI may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.

Group means the employer, labor union, trust, association, partnership, department, other organization or entity through which coverage and/or benefits are issued by HOI, and through which Eligible Employees and Eligible Dependents become entitled to the Covered Services described herein.

Group Application means the form acceptable to HOI which the Group must submit to HOI when applying for coverage.

Group Plan means the group health benefit plan established and maintained by the Group through the purchase of comprehensive health care coverage and benefits from HOI.

HOI means HEALTH OPTIONS, INC., a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

Home Health Agency means a properly licensed agency or organization which provides health services in the home pursuant to Chapter 400 of the *Florida Statutes*, or other states' applicable laws.

Hospice means a public agency or private organization which is duly licensed by the state to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

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

The term Hospital does not include: an Ambulatory Surgical Center, a Skilled Nursing Facility, a stand-alone Birth Center; a facility for diagnosis, care and treatment of Mental and Nervous Disorders or alcoholism and drug dependency; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or rehabilitative care.

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

Individual Application for Group Insurance/Membership means the form(s) provided by or acceptable to HOI, which an individual must complete and submit to HOI when applying for Membership as a Subscriber.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

Medical Director of HOI means a Physician serving as the Medical Director in the Service Area of HOI in which the Member is enrolled.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or ***Medical Necessity*** means, for coverage and payment purposes, that a medical service or supply is required for the identification, treatment, or management of a Condition, and is, in the opinion of HOI:

1. consistent with the symptom, diagnosis, and treatment of the Member's Condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not Experimental or Investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of the Member, the Member's family, the Physician or other provider; and,
7. the most appropriate level of service, care or supply which can safely be provided to the Member. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Member in an alternative setting.

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.

Member means any Subscriber or Dependent.

Membership means having the status of being a current Member.

Membership Card means the identification card issued by HOI to Members. The Membership Card is the property of HOI, and is not transferable to another person. Possession of such Membership Card in no way verifies that a particular individual is eligible for or covered under the Group Plan.

Member Status Change Request Form means the form(s) provided by or acceptable to HOI, which a Subscriber must complete and submit to HOI when adding or deleting a Dependent.

Mental Health Professional means a person properly licensed to treat mental health problems pursuant to Chapter 491 of the *Florida Statutes*, or other states' applicable laws. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination or sect who provide counseling services.

Mental and Nervous Disorders means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the *Florida Statutes,* or other states' applicable laws.

Non-Contracting Provider means any health care institution, facility, pharmacy, Physician, or other health care provider with whom HOI does not have a contract in effect at the time the health care services are provided.

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Occupational Therapist means a person properly licensed to practice occupational therapy pursuant to Chapter 468 of the *Florida Statutes*, or other states' applicable laws.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Partial Hospitalization means treatment in which the patient receives at least seven (7) hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Physical Therapy means the treatment of disease or injury by physical or mechanical means. Such therapy may include traction, active or passive exercises, or heat therapy.

Physical Therapist means a person properly licensed to practice physical therapy pursuant to Chapter 486 of the *Florida Statutes*, or other states' applicable laws.

Physician Assistant means a person properly licensed to perform surgical first assisting services pursuant to Chapter 458 of the *Florida Statutes*, or other states' applicable laws.

Physician means any individual who is properly licensed by the State of Florida, or other states' applicable laws, as a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Chiropractic, Doctor of Dental Surgery or Dental Medicine, or Doctor of Optometry.

Premium means the amount required to be paid periodically by the Group on behalf of Members enrolled hereunder.

Primary Care Physician means the Physician who is the Primary Care Physician for the Member, according to HOI's records, and who provides primary care medical services to Members under a Primary Care Physician provider contract with HOI then in effect. A Primary Care Physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with HOI as a Primary Care Physician. Refer to the Primary Care Physicians section(s) of the provider directory for Physicians who are Primary Care Physicians.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

Psychiatric Facility means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For coverage purposes, a psychiatric facility is not a Hospital, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the *Florida Statutes*, or other states' applicable laws.

Service Area means the geographic area(s) described in Attachment A.

Skilled Nursing Facility means an institution or part thereof which is licensed as a skilled nursing facility by the State of Florida, or other states' applicable laws, accredited as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by HOI; and which provides Covered Services that are skilled nursing services, as determined by HOI, to Members under a contract then in effect.

Specialist means a Physician, who is a Contracting Provider, or a Physician who is a Non-Contracting Provider when authorized by HOI, who limits practice to specific services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective

practice and may or may not be certified by a related specialty board. (Refer to the Physicians who are listed under Specialty Physicians in the HOI Provider Directory.)

Speech Therapy means the treatment of speech and language disorders by a qualified health care provider including language assessment and language restorative therapy services.

Speech Therapist means a person properly licensed to practice speech therapy pursuant to Chapter 468 of the *Florida Statutes*, or other states' applicable laws.

Standard Reference Compendium means (1) The United States Pharmacopoeia Drug Information; (2) The American Medical Association Drug Evaluation; (3) The American Hospital Formulary Service Hospital Drug Information.

State or state means the State of Florida or any other state of the United States in which HOI is authorized and licensed to operate and in which a Service Area has been established.

Subscriber means an Eligible Employee who meets and continues to meet all applicable eligibility requirements of the *Eligibility Requirements for Subscribers* subsection, who enrolls hereunder, and for whom the payment(s) required by HOI has been received.

Substance Dependency means a condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Waiting Period means the period of time specified on the Group Application, if any, which must follow the date an individual is initially employed by the Group before such individual may become a Member.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the result zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

SECTION 2: ELIGIBILITY FOR MEMBERSHIP

Each employee or other individual who is eligible to participate in the Group Plan, and who meets and continues to meet HOI's eligibility requirements described in the Group Plan, shall be entitled to apply to become a Member of HOI. Such eligibility requirements shall be binding upon the Group and the Member and no change in such requirements shall be permitted unless HOI has been notified of and has agreed in writing to any such change in advance.

Eligibility Requirements for Subscribers

To be an Eligible Employee, a person must be a bona fide employee of the Group and must meet each of the following requirements:

1. the employee's job must fall within a job classification set forth on the Group Application;

2. the employee must maintain his/her primary residence in the Service Area or be regularly employed in the Service Area;

3. the employee must have completed any applicable Waiting Period set forth on the Group Application; and

4. the employee must meet any other applicable eligibility requirement(s) set forth on the Group Application or in the Group Plan.

This Subscriber eligibility class may be modified, and may be expanded to include:

- retired employees;
- additional job classifications;
- employees of affiliated or subsidiary companies of the Group, provided such companies and the Group are under common control; and
- other individuals as determined by HOI and the Group (e.g., members of associations or labor unions).

Any expansion of the Subscriber eligibility class must be approved by HOI and the Group, in writing, prior to such expansion.

Eligibility Requirements for Dependent(s)

To be an Eligible Dependent, a person must:

1. be the present spouse of a Subscriber; or

2. be a Member's natural child (including a newborn child), step-child, adopted child (including a newborn child who is required to be eligible for Membership hereunder as an adopted child in conformity with applicable law), or a child for whom the Subscriber has been appointed legal guardian, pursuant to a valid court order, and who is:

    a. unmarried, and principally dependent upon the Subscriber for financial support as determined by HOI; and

        b. (1) under 19 years of age and maintaining his/her primary residence in the Service Area (eligibility automatically terminates at the end of the Calendar Year in which the Dependent has his or her 19th birthday); or

        (2) the limiting age may be extended until the end of the Calendar Year in which the child reaches age 25, if the child meets all of the following requirements:

            (a) the child is Dependent upon the Subscriber for support and maintaining his/her primary residence in the Service Area; and

            (b) the child is living in the household of the Subscriber, or the child is a full-time or part-time student.

        NOTE: The extended eligibility will terminate on the last day of the month in which the child no longer meets any one of the requirements for extended eligibility as a Dependent child.

        (3) a Dependent child, who maintains his/her primary residence in the Service Area and is 19 years of age or older who is, in the opinion of HOI, incapable of self-sustaining employment as a result of mental retardation or physical handicap which commenced prior to the time such Dependent reached his or her 19th birthday. Satisfactory proof of such incapacity and dependency must be furnished to HOI by the Subscriber within 30 days of such Dependent's 19th birthday and within 30 days of each birthday thereafter. In the event the Dependent ceases to be incapable of self-sustaining employment as set forth above,

eligibility automatically terminates at the end of the Calendar Year in which the Dependent ceases to be so incapable.

Other Requirements/Rules Regarding Eligibility

1. A foster child shall in no event be eligible to be a Member.

2. No individual whose Membership in HOI has been terminated for cause (see the *Termination of Individual Membership for Cause* subsection) shall be eligible to re-enroll in HOI.

3. No person shall be refused enrollment or re-enrollment in HOI because of race, color, creed, marital status, sex, or age (except as provided in the *Eligibility Requirements for Dependents* subsection above).

4. The Subscriber must notify HOI as soon as possible when a Dependent Member is no longer eligible for Membership. If a Dependent fails to continue to meet each of HOI's eligibility requirements, and such proper notification is not timely provided by the Subscriber to HOI, HOI shall have the right to retroactively terminate Membership of such Dependent to the date any such eligibility requirement was not met, and to recover an amount equal to the Allowance for services and/or supplies provided following such date less any Premium received by HOI for such Dependent for coverage after such date. Upon HOI's request, the Subscriber shall provide proof, which is acceptable to HOI, of a Dependent's continuing eligibility for Membership.

5. If the Group offers an alternative health benefits plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for Membership.

SECTION 3: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Any individual who is not properly enrolled will not be eligible for Covered Services hereunder and HOI shall have no obligation whatsoever with respect to such individual.

Eligible Employees and Eligible Dependents may apply for Membership according to the provisions set forth below.

General Rules for Enrollment

1. All factual representations on the enrollment forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) HOI may have, in disqualification for, termination of, or rescission of Membership.

2. HOI shall not be required to provide coverage and/or benefits to any individual who would not have been entitled to Membership in HOI had accurate and complete information been provided on a timely basis on the enrollment forms. In such cases, HOI may require such individual, or an individual legally responsible for that individual, to reimburse HOI for any such Covered Services provided or payments made by HOI on behalf of such individual.

3. If the Group requires an individual to make a periodic financial contribution in order to be a Member, such individual shall have agreed in writing to make, and actually shall make, all required financial contributions.

Enrollment Forms/Electing Coverage

To apply for Membership, the Eligible Employee must:

a. Complete and submit, through his or her employer, an Individual Application for Group Insurance/Membership form to HOI;

b. Provide any additional information needed to determine eligibility, if requested by HOI;

c. Agree to pay his or her portion of the required Premium; and

d. Complete and submit, through his or her employer, a Member Status Change Request form to add or delete Dependents.

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Group's program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.

2. Employee/Spouse Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's present lawful spouse only.

3. Employee/Child(ren) Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's eligible child(ren) only.

4. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

There may be additional Premium for each Dependent based on the coverage selected by the Group.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is an annual 30-day period occurring no less than 30 days prior to the Anniversary Date, during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the Group's health benefit program.

Special Enrollment Period is the 30-day period immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for Membership. Special circumstances are described in the Special Enrollment subsection.

Employee Enrollment

1. An individual who is an Eligible Employee on the Group's Effective Date must enroll during the Initial Enrollment Period. The Eligible Employee shall become a Subscriber as of the Effective Date of the Group. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) shall be the same as the Subscriber's Effective Date.

2. An individual who becomes an Eligible Employee after the Effective Date of the Group (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual shall be the first HOI billing date (1st or 15th of each month) following the date the individual first became enrolled.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Subscriber. Please refer to the Coverage Access Rules for choosing a Dependent's Primary Care Physician.

1. Newborn Child -- To enroll a newborn child who is an Eligible Dependent, submit a Member Status Change Request form to HOI prior to or during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

   HOI must be notified, in writing, within 30 days after the birth. If timely notice is given, no additional Premium will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, HOI will charge the applicable Premium from the date of birth. The applicable Premium for the child will be charged after the initial 30-day period in either case. Coverage will be denied if notice is not given within 60 days of the date of birth of the newborn child; however, such newborn child may be enrolled during the next Annual Open Enrollment Period.

   NOTE: Coverage for a newborn child of a Member other than the Subscriber or the Subscriber's Dependent spouse will automatically terminate 18 months after the birth of the newborn child.

2. Adopted Newborn Child -- To enroll an adopted newborn child, the Subscriber must submit a Member Status Change Request form to HOI prior to or during the 30-day period immediately following the date of adoption and pay the additional Premium, if any. The Effective Date of coverage for an adopted newborn child eligible for Membership shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Member prior to the birth of such child, whether or not such agreement is enforceable; or,

   If the adopted newborn child is enrolled within this 30-day period, Premium will not be charged for the first 30 days of coverage. If the adopted newborn child is enrolled after this 30-day period, Premium will be charged from the moment of birth. Coverage will be denied if notice is not given within 60 days of the date of birth of the adopted newborn child; however, such adopted newborn child may be enrolled during the next Annual Open Enrollment Period.

   If the adopted newborn child is not ultimately placed in the residence of the

Subscriber, there shall be no coverage for the adopted newborn child under the Group Plan. It is the responsibility of the Subscriber to notify HOI within ten (10) calendar days if the adopted newborn child is not placed in the residence of the Subscriber.

3. Adopted Child -- To enroll an adopted child, the Subscriber must submit a Member Status Change Request form to HOI prior to or during the 30-day period immediately following the date of placement and pay the additional Premium, if any. The Effective Date for an adopted child (other than an adopted newborn child) shall be the date such adopted child is placed in the residence of the Member in compliance with Florida law; provided that the adopted child is so placed in the residence of the Member. If the adopted child is enrolled within this 30-day period, Premium will not be charged for the first 30 days of coverage. If the adopted child is enrolled after this 30-day period, Premium will be charged from the date such adopted child is placed in the residence of the Member.

   For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child under the Group Plan. Proof of final adoption must be submitted to HOI. It is the responsibility of the Subscriber to notify HOI if the adoption does not take place. Upon receipt of this notification, HOI will terminate the coverage of the child on the first billing date following our receipt of your written notice.

4. Marital Status -- A Subscriber may apply for coverage of an Eligible Dependent due to marriage. To apply for coverage, the Subscriber must complete the Member Status Change Request form and forward it to HOI. The Subscriber must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

5. Court Order -- A Subscriber may apply for coverage for an Eligible Dependent under the Group Plan outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Subscriber's plan. To apply for coverage, the Subscriber must complete the Member Status Change Request form and forward it to HOI. The Subscriber must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court order or the next billing date.

Annual Open Enrollment

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by submitting the Universal Individual Application for Group Insurance/Membership form during the Annual Open Enrollment Period.

The Effective Date of Coverage for an Eligible Employee and any Eligible Dependent(s) will be the first of the month following the Annual Open Enrollment Period.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period must wait until the next Annual Open Enrollment Period, unless the Eligible Employee is enrolled due to a special circumstance as outlined in the Special Enrollment subsection.

Special Enrollment

An Eligible Employee who declined coverage in writing at the time of his/her Initial Enrollment Period may apply for coverage due to the loss of coverage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the Individual Application for Group Insurance/Membership form and forward it to HOI. The Eligible Employee must make application for enrollment within 30 days of the special circumstance.

<u>Loss of Coverage</u> -- An Eligible Employee and/or Eligible Dependent(s) may request enrollment outside of the Initial Enrollment Period and Annual Open Enrollment Period if the individual:

1. was covered under another group health benefit plan as an employee or dependent, or, was covered under an individual health policy or, was covered under COBRA continuation coverage, at the time he or she was initially eligible to enroll with HOI;

2. when offered coverage by HOI at the time of initial eligibility, states, in writing, that coverage under another employer-provided health plan was the reason for declining enrollment;

3. demonstrates that he or she has lost coverage under another health benefit plan within the past 30 days as a result of legal separation, divorce, death; or, for an employer-provided health benefit plan, termination of employment, exhaustion of COBRA or Florida Continuation, or reduction in the number of hours of employment; and

4. requests enrollment within 30 days after the termination of coverage under another

health benefit plan.

Special Circumstances -- An Eligible Employee may apply for coverage due to the following special circumstances: birth of a child or placement for adoption, or marriage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the Individual Application for Group Insurance/Membership form and forward it to HOI. The Eligible Employee must make application for enrollment within 30 days of the special circumstance. The Effective Date of coverage for an Eligible Employee and any other Dependent(s) who are enrolled as a result of birth, adoption, placement for adoption, or marriage is the date of the event.

Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period.

Other Requirements/Rules Regarding Enrollment

All of the following additional requirements must be met in order for an individual to be enrolled.

1. HOI must be properly notified on a timely basis by the Group of any changes in the Member's status (see the *Records* subsection). Additionally, the Group shall immediately forward any enrollment form submitted by a Subscriber to HOI.

2. Entitlement to Covered Services is subject to the timely receipt by HOI from the Group of the monthly Premium on behalf of Eligible Employees and their Dependents enrolled as Members of HOI. HOI is not obligated to provide any Covered Services to any individual for whom HOI has not received such fees and charges in advance.

3. Subscribers are responsible for adding and deleting Dependents in accordance with HOI's requirements and on a timely basis. Subscribers must advise the Group immediately in the event a Dependent no longer meets the eligibility requirements by submitting a Member Status Change Request form to the Group. HOI is not responsible for providing Covered Services for any individual who should not have been added or who should have been deleted. The Group and the Subscriber are liable to HOI for any such Covered Services provided by HOI.

SECTION 4: TERMINATION OF INDIVIDUAL MEMBERSHIP

Termination of Subscriber Membership

A Subscriber's Membership will automatically terminate at 12:01 a.m. on the date:

1. the Group Plan terminates;
2. the Subscriber becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. the Subscriber otherwise fails to continue to meet each of the eligibility requirements specified by HOI or the Group; or
4. the Subscriber's Membership is terminated for cause (see the *Termination of Individual Membership for Cause* subsection).

Termination of Dependent Membership

A Dependent's Membership will automatically terminate at 12:01 a.m. on the date:

1. the Group Plan terminates;
2. his or her Subscriber's Membership terminates for any reason;
3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
4. the Dependent otherwise fails to continue to meet each of the eligibility requirements; or
5. the Dependent's Membership is terminated for cause (see the *Termination of Individual Membership for Cause* subsection).

Termination of Individual Membership for Cause

1. If, in HOI's opinion, any of the following events occur, HOI may terminate an individual's Membership for cause:

   a. disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Member's continued Membership in HOI impairs HOI's ability to provide coverage and/or benefits or to arrange for the delivery of health care

services to such Member or to other Members. Prior to disenrolling a Member for any of the above reasons, HOI will:

(1) make a reasonable effort to resolve the problem presented by the Member, including the use or attempted use of HOI's Complaint and Grievance Process (refer to the Complaint and Grievance Process Section of this Member Handbook); and
(2) ascertain, to the extent possible, that the Member's behavior is not related to the use of medical services or mental illness; and
(3) document the problems encountered, efforts made to resolve the problems, and any of the Member's medical conditions involved.

b. the knowing misrepresentation, omission, or the giving of false information on the Individual Application for Group Insurance/Membership, Member Status Change Request form, or other forms completed for HOI, by or on behalf of the Member;

c. fraud, material misrepresentation, or omission in applying for Membership or in requesting the receipt of Covered Services;

d. misuse of the Membership Card;

e. no longer lives, resides or works in the Service Area; or

f. a Dependent reaches the limiting age as specified in the Eligibility for Membership and Enrollment and Effective Date of Coverage Sections.

2. Any termination made under the provisions stated above is subject to review in accordance with the Complaint and Grievance Process described herein.

NOTE: Relative to a misstatement in the application, after two (2) years from the issue date, only fraudulent misstatements in the application may be used to void Membership or deny any claim for loss incurred or disability starting after the two (2)-year period.

Notice of Member Termination

Notice by HOI -- If an individual's Membership terminates for reasons other than the termination of the Group Plan, or for nonpayment of Premium, or as a result of termination of eligibility, HOI shall notify such Member and the Group, in writing, at the respective addresses then on file with HOI, at least 45 days prior to the date of termination. Such notice to Members who are Dependents may be made through such Dependent's Subscriber. This notice shall state the reason(s) and effective date of termination of Membership.

Responsibilities of HOI Upon Termination of an Individual's Membership

Upon termination of an individual's Membership for any reason, HOI shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Member Handbook.

SECTION 5: FINANCIAL OBLIGATIONS OF THE MEMBER

Copayments

Each Member is obligated to pay the Copayment amounts set forth in the Schedule of Copayments. The Subscriber shall also be responsible for the payment of all Copayments for Covered Services with respect to every individual enrolled as his or her Dependent. There is no Copayment for a newborn child or adopted newborn child in connection with the newborn's initial Hospital stay following birth. All such payment obligations are due and payable as they are incurred, and are paid directly to the health care provider.

Non-Covered Services

Members are responsible for the payment of charges for non-Covered Services and for the payment of charges in excess of any maximum benefit limitation set forth in the Schedule of Copayments.

Contributions

The Subscriber is responsible for any Premium contribution amount required by the Group.

Maximum Copayments

Total Copayments in any Calendar Year shall not exceed the amount indicated in the Schedule of Copayments, which in no event shall exceed twice the total annual Premium costs which a Subscriber (or, if there are Dependents, the Subscriber and his or her Dependents) would be required to pay if such individual(s) were enrolled under an option with no Copayments. Thereafter, Covered Services will be provided for that Member with no Copayment charge for the remainder of the Calendar Year. It is the Member's responsibility to retain receipts and to notify and document to the satisfaction of HOI when either of these Copayment limits has been reached.

SECTION 6: EXTENSION OF BENEFITS/CERTIFICATION OF CREDITABLE COVERAGE

Extension of Benefits

In the event the entire Group Plan is terminated, coverage shall end as of the termination date. HOI will not provide coverage or benefits for any service rendered on or after the termination date, except as set forth below. The extension of benefits provisions set forth below only apply when the Group Plan is terminated, and the benefits provided under an extension of benefits is subject to all other provisions, including the limitations and exclusions, set forth in this Member Handbook.

NOTE: It is the Member's responsibility to provide acceptable documentation to HOI that the Member is entitled to an extension of benefits.

1. In the event a Member is totally disabled on the termination date of the Group Plan as a result of a specific accident or illness incurred while the Member was covered under the Group Plan, as determined by HOI, HOI will provide a limited extension of benefits for the disabled Member only. This extension of benefits is for Covered Services necessary to treat the disabling condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Plan.

   For purposes of this section, a person is totally disabled only if, in the opinion of HOI, the Member is unable to work at any gainful job for which the Member is suited by education, training, or experience, and the Member requires regular care and attendance by a Physician. This would also apply to a Member who, although not engaged in an occupation (e.g., a student, non-working spouse, or children), is not able to perform the normal day-to-day activities which they would otherwise be able to perform.

2. In the event a Member is pregnant as of the termination date of the Group Plan, HOI will provide a limited extension of the maternity expense benefits, provided the pregnancy commenced while the pregnant Member was covered by HOI. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. This extension of benefits is not predicated upon the Member being totally disabled.

<u>HOI is not required to provide an extension of benefits if this entire Group Plan is terminated by HOI based upon any event referred to in §641.3922(7)(a) and (e) *Florida Statutes*.</u>

Certification of Creditable Coverage

In the event Membership terminates for any reason, HOI will issue a written Certification of Creditable Coverage to the Member.

The Certification of Creditable Coverage will indicate the period of time the Member was enrolled with HOI. Creditable Coverage may reduce the length of any pre-existing condition exclusion period by the length of time the Member had prior Creditable Coverage.

Members may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if the HOI coverage meets the qualifying creditable coverage guidelines (e.g., no more than a 63-day break in coverage).

SECTION 7: THE EFFECT OF MEDICARE COVERAGE/ MEDICARE SECONDARY PAYER PROVISIONS

When a Member becomes covered under Medicare and continues to be eligible and covered under the Group Plan, HOI's coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, HOI's coverage hereunder shall be secondary to any Medicare benefits. To the extent HOI is primary payer, claims for Covered Services should be filed with HOI first.

Under Medicare, the Group MAY NOT offer, subsidize, procure or provide a Medicare supplement insurance policy to such individual. Also, the Group MAY NOT induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

Working Elderly

A Member who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease (ESRD) should notify the Group.

Individuals With End Stage Renal Disease

For a Member who is entitled to Medicare coverage because of ESRD, HOI will provide group health coverage on a primary basis for 30 months beginning with the earlier of:

a. the month in which the individual became entitled to Medicare Part A ESRD benefits; or

b. the first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, HOI will provide group health coverage, as set forth herein, on a primary basis for 30 months.

Disabled Active Individuals

HOI will provide primary coverage to Members, if:

- The Group is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year; and

- The Members are entitled to Medicare coverage because of disability (unless they have ESRD).

Primary coverage under the Group Plan is pursuant to the following terms:

1. For a Member, HOI will provide group health coverage, as set forth in the Group Plan, on a primary basis during any month in which that individual is entitled to Medicare coverage because of disability.

2. Individual entitlement to primary coverage under this subsection will terminate automatically when:

   a. the individual turns 65 years of age; or
   b. the individual no longer qualifies for Medicare coverage because of disability; or
   c. the individual elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

Under Medicare, the Group MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

3. Entitlement of the Member to primary coverage under this subsection will terminate automatically if the Member no longer qualifies as such under applicable Medicare regulations and instructions. The Group shall notify HOI, without delay, of any such change in status.

Miscellaneous

1. This section shall be subject to, modified if necessary to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Group Plan.

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

3. If HOI should elect to make primary payments covering services rendered to a Member described in this section in a period prior to receipt of the information required by the terms of this section, HOI may require the Group to reimburse HOI for such payments. Alternatively, HOI may require the Group to pay the rate differential that resulted from the Group's failure to provide HOI with the required information in a timely manner.

SECTION 8: CONTINUATION OF COVERAGE UNDER COBRA

Federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, also known as Section 4980B of the Internal Revenue Code of 1986, may apply to the Group. If COBRA applies to the Group, a Member may be entitled to continue his or her group health coverage for a limited period of time, if the Member meets the applicable requirements, makes a timely election, and pays the proper Premium.

A Member must contact the Group to determine if he/she is entitled to COBRA continuation of coverage. The Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Subscribers and Dependents of their rights under COBRA. If the Group or the Member fails to meet its obligations under COBRA and the Group Plan, HOI shall not be liable for any claims incurred by the Member after his/her termination of coverage.

Solely for the convenience of the Group and Members, a summary of COBRA rights of a Member and the general conditions for a Member's qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by establishing the Group Plan; the duty to meet such obligations remains with the Group.

If COBRA applies to the Group and the Member is eligible for such coverage, Members may elect to continue their group health coverage if they qualify under one of the following circumstances:

1. If coverage would otherwise be lost due to the death of a Subscriber, the surviving Dependent(s) may qualify to elect to continue group health coverage for a period of time not to exceed 36 months from the date of death.

2. A Dependent who would otherwise lose coverage due to a divorce or legal separation from a Subscriber, may qualify to elect to continue group health coverage for a period of time not to exceed 36 months from the date of divorce or legal separation.

3. A Dependent of a Subscriber who would otherwise lose coverage due to the Subscriber's entitlements to Medicare, may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the Subscriber first becomes entitled to Medicare.

4. Children who are Dependents of a Subscriber, who would otherwise lose coverage due to a failure to meet HOI's eligibility requirements (e.g., exceeding the limiting age), may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the child ceased to meet such eligibility

requirements.

5. a. Subscribers and Dependents may qualify to elect to continue group health coverage if coverage would otherwise be lost due to termination of employment with the Group (other than for reasons of gross misconduct), or due to a reduction in hours of employment with the Group. This continuation of coverage may continue for a period not to exceed 18 months from the date of termination or reduction in hours.

   b. If the Member is totally disabled (as defined by the Social Security Administration) at the time of the Subscriber's termination, reduction in hours, or within the first 60 days of COBRA continuation of coverage, an extension of coverage of up to 11 additional months may be available (29 months total), if all notification and eligibility requirements have been met. Extension of coverage 11 additional months will not be provided if the Member fails to provide the Group with a copy of the "Determination of Disability" letter from the Social Security Administration within 60 days of the date of the determination of disability. The "Determination of Disability" letter must be provided to the Group prior to the end of the 18-month COBRA continuation period. If the extension of coverage for the 11 additional months is granted, the extension is also applicable to all non-disabled family members who were entitled to COBRA coverage during the 18 months of coverage.

6. If a Member is receiving continuation of coverage under paragraph 5 above, such coverage may continue for a period longer than the time stipulated in that paragraph if an event that would otherwise have entitled the Member to COBRA continuation of coverage (for example, divorce, legal separation, or death) later occurs. But in no case will the Member receive coverage beyond 36 months from the event that originally made him or her eligible for coverage.

7. If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to the Group, continuation rights shall be provided to the Member to the extent required under COBRA.

In order for the group health coverage to continue pursuant to COBRA, the following conditions must be met:

1. a. If coverage would be lost due to a reduction in hours or termination of employment (for reasons other than gross misconduct), the Group must notify the Subscriber and Dependents of their continuation of coverage rights under COBRA within 14 days of the termination of employment or reduction in hours causing a loss of coverage.

   b. If coverage would be lost due to Medicare entitlement, divorce, legal separation, or the failure of a Dependent child to meet eligibility requirements,

the Subscriber or Dependent must notify the Group, in writing, within 60 days of any of these events. The Group must notify the Dependents of their continuation of coverage rights within 14 days of receipt of notice from the Subscriber or Dependent.

2. The qualified Member must elect to continue the group health coverage within 60 days of the later of the date that the coverage terminates or the date the notification of continuation of coverage rights is sent by the Group.

3. The qualified Member who elects continuation of coverage must not become covered under any other group health coverage plan. However, COBRA coverage may continue if the new group health coverage plan contains exclusions or limitations due to a pre-existing condition that would affect the continuant's coverage.

4. The qualified Member must not become entitled to Medicare after electing continuation of coverage.

5. A totally disabled Member who is eligible to extend and who elects to extend his or her continuation of coverage after 18 months may not continue such coverage more than 30 days after a determination by the Social Security Administration that the Member is no longer disabled. The Member must inform the Group of the Social Security determination within 30 days of such determination.

6. The qualified Member electing continuation of coverage must meet all Premium payment requirements, and all other requirements, and all other eligibility requirements set forth in COBRA, and, to the extent not inconsistent with COBRA, in this Member Handbook.

7. The Group must continue to provide group health coverage to its employees through HOI.

An election by an employee or spouse shall be deemed to be an election for any other qualified beneficiary related to that employee or spouse, unless otherwise specified in the election form.

The Member does not need to show insurability to receive COBRA continuation of coverage. However, the Member must pay the applicable Premium charged by the Group.

In the case of a qualified Member whose maximum period of continuation of coverage expires, the Group must, during the 180-day period prior to such expiration date, provide the qualified Member the option of enrolling in a conversion health plan made available to the Members of the Group by HOI. Additionally, HOI shall allow such Member to apply for a conversion policy during the 63-day period immediately following the date such Member's maximum period of continuation of coverage expires.

NOTE: This section shall not be interpreted to grant any Member any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Group Plan shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

SECTION 9: CONVERSION PRIVILEGE

An individual whose Membership has terminated may apply for conversion to non-group membership. HOI and the Group have no obligation to notify any such individual of the conversion privilege. **It is the sole responsibility of the Member to exercise this conversion privilege subject to the provisions set forth below**.

Eligibility Criteria for Conversion

A Member is entitled to apply for either a Conversion Option A or Conversion Option B contract for non-group membership if:

1. the Member has been continuously covered under this Group Plan for three (3) months;

2. the Member was covered for at least three (3) months under any group policy providing similar benefits that this Group Plan immediately replaced;

3. the Member's coverage has been terminated for any reason, including discontinuance of this Group Plan in its entirety and termination of continued coverage under COBRA; and

4. the Member maintains his/her primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for health care services. **HOI must receive the completed conversion application and the applicable Premium payment within the 63-day period beginning on the date coverage under this Group Plan terminated.**

In the event HOI does not receive the conversion application and the initial Premium payment within such 63-day period, the Member's conversion application will be denied. Furthermore, the Member will not be entitled to a conversion policy.

Conversion is not available if termination occurred for any of the following reasons:

1. An individual had not been continuously covered under a group agreement for at least three (3) months prior to termination;

2. Failure to pay any required Premium unless such nonpayment was due to acts of an employer or person other than the individual;

3. Any Member contribution(s) required by HOI are not paid by the Member when due;

4. Replacement of coverage by similar group coverage within 31 days of termination;

5. Fraud or intentional misrepresentation in applying for Membership or for any Covered Services;

6. Termination for cause as set forth in the Termination of Individual Membership for Cause subsection;

7. The individual has left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or

8. The individual is eligible for, or covered under, Medicare, Title XVIII of the Social Security Act of 1965.

Additionally, conversion is not available:

- if the individual is eligible for similar benefits, whether or not covered under any arrangement of coverage for individuals in a Group, whether on a Member or non-Member basis;

- if the individual is covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service insured contract or medical practice or other prepayment plan, or by any other plan or program;

- if similar benefits are provided for or are available to the individual pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA); or

- if the benefits provided or available to the individual, together with the benefits provided by HOI, would result in excess of coverage, as determined by HOI's standards.

Conversion Coverage

The conversion contract issued to each individual who converts to non-group membership shall include a level of benefits for "minimum services" which is similar to the level of benefits for the services included in this Member Handbook. For purposes of this section, the term "minimum services" shall mean services which include any of the following: emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services. Conversion coverage is not a continuation

of the Group Plan. Benefits under such conversion coverage may differ from benefits under the Group Plan and any riders or endorsements attached thereto. Conversion coverage may continue in effect as long as each individual: (1) continues to meet all applicable eligibility requirements; (2) pays all applicable fees and charges; and, (3) otherwise complies with all requirements under the conversion contract.

Effective Date of Conversion; Reimbursement

The effective date of conversion coverage shall be the day following the termination of Membership. However, until such time as coverage under the conversion contract becomes effective, the individual shall pay the Allowance for any services or supplies rendered during the 63-day period immediately following such termination of Membership. In the event such conversion coverage becomes effective, an individual may request reimbursement from HOI for any payment for Covered Services. The individual must submit proof of payment to HOI in order to obtain reimbursement.

SECTION 10: DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided by HOI. It is designed to avoid the costly duplication of payment for health care services and/or supplies. HOI shall coordinate payment of Covered Services to the maximum extent allowed by law provided Members follow the Coverage Access Rules set forth in the Coverage Access Rules Section. Contracts which may be subject to Coordination of Benefits include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

- any group insurance, group-type self-insurance, or HMO plan;
- any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
- any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
- Medicare, as described in the Effect of Medicare Coverage/Medicare Secondary Payer Provisions Section.

The amount of payment by HOI, if any, is based on whether or not HOI is the primary payer. When HOI is primary, HOI will provide Covered Services without regard to the Member's coverage under other plans. When HOI is other than primary, Covered Services may be reduced so that, total benefits under all such plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services. In the event the Covered Services were rendered by a Contracting Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount HOI is obligated to pay such Contracting Provider pursuant to the applicable provider contract.

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. When HOI covers the Member as a Dependent and the other plan covers the Member as other than a Dependent, HOI will be secondary.

2. When HOI covers a Dependent child whose parents are not separated or divorced:

    - The plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary;
    - If both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than HOI, HOI will be secondary.

3. When HOI covers a Dependent child whose parents are separated or divorced:

- If the parent with custody is not remarried, the plan of the parent with custody is primary;
- If the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.

4. When HOI covers the Member as a Dependent child and the other plan covers the Member as a dependent child:

   - The plan of the parent who is neither laid off nor retired will be primary;
   - If the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the Member the longest shall be primary.

   HOI will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare Supplement policy.

Subrogation

If a Member is injured or becomes ill as a result of another party's intentional act or negligence, the Member must notify HOI concerning the circumstances under which the Member was injured. Under §768.76, *Florida Statutes* the Member or the Member's lawyer must notify HOI, by certified or registered mail, if the Member intends to claim damages from someone for injuries or illness. If the Member recovers money to compensate for the cost/expense of health care services to treat the Member's illness or injury, HOI is legally entitled to be reimbursed for payments made on the Member's behalf to the doctors, hospitals, or other providers who treated the Member. HOI's legal right to be reimbursed in such cases is called "subrogation." Normally, HOI may recover the amount of any payments it made on the Member's behalf minus its pro rata share for any costs and attorney fees incurred by the Member in pursuing and recovering damages. HOI may "subrogate" against all money recovered regardless of the source of the money including but not limited to uninsured motorists coverage.

Right to Receive and Release Necessary Information

In order to administer coverage and/or benefits, HOI may, without the consent of or notice to any person, plan, or organization, release to or obtain from any person, plan, or organization any information with respect to any Member or applicant for enrollment which HOI deems to be necessary.

Facility of Payment

Whenever payments which should have been made by HOI are made by any other person, plan, or organization, HOI shall have the right, exercisable alone and in its sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts HOI shall determine to be required in order to satisfy its coverage obligations hereunder. Amounts so paid shall be deemed to be paid under the Group Plan and, to the extent of such payments, HOI shall be fully discharged from liability.

Right of Recovery

Whenever HOI has made payments in excess of the maximum provided, HOI shall have the right to recover any such payments, to the extent of such excess, from any Member, person, plan, or other organization that received such payments.

Non-Duplication of Government Programs

The coverage and/or benefits provided by HOI hereunder shall not duplicate any benefits to which Members are entitled, or for which they are eligible, under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Act, to the extent that such Member has been paid under any such programs. In the event HOI has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to HOI to the extent of such duplication.

Cooperation Required of Members

Each Member shall cooperate with HOI, and shall execute and submit to HOI such consents, releases, assignments, and other documents as may be requested by HOI in order to administer, and exercise its rights. Failure to do so shall constitute grounds for termination for cause by HOI under the *Termination of Individual Membership* subsection.

SECTION 11: CLAIMS PROCESSING

Contracting Providers

If a Member receives services from a Contracting Provider, HOI pays, or has already paid, the provider directly for all Covered Services received, subject to any applicable Copayments. The Member will not have to submit a claim for payment for services provided by Contracting Providers. If the Member receives a bill from a Contracting Provider, it should be forwarded to HOI.

Non-Contracting Providers

If the Member requires Emergency Services and Care from a Non-Contracting Provider while inside or outside the Service Area or, if HOI refers the Member to a Non-Contracting Provider, HOI will pay for Covered Services provided to the Member. If the Member receives a bill from a Non-Contracting Provider for such services, it should be forwarded to HOI.

Claims Processing

The following provisions apply if the Member needs to file a claim for Covered Services rendered by a Non-Contracting Provider.

In order for HOI to be obligated to pay any claim for any service or supply provided by a Non-Contracting Provider, written proof, satisfactory to HOI, of such claim must be furnished to HOI within 90 days from the date the services for Covered Services, for which such claim is made, were rendered. Failure to furnish such proof within such 90-day period, if it was not reasonably possible to do so, shall not invalidate or reduce the claim, provided that the proof is furnished as soon as reasonably possible.

HOI shall not be obligated to pay for any such Covered Services if written proof is not received by HOI within a one-year period from the date the Covered Services were rendered, except in the absence of legal capacity of the Member or if the Member is unable to obtain the required information after a good faith effort and so notifying HOI.

Claims will not be paid, or if already paid, HOI may obtain a refund of any payments made if either the Member or the Group is in default as of the date of service on which such claim for payment is based and such default has not been properly cured prior to termination of coverage. In no event shall HOI be required to pay more than the Allowance for Covered Services other than Emergency Services and Care.

Timely Payment of Claims

After receiving written proof of claims, HOI will pay uncontested claims or any portion of any uncontested claim for Covered Services from Contracting Providers within 35 days after receipt of the claim by HOI. If a claim or portion of a claim is contested by HOI, the provider will be notified, in writing, that the claim is contested, within 35 days after the receipt of the claim by HOI. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. HOI, upon receipt of additional information requested from the provider, will pay or deny the contested claim or portion of the contested claim within 45 days.

For claims related to services rendered by a Non-Contracting Provider, it is the Member's responsibility to ensure that HOI receives all the information that HOI determines is necessary to complete processing of the claim. HOI, upon receipt of a claim from a Subscriber, will pay or deny the claim within 30 days.

Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

Upon written notification by a Member, HOI will investigate any claim of improper billing by a Physician, Hospital, or other health care provider. HOI will determine if the Member was properly billed for only those procedures and services that the Member actually received. If HOI determines that the Member has been improperly billed, HOI will notify the Member and the provider of its findings and will reduce the amount of the payment to the provider by the amount determined to be improperly billed.

HOI shall pay for Covered Services or deny any claim no later than 120 days after receiving a claim.

Right To Require Medical Exams

HOI has the right to require medical examinations be performed on any claimant for whom a claim is pending as often as HOI may reasonably require. If HOI requires a medical examination, it will be performed at HOI's expense. HOI also has the right to request an autopsy in the case of death, if the state law so permits.

Legal Actions and Limitations

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

SECTION 12: COVERAGE ACCESS RULES

It is important that Members become familiar with the rules for accessing health care coverage through HOI. The following sections explain the role of HOI and the Primary Care Physician (PCP), how to access specialty care coverage through HOI and the Primary Care Physician, and what to do if Emergency Services and Care is needed. It is also important for the Member to review all Service Area-specific Coverage Access Rules for particular types of services and Contracting Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated provider contracts and other network factors specific to the Service Area.

Choosing A Primary Care Physician

The first and most important decision each Member must make when joining a health maintenance organization is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of Specialists, are obtained. The Member is free to choose any Primary Care Physician listed in HOI's published list of Primary Care Physicians whose practice is open to additional Members. This choice should be made when the Member enrolls. The Subscriber is responsible for choosing a Primary Care Physician for all minor Dependents including a newborn child or an adopted newborn child. If the Member fails to choose a Primary Care Physician when enrolling, HOI will assign one to the Member and notify the Member of that assignment. Some important rules apply to the Member's Primary Care Physician relationship:

1. The Primary Care Physician selected by the Member will maintain a Physician-patient relationship with the Member, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for providing, authorizing and coordinating all medical services for the Member.

2. Except as specified in the Coverage Access Rules set forth in the provider directory, if any, the Member must look to the Primary Care Physician to provide or coordinate his/her care.

3. Except in an emergency, all services must be received from the Member's Primary Care Physician, from Contracting Providers on referral from or authorization of the Primary Care Physician, or through another health care provider designated by the Member's Primary Care Physician or HOI. See the *Access to Other Contracting Providers* subsection of this section for exceptions to this rule.

4. HOI wants the Member and the Primary Care Physician to have a good relationship. To be certain this relationship is conducive to effective health care, both the Member

and the Primary Care Physician may request a change in the Primary Care Physician assignment:

a. The Member may request a transfer to another Primary Care Physician whose practice is open to enrollment of additional Members. The transfer of care to the newly selected Primary Care Physician shall be effective the first day of the following calendar month provided the date of receipt by HOI of the request is before the 15th of the month.

b. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with the Member. In such a circumstance, the Primary Care Physician may request that HOI assist the Member in the selection of another Primary Care Physician.

5. If the Primary Care Physician selected by the Member terminates his or her contract with HOI or is unable to perform his or her duties or is on a leave of absence, HOI may assist the Member in selecting, or HOI may assign, another Primary Care Physician to the Member.

Specialist Care

Except as specified in the Coverage Access Rules set forth in the provider directory, if any, the Primary Care Physician selected by the Member is responsible for referring the Member to Specialists when Medically Necessary, using the referral procedure authorized by HOI. The referral will identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the Member's Condition.

Once the referral has been obtained by the Member, the Member may make an appointment with the Specialist at his/her convenience provided it is within 60 days from the date of issue of the referral and does not exceed the specified number of visits or treatments.

When additional services or visits are suggested by the Specialist, Members must first consult with their Primary Care Physician to obtain additional authorization/referrals.

The Member's Primary Care Physician may consult with HOI regarding coverage or benefits and with the Specialist in order to coordinate the Member's care. This procedure provides the Member with continuity of treatment by the Physician who is most familiar with the Member's medical history and who understands the Member's total health profile.

If a specialist who is a Non-Contracting Provider is required, the Primary Care Physician may refer the Member but payment for such services will only be made if coverage is

authorized by HOI. An agreed-upon treatment plan will then be implemented.

Emergency Services and Care

If necessary, the Member should seek Emergency Services and Care and then contact his/her Primary Care Physician as soon as possible. Prior authorization is not required for Emergency Services and Care. It is the Member's responsibility to notify HOI as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. **Follow-up care must be received, prescribed, directed or authorized by the Member's Primary Care Physician.** If the follow-up care is provided by other than the Member's Primary Care Physician, coverage may be denied. If a determination is made that an Emergency Medical Condition does not exist, payment for other than Emergency Services and Care will be the responsibility of the Member.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges or the charge mutually agreed to by HOI and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is the responsibility of the Member to furnish to HOI written proof of loss in accordance with the Claim Processing Section.

Non-emergency services rendered outside of the Service Area must be authorized in advance by HOI in order to be Covered Services.

Verifying Provider Participation

The Member is responsible for verifying the participation status of the Physician, Hospital, or other provider prior to receiving the health care service. To determine if a particular health care provider is in the HOI provider network, review the most recent provider directory listing those Primary Care Physicians and Contracting Providers under the Group Plan and verify a specific health care provider's participation status by contacting the local HOI office. When failure to verify participation status or to show the Membership Card results in noncompliance with required HOI procedures, coverage may be denied.

Case Management

HOI reserves the right (but, in no event shall it be required) to offer its case management program to its Members. If the Member and the Member's Physician agree, HOI may use its case management program policies and procedures then in effect. HOI's use of case management program policies and/or procedures with respect to any Member shall not restrict or otherwise modify HOI's right to administer coverage and/or benefits in strict accordance with the terms of this Member Handbook with respect to said Member, or with respect to any other Member or other individual under any other policy or contract. Further, when the cost of providing alternative or equivalent services varies, depending upon whether or not a particular provider or supplier is used to provide such service, HOI may (but shall not be required to) take such variations into consideration when authorizing or approving payment, coverage, or benefits for such services under the case management program.

Access to Osteopathic Hospitals

At the option of the Member, inpatient and outpatient services, similar to inpatient and outpatient services by allopathic hospitals, may be obtained from a Hospital accredited by the American Osteopathic Association when such services are available in the Service Area and when such Hospital has not entered into a written agreement with HOI with regard to such services. The Hospital providing such services may not charge rates that exceed the Hospital's usual and customary rates less the average discount that HOI has with allopathic Hospitals within the Service Area. It is the Member's responsibility to contact HOI to obtain the documents necessary to comply with this provision.

Access to Other Contracting Providers

Chiropractors and Podiatrists: Upon request by a Member, a Doctor of Chiropractic or a Doctor of Podiatry who is a Contracting Provider shall be assigned to the Member for the purpose of providing chiropractic services and podiatric services, respectively. Members shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need of referrals from the Primary Care Physician who is licensed as a Doctor of Medicine or Doctor of Osteopathy.

Dermatologists: Members have access to dermatologists who are Contracting Providers for a maximum of five (5) visits within a Calendar Year without an authorization or referral from the Member's Primary Care Physician. Any services rendered above these five (5) visits require an authorization from the Member's Primary Care Physician. If you do not get an authorization, visits over five (5) within a Calendar Year will not be covered.

Physician Assistant: Members have access to surgical assistant services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other services covered hereunder may be rendered by licensed physician assistants, nurse practitioners or other individuals who are not Physicians.

Certified Registered Nurse Anesthetist: Members have access to anesthesia services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if the Member requests such services, provided such services are available, as determined by HOI, and are Covered Services under the Group Plan.

Services Not Available from Contracting Providers

Except as provided in the Covered Services sections, if a Covered Service is unavailable through Contracting Providers, the Medical Director will authorize coverage for such services to be rendered by a Non-Contracting Provider. Covered Services provided by a Non-Contracting Provider under this provision must be authorized by the Medical Director.

Contracting Provider Financial Incentive Disclosure

Health care decisions are the shared responsibility of Members, their families, and health care providers. A health care provider's decisions regarding medical care may have a financial impact on the Member and/or the provider. For example a provider in his/her provider contract with HOI may agree to accept financial responsibility for medical expenses of Members. Consequently, HOI encourages Members to discuss with their providers how, and to what extent, the acceptance of financial risk by the provider may affect the provider's medical care decisions.

SECTION 13: RELATIONSHIPS BETWEEN THE PARTIES

HOI and Health Care Providers

Neither HOI nor any of its officers, directors or employees provide health care services to Members. By accepting HOI coverage and/or benefits, Members agree that health care providers rendering health care services are not the employees or agents of HOI. **In this regard, HOI hereby expressly disclaims any agency relationship, actual or implied, with any health care provider.** HOI does not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care provider. Any decisions made by HOI concerning appropriateness of setting, or whether any service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether Covered Services are due, and not for purposes of recommending any treatment or non-treatment. Neither HOI nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care provider.

Members and Contracting Providers

The relationship between Members and Contracting Providers shall be that of a health care provider-patient relationship, in accordance with any applicable professional and ethical standards.

HOI and the Group

Neither the Group nor any Member is the agent or representative of HOI, and neither shall be liable for any acts or omissions of HOI, its agents, servants, or employees. Additionally, neither the Group, any Member, nor HOI shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which HOI has made or hereafter makes arrangements for the provision of Covered Services. HOI is not the agent, servant, or representative of the Group or any Member, and shall not be liable for any acts or omissions of the Group, its agents, servants, employees, any Member, or any person or organization with which the Group has entered into any agreement or arrangement. By acceptance of Covered Services hereunder, each Member agrees to the foregoing.

Medical Decisions--Responsibility of Member's Physician, Not HOI

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services or supplies, must be made solely by the Member, the Member's family and the Member's treating Physician in accordance with the patient/physician relationship. It is possible that the Member or the Member's treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

SECTION 14: GENERAL MEMBER HANDBOOK PROVISIONS

Access to Information

HOI shall have the right to receive, from any health care provider rendering services to a Member, information that is reasonably necessary, as determined by HOI, in order to administer the coverage and/or benefits it provides, subject to all applicable confidentiality requirements set forth below. By accepting Membership, each Member authorizes every health care provider who renders services or furnishes supplies to such Member, to disclose to HOI or to entities affiliated with HOI, upon request, all facts, records, and reports pertaining to such Member's care, treatment, and physical or mental Condition, and to permit HOI to copy any such records and reports so obtained.

Amendment

The terms of coverage and/or benefits to be provided by HOI under the Group Plan may be amended at any time by HOI, without the consent of the Group, any Member or any other person upon 30 days prior written notice to the Group. In the event the amendment is unacceptable to the Group, the Group may terminate the Group Plan upon at least ten (10) days prior written notice to HOI. Any such amendment shall be without prejudice to claims filed with HOI prior to the date of such amendment. No agent or other person, except a duly authorized officer of HOI, has the authority to modify the terms of this Member Handbook, or to bind HOI in any manner not expressly set forth herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and/or benefits to be provided by HOI under the Group Plan may not be amended by the Group unless such amendment is evidenced in writing and signed by a duly authorized representative of the Group and a duly authorized officer of HOI. The Group shall immediately notify each Subscriber of any such amendment and shall assist HOI in so notifying the Subscribers if requested by HOI.

Assignment and Delegation

The obligations arising hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that HOI may assign its coverage and/or benefit obligations to its successor in interest or an affiliated entity without the consent of the Group at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Attorney Fees: Enforcement Costs

Unless otherwise agreed to in writing, if any legal action or other proceeding is brought under the Group Plan to enforce the terms of coverage and/or benefits provided, or to be provided, by HOI, or because of an alleged dispute concerning, or breach of such terms, the successful or prevailing party or parties shall be entitled to recover reasonable attorney's fees, court costs, and other reasonable expenses incurred in connection with maintaining or defending such action or proceeding. Such entitlement to recover shall include attorney's fees, costs, or expenses incurred in connection with any appeal. These recoveries are in addition to any other relief to which such party or parties may be entitled.

Changes in Premium

HOI may modify the Premium, without the consent of the Subscriber or any Member, upon at least 30 days prior notice to the Group.

Complaint and Grievance Process

HOI has established and will maintain a process for hearing and resolving grievances raised by Members. Members are required to first bring grievances to the attention of an HOI Grievance Coordinator, at the HOI Office in their Service Area. Details regarding the grievance resolution process are provided in the HOI Complaint and Grievance Process Section.

If any Member or former Member files any action or complaint regarding services received by the Member (including, without limitation, the filing of a lawsuit, administrative action, or grievance) against HOI or a Contracting Provider, HOI shall have the right to receive from any health care provider rendering services to the Member or former Member information and records reasonably necessary to investigate the allegations in such action or complaint. This right includes, without limitation, authorization by the Member or former Member for HOI, or its legal representatives, to discuss the Member's or former Member's Condition with, and receive all relevant reports and records from, Contracting Providers and Non-Contracting Providers who provided services to, or consulted with, the Member or former Member as a result of injuries alleged in any action or complaint, even if such services or consultations are provided subsequent to termination of Membership. The authorization set forth in this section survives the termination of coverage by HOI.

Compliance With State and Federal Laws and Regulations

The terms of coverage and/or benefits to be provided by HOI under the Group Plan shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of a Member, the Group, or HOI.

Confidentiality

Except as otherwise specifically provided herein the Group Plan, and except as may be required in order for HOI to administer coverage and/or benefits under the Group Plan, specific medical information concerning Members received by Contracting Providers shall be kept confidential by HOI. Such information shall not be disclosed to third parties without the written consent of the Member involved, except for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and/or benefits under the Group Plan, specifically including HOI's quality assurance and utilization review activities. Additionally, HOI may disclose such information to entities affiliated with HOI. However, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

HOI's financial arrangements with Contracting Providers may require that HOI release certain claims and medical information about Members even if the Member has not sought treatment by or through that provider. By accepting Membership, each Member hereby authorizes HOI to release to its Contracting Providers claims information, including related medical information, pertaining to the Member, in order for the Contracting Providers to evaluate financial responsibility under their contracts with HOI.

Evidence of Coverage

Each Subscriber will be provided with a Member Handbook and a Membership Card for enrolled Members.

Governing Law

The terms of coverage and/or benefits to be provided by HOI under the Group Plan and the rights of the parties hereunder shall be construed in accordance with the laws of the State of Florida and/or the United States, when applicable.

Membership Cards

The Membership Cards issued to Members in no way create, or serve to verify, eligibility to receive coverage and/or benefits hereunder.

Modification of Provider Network

The HOI provider network is subject to change at any time without prior notice to, or approval of, the Group or any Member. Additionally, HOI may, at any time, terminate or modify the terms of any provider contract and may enter into additional provider contracts without prior notice to, or approval of, the Group or any Member.

Non-Waiver of Defaults

Any failure by HOI at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect the right of HOI at any time to enforce or avail itself of any such remedies as it may be entitled to under applicable law.

Notices

Any notice required or permitted hereunder shall be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as set forth below. Such notice shall be deemed effective as of the date delivered or so deposited in the mail.

If to HOI:

To the address printed on the Group Application and/or the Membership Card.

If to Member:

To the latest address provided by the Member or to the Subscriber's latest address on the Individual Application for Group Insurance/Membership or change of address form actually delivered to HOI.

If to Group:

To the address indicated on the Group Application.

Obligations of HOI Upon Termination

Upon termination of an individual's Membership for any reason, HOI shall have no further liability or responsibility under the Group Plan with respect to such individual, except as specifically set forth herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Member Handbook.

SECTION 15: COVERED SERVICES INTRODUCTION

The sections that follow describe the Covered Services for which expenses are covered. It is very important that these sections be reviewed with the Exclusions and Limitations Section and other provisions. Important information is also contained in the Schedule of Copayments. The level of coverage and/or benefits for certain Covered Services depends on whether the Member has followed the Coverage Access Rules. (See the Coverage Access Rules Section.) Coverage hereunder is limited for Pre-existing Conditions. ALL OF THE PROVISIONS OF THIS MEMBER HANDBOOK SHOULD BE READ CAREFULLY TO UNDERSTAND THE COVERAGE AND/OR BENEFITS PROVIDED.

Covered Services

Expenses for the health care services listed below will be covered under the Group Plan only if the services are:

1. within the service categories set forth in the Covered Services sections;

2. Medically Necessary;

3. rendered while coverage is in force;

4. not specifically limited or excluded; and

5. received in accordance with the Coverage Access Rules.

The applicable Copayments for which the Member is responsible for each category of Covered Services are set forth in the Schedule of Copayments.

Medical Necessity

Except for any preventive care benefits specifically described in the Covered Services sections, HOI does not cover or provide benefits for any service which is otherwise covered if, in the opinion of HOI, such service is not Medically Necessary, as defined in the Glossary Section. **HOI will make Medical Necessity decisions for coverage and payment purposes only.** In some instances, these decisions are made by HOI after the Member has been hospitalized or has received other health care services and after a claim for payment has been submitted.

HOI's Medical Necessity decisions under this Member Handbook, are solely for the purpose of coverage or payment. In this respect, HOI may review medical facts in making a coverage or payment decision, however, any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services, must be made solely by the Member and the Member's treating Physicians. It is possible that a Member or the Member's treating Physician may conclude that a particular service is beneficial, appropriate, or desirable even though expenses for such service may be denied as not being Medically Necessary.

SECTION 16: PHYSICIAN AND OTHER MEDICAL SERVICES

The following Physician and other medical services may be Covered Services, subject to the Copayment amount set forth in the Schedule of Copayments, when provided to a Member by Contracting Providers:

Accidental dental care: Dental services rendered within 62 days of an Accidental Dental Injury provided such services were for the treatment of damage to sound natural teeth, resulting from an Accidental Dental Injury occurring while a Member of HOI. See the definition of Accidental Dental Injury in the Glossary Section.

Allergy treatment, including testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

Anesthesia services for medical care by a Physician, other than the operating Physician or his or her partner or associate.

Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Member in a Hospital or Ambulatory Surgical Center if:

1. The Member is under 8 years of age when it is determined by a dentist and the Member's Primary Care Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Member has a developmental disability in which patient management in the dental office has proved to be ineffective; or

2. The Member has one or more medical Conditions that would create significant or undue medical risk for the Member in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Breast Reconstructive Surgery and implanted prostheses, incident to Mastectomy. The term "Breast Reconstructive Surgery" means surgery to reestablish symmetry between the two breasts. In order to be covered, such surgery must be in a manner chosen by the Member's Contracting Physician, consistent with prevailing medical standards, and in consultation with the Member.

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

Child cleft lip and cleft palate treatment services: Medical, dental, Speech Therapy, audiology, and nutrition services for treatment of a child under the age of 18 who has cleft

lip or cleft palate. In order for such services to be covered, the Member's Primary Care Physician, or a Contracting Provider on referral from the Member's Primary Care Physician, must specifically (1) prescribe such services and (2) certify, in writing, that the services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Child health supervision services: Periodic Physician-delivered or Physician-supervised services that are Covered Services provided to a Dependent from the moment of birth up to the 17th birth date as follows:

1. Periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;

2. Oral and/or injectable immunizations; and

3. Laboratory tests normally performed for a well child.

These Covered Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Dermatology services are limited to the following: Medically Necessary minor surgery, tests, and office visits provided by a dermatologist who is a Contracting Provider for a maximum of five (5) visits within a Calendar Year without an authorization or referral from the Member's Primary Care Physician. Any services rendered above these five (5) visits require an authorization from the Member's Primary Care Physician.

Diabetes treatment services: Covered Services include diabetes outpatient self-management training and educational services and nutrition counseling, including all medically appropriate and necessary equipment and supplies, when used to treat diabetes, if the Member's Primary Care Physician, or a Contracting Provider on referral from the Primary Care Physician who specializes in the treatment of diabetes, certifies that such services are necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. In order to be covered under this Agreement, nutrition counseling must be provided by a licensed dietitian.

Diagnostic services, including radiology, ultrasound, laboratory, pathology, approved machine testing (e.g., electrocardiogram [EKG]). Diagnostic services involving bones or joints of the jaw and facial region if, under accepted medical standards, such diagnostic services are Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury.

Infertility services for a Member who meets the criteria established by HOI, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility,

laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility.

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

1. a baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age;

2. a mammogram every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based upon a Physician's recommendation;

3. a mammogram every year for any woman who is 50 years of age or older; or,

4. one or more mammograms a year, 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 mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before age 30.

Except for mammograms done more frequently than every two years for women 40 years of age or older, but younger than 50 years of age, Covered Services are payable when, with or without a prescription from a Physician, the Member obtains a mammogram in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies for breast cancer screening. Covered Services are subject to all other terms and conditions applicable to other Covered Services.

Mastectomy services for breast cancer treatment and outpatient post-surgical follow-up in accordance with prevailing medical standards. As used in this subsection, the term "Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician. Outpatient post-surgical follow-up care for Mastectomy services shall be covered when provided by a Contracting Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Member. The treating Physician, after consultation with the Member, may choose the appropriate setting.

Maternity care: Physician services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the HOI Service Area only, unless the need for such services was not, and could not reasonably have been, anticipated before leaving the Service Area.

Routine office visits to a Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician for pre- and post-natal care.

Health care services, including prenatal care, delivery and postnatal care, provided to a Member. Care for a mother and her newborn infant including a postpartum assessment and newborn assessment may be provided at the Hospital, at the attending Physician's office, at a Birth Center or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife. These services include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Newborn child care: Covered Services applicable for children shall be provided with respect to a newborn child of a Member from the moment of birth provided that the newborn child is properly enrolled. Covered Services for a covered newborn child shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity.

Care for a newborn child may be provided at the Hospital, at the attending Physician's office, at a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife. These services include physical assessment of the newborn child, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Ambulance services when necessary to transport the newborn child to and from the nearest appropriate facility which is appropriately staffed and equipped to treat the newborn child's Condition, as determined by HOI and certified by the Primary Care Physician or a Contracting Physician as Medically Necessary to protect the health and safety of the newborn child.

NOTE: Coverage for a newborn child of a Member other than the Subscriber or the Subscriber's Dependent spouse will automatically terminate 18 months after the birth of the newborn child.

Non-surgical spine and back disorder treatments consisting of Medically Necessary manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by X-ray.

Osteoporosis screening: Diagnosis and Medically Necessary treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Oxygen, including the use of equipment for its administration.

Physician services, medical and surgical care, in a Physician's office, a Hospital, or a

Skilled Nursing Facility. Both Specialist and Primary Care Physician services are available.

Preventive health services according to standards established by the Medical Directors of HOI after periodic review of major scientific publications, for health maintenance and the prevention and detection of disease. Preventive health services includes:

1. periodic health assessments;
2. instruction in personal health care measures;
3. routine immunizations and inoculations;
4. eye and ear screening examinations in the office of a Primary Care Physician to determine the need for vision and hearing correction;
5. family planning counseling and services, including counseling and information on birth control; sex education, including prevention of venereal disease; and fitting of diaphragms;
6. health education programs organized, sponsored, or offered by HOI, including nutrition education and counseling; instruction in personal health care and the appropriate use of health services; information regarding the coverage and/or benefits offered by HOI and the generally accepted medical standards for the use and frequency of each.
7. one annual routine preventive gynecological examination per Calendar Year by a Contracting Provider, who is an obstetrician or gynecologist, without a referral from the Primary Care Physician. This examination may include a manual breast exam, a pelvic exam, and a pap smear.

Second medical opinion: Members who elect to obtain a second medical opinion must notify their Primary Care Physician of their intent to do so prior to obtaining the second medical opinion. The Member is entitled to request and to obtain a second medical opinion when the Member disputes either HOI's or a Contracting Physician's opinion of the reasonableness or necessity of a surgical procedure or is subject to a serious injury or illness. A Member may request and obtain a second medical opinion if they feel that they are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated. HOI also may require a Member to obtain such a second medical opinion. In either case, the Member may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion. **All tests in connection with rendering the second medical opinion, including tests deemed necessary by a Non-Contracting Physician, must be Medically Necessary and must be performed within the HOI network of Contracting Providers.**

Services rendered by a Contracting Provider related to a second medical opinion will be subject to the same Copayment requirement as set forth in the Schedule of Copayments. Services rendered by a Non-Contracting Provider for a second medical opinion are subject to a Copayment amount equal to 40% of the Allowance. Subscribers are responsible for the payment of any charges billed by a Non-Contracting Provider in excess of the Allowance.

HOI may deny benefits, granted under this provision, in the event a Member seeks in excess of three (3) second medical opinions per Calendar Year if the second medical opinion costs are deemed by HOI to be evidence that the Member has unreasonably over-utilized the second medical opinion privileges. The decision of the Medical Director, derived after review of the documentation from the second medical opinion which you obtained, will be controlling as to HOI's coverage obligations for the treatment.

Surgical assistant services rendered by a Physician or a Physician Assistant. Surgical assistant services only rendered by a Physician Assistant when acting as a surgical assistant when such assistance is Medically Necessary.

Surgical procedures including:

1. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;

2. surgical procedures involving bones or joints of the jaw and facial region if, under accepted medical standards, such surgery is Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and,

3. surgery resulting from a traumatic injury or disease and for a congenital anomaly, performed to restore normal bodily function as determined by the Medical Director of HOI.

Surgical sterilization including tubal ligations and vasectomies.

SECTION 17: HOSPITAL SERVICES

Hospital services provided at Contracting Hospitals for a Member when such Member is an outpatient or inpatient admitted upon the instruction, written authorization, or referral by a Primary Care Physician. Such services may include:

- room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
- intensive care units, including cardiac, progressive and neonatal care;
- use of operating and recovery rooms;
- use of emergency rooms;
- respiratory therapy (e.g., oxygen);
- drugs and medicines administered by the Hospital;
- intravenous solutions;
- administration of, including the cost of, whole blood or blood products;
- dressings, including ordinary casts;
- anesthetics and their administration;
- transfusion supplies and equipment;
- diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
- chemotherapy treatment for proven malignant disease;
- Physical Therapy (in connection with a covered Condition);
- other Medically Necessary services; and
- transplants as set forth in the Transplants section.

Maternity Care

Hospital services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the HOI Service Area only, unless the need for such services was not, and could not reasonably have been, anticipated before leaving the Service Area.

SECTION 18: AMBULATORY SURGICAL CENTER SERVICES

The following health care services may be Covered Services, subject to the Copayment amount set forth in the Schedule of Copayments, when furnished to a Member by a Contracting Provider when such Member receives care at an Ambulatory Surgical Center that is a Contracting Provider:

- use of operating and recovery rooms;
- respiratory therapy (e.g., oxygen);
- drugs and medicines administered at the Ambulatory Surgical Center;
- intravenous solutions;
- dressings, including ordinary casts;
- anesthetics and their administration;
- administration of, including the cost of, whole blood or blood products;
- transfusion supplies and equipment;
- diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
- chemotherapy treatment for proven malignant disease; and
- other Medically Necessary services.

SECTION 19: EMERGENCY SERVICES AND CARE

Emergency Services and Care

IN THE EVENT OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR CLOSEST EMERGENCY ROOM OR CALL 911.

Emergency Services and Care in or out of the Service Area shall be Covered Services without prior notification to HOI, subject to the Copayment amount set forth in the Schedule of Copayments. It is the Member's responsibility, however, to notify HOI as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination will be the responsibility of the Member.

Follow-up care must be received, prescribed, directed or authorized by the Member's Primary Care Physician. If the follow-up care is provided by other than the Member's Primary Care Physician, coverage may be denied.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges or the charge mutually agreed to by HOI and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is the responsibility of the Member to furnish to HOI written proof of loss in accordance with the Claims Processing Section.

Ambulance Services for Emergency Services and Care

Medically Necessary transportation by ambulance to the nearest medical facility capable of providing required Emergency Services and Care to determine if an Emergency Medical Condition exists; **except as previously stated, all ambulance or other transportation services must be authorized by HOI and ordered by the Member's Primary Care Physician.**

SECTION 20: SPECIAL SERVICES

Durable Medical Equipment

Durable Medical Equipment which has been prescribed by the Member's Primary Care Physician, or a Contracting Provider on referral from the Primary Care Physician and which has been authorized by HOI as a Covered Service. HOI reserves the right to rent or purchase the most cost-effective durable medical equipment which meets the Member's needs. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. Supplies and services to repair medical equipment, which have been authorized by HOI, may be a Covered Service only if the Member owns the equipment or is purchasing the equipment, or when necessitated due to growth of a Dependent child or due to change in the Member's Condition.

The wide variety of durable medical equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered durable medical equipment, however, some Durable Medical Equipment has been specifically excluded. Please refer to the Exclusions and Limitations Section.

Enteral Formulas

Prescription and non-prescription enteral formulas for home use which are prescribed by a Primary Care Physician or Contracting Physician as Medically Necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Coverage to treat inherited diseases of amino acid and organic acids shall include food products modified to be low protein, in an amount not to exceed $2,500 annually for any Member, through the age of 24. This section applies to any person or family notwithstanding the existence of any Pre-existing Condition.

Home Health Care

The following home health care services only when provided by or through a Home Health Agency within the Service Area if: (1) the Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician submits a written treatment plan to HOI; (2) HOI approves the written treatment plan; and (3) the Member is confined to home and is unable to carry out the basic activities of daily living:

1. part-time or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse;

2. Physical Therapy, by a Physical Therapist;
3. Occupational Therapy, by an Occupational Therapist;
4. Speech Therapy, by a Speech Therapist;
5. home health aide services;
6. medical social services;
7. nutritional guidance; and
8. respiratory or inhalation therapy (e.g., oxygen).

The following home health care services are not Covered Services:

1. homemaker services;
2. domestic maid services;
3. sitter services;
4. companion services;
5. services rendered by an employee or operator of an adult congregate living facility; an adult foster home; and adult day care center, or a nursing home facility; and
6. Custodial Care.

Hospice Services

Home Care: When available in the Service Area, Hospice home care will be provided as part of a Hospice program approved by HOI, limited to those outpatient services which are Covered Services.

Hospice Outpatient Care: Outpatient services which are Covered Services, when received while the Member is in a Hospice outpatient program approved by HOI.

Hospice Inpatient Care: Inpatient services which are Covered Services received while the Member is in a Hospice program approved by HOI and the inpatient status is Medically Necessary, as determined by the Medical Director of HOI.

Prosthetic and Orthotic Devices

Coverage includes the following, when authorized in advance by HOI and arranged by a Primary Care Physician or a Contracting Provider on referral from the Primary Care Physician or HOI:

Prosthetic and Orthotic Devices - braces, cardiac pacemakers, and artificial limbs and eyes to replace natural limbs and eyes lost while a Member. Covered prosthetic devices (except cardiac pacemakers and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be Medically Necessary) prescribed for each specific Condition. Coverage for Prosthetic and

Orthotic Devices is based on the most cost-effective Prosthetic and Orthotic Device which meets the Member's medical needs as determined by HOI.

Benefits may be provided for necessary replacement of a Prosthetic or Orthotic Device which is owned by the Member when due to irreparable damage, wear, a change in the Member's Condition, or when necessitated due to growth of a Dependent child.

Rehabilitation Services

Prescribed short-term inpatient and outpatient rehabilitation services limited to the therapy categories listed below.

In order to be covered: (1) HOI must review, for coverage purposes only, a Rehabilitation Plan submitted or authorized by the Member's Primary Care Physician or a Contracting Provider on referral from the Primary Care Physician; (2) HOI must agree that the Member's Condition is likely to improve significantly within 62 days from the first date such services are to be rendered; (3) such services must be provided to treat functional defects which remain after an illness or injury; and (4) such services must be Medically Necessary for the treatment of a Condition.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of rehabilitation services to be provided to a Member with rehabilitation potential. Such a plan must have realistic goals which are attainable by the Member within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such services are to be rendered. The Rehabilitation Plan must be renewed every 30 days.

Outpatient

Outpatient rehabilitation services are limited per Member per Condition to the number of Medically Necessary rehabilitation services which are received by the Member within the consecutive 62-day period which immediately follows the first date that the Member begins such services. Outpatient rehabilitation services are limited to the therapy categories listed below:

Speech Therapy: Services of a Speech Therapist or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from illness, injury, stroke, or surgical procedure while this coverage was in force.

Physical/Occupational Therapy: Services of a Physical Therapist or Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to illness, injury, stroke or a surgical procedure while this coverage was in force.

Cardiac Therapy: Services provided for cardiac rehabilitation for the purpose of aiding in the restoration of normal heart function lost due to illness, injury, stroke, or a surgical procedure while this coverage is in force.

Inpatient

Rehabilitation services of the therapy categories described above provided during a covered inpatient confinement will be covered for the duration of the confinement.

Skilled Nursing Facilities

Those Skilled Nursing Facility services which are authorized in writing by a Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician, and for which coverage is approved by the Medical Director of HOI. Such services may include:

1. room and board;
2. respiratory therapy (e.g., oxygen);
3. drugs and medicines administered while an inpatient;
4. intravenous solutions;
5. administration of, including the cost of, whole blood or blood products;
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease;
10. Physical Therapy (in connection with a covered Condition); and
11. other Medically Necessary services.

Benefits for Covered Services at a Skilled Nursing Facility are limited to the number of days per Member per Calendar Year set forth in the Schedule of Copayments.

Transplant Services

Transplants as set forth below, if coverage is pre-determined by HOI and if performed at a facility acceptable to HOI, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge services, expenses related to the donation or acquisition of an organ or tissue for a Member once the donor has been identified and has agreed to donate the organ, and treatment of complications after transplantation. HOI will pay Covered Services only for services, care and treatment received for or in connection with a:

1. Bone Marrow Transplant, as defined in this Member Handbook, which is specifically listed in Chapter 10D-127.001 of the *Florida Administrative Code* or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Health Care Financing Administration;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. kidney transplant;
6. liver transplant;
7. lung-whole single or whole bilateral transplant; or
8. pancreas transplant performed simultaneously with a kidney transplant.

For a transplant to be covered, a written prior benefit determination from HOI's Medical Director is required in advance of the procedure. The Member or the Member's Physician must notify HOI's Medical Director prior to the Member's initial evaluation for the transplant in order for HOI to determine if the transplant services are covered. HOI's Medical Director must be given the opportunity to evaluate the clinical results of the Member's evaluation. HOI's benefit determination will be based on the terms of this Member Handbook as well as written criteria and procedures established by HOI's Medical Director. If prior benefit determination is not given, the transplant will not be covered.

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

1. The transplant is excluded.

2. HOI's Medical Director and the Member's Primary Care Physician are not contacted for authorization prior to referral for evaluation of the transplant.

3. HOI's Medical Director does not pre-authorize coverage for the transplant.

4. The expense relates to the transplantation of any non-human organ or tissue.

5. The expense relates to the donation by a Member of an organ or tissue for a recipient who is not covered by HOI.

6. The expense relates to the acquisition of an organ or tissue for a recipient who is not covered by HOI.

The following services/supplies/expenses are also not covered:

Artificial heart devices used as a bridge to transplant.

Once a coverage decision is made, HOI's Medical Director will advise the Member or the Member's Physician of the coverage decision. Covered Services are payable only if the pre-transplant services, the transplant and post-discharge services are performed in a facility acceptable to HOI.

For covered transplants and all related complications, HOI will cover Hospital expenses and Physician's expenses provided that such services will be paid under the Hospital Services Section and Physician and Other Medical Services Section in accordance with the same terms and conditions for care and treatment of any other covered Condition.

SECTION 21: BEHAVIORAL HEALTH SERVICES

Mental Health Services

Inpatient services for short-term evaluation, diagnosis or Crisis Intervention of a Mental and Nervous Disorder may be Covered Services if coverage is authorized in accordance with criteria established by HOI. These services must be provided by a licensed Physician, Psychologist, or Mental Health Professional while confined in a Hospital or a Psychiatric Facility for the treatment.

Partial Hospitalization for mental health services is a Covered Service when it is provided in lieu of inpatient hospitalization and is combined with the inpatient hospital benefit. Two days of Partial Hospitalization will count as one day toward the inpatient Mental and Nervous Disorder benefit.

Note: To be covered, Partial Hospitalization services must be provided under the direction of a Physician who is a Contracting Provider.

Outpatient treatment of a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy may be a Covered Service if coverage is authorized in accordance with criteria established by HOI. Treatment must be provided by a licensed Physician, Psychiatrist, Psychologist, or Mental Health Professional.

Substance Dependency Treatment Services

Detoxification limited to the time necessary for the removal of toxic substances from the blood and outpatient follow-up care. Inpatient and outpatient Detoxification coverage must be authorized in accordance with criteria established by HOI for this benefit to be a Covered Service.

Outpatient visits for the care and treatment of Substance Dependency. Consultations may be provided by a Specialist or Psychologist who are Contracting Providers, and authorized in accordance with criteria established by HOI for this benefit to be a Covered Service.

Referral to, but not payment of, non-medical ancillary services such as vocational rehabilitation or employment counseling, when HOI is appropriately able to make such referrals. Such services are to be provided solely at the Member's expense. The Member acknowledges that HOI does not have any contractual or other formal arrangements with the providers of such services.

SECTION 22: EXCLUSIONS AND LIMITATIONS

Exclusions

The following are excluded from coverage:

1. Any services not specifically listed in the Covered Services sections or in any rider, or endorsement attached hereto, unless such expenses are specifically required to be covered by applicable law.

2. If the Member does not follow HOI's Coverage Access Rules, any services provided to, or received by, the Member are not covered. For further information, please refer to the Coverage Access Rules Section.

3. Any service which, in the opinion of HOI was, or is, not Medically Necessary. The ordering of a service by a health care provider, including without limitation, a health care provider who is a Contracting Provider, other than as authorized by HOI, does not in itself make such service Medically Necessary or a Covered Service.

4. **Abortion**, elective (by choice; not Medically Necessary).

5. **Ambulance services** other than those specifically provided for in the Covered Services sections.

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

7. **Autopsy** or postmortem examination services, unless specifically requested by HOI.

8. **Complementary and alternative healing methods** including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; massage; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, Swedish massage, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

9. **Complications of non-Covered Services**, including the diagnosis or treatment of any Condition which arises as a complication of a non-Covered Service (e.g.,

services or supplies to treat a complication of cosmetic surgery are not covered).

10. **Contraceptive medications**, except when dispensed for specific treatment of a Condition; contraceptive devices; or contraceptive appliances.

11. **Copayments**, whether or not the Copayment has been waived by the provider.

12. **Cosmetic services**, including any service to improve the appearance or self-perception of an individual, including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A).

13. **Costs** related to telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.

14. **Custodial Care**, and any service of a custodial nature, including without limitation: services or supplies primarily to assist the Member in the activities of daily living; rest homes; home companions or sitters; home mothers; domestic maid services; and respite care.

15. **Dental care**, care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion does not apply to Accidental Dental Care, Child Cleft Lip and Cleft Palate Treatment Services.

16. **Drugs** prescribed for uses other than the United States Food and Drug Administration (FDA)-approved label indications. This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Member's cancer in a Standard Reference Compendium or recommended for treatment of the Member's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

17. **Durable Medical Equipment** which is for patient convenience and/or comfort or which has not been authorized by HOI. This exclusion includes, but is not limited to, modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, dental braces, air conditioners, humidifiers, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails, heat appliances and dehumidifiers. Also excluded is coverage for repair or replacement except when authorized by HOI.

18. **Experimental or Investigational** services except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection, and except for any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Member's cancer in a Standard Reference Compendium or recommended for treatment of the Member's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

19. **Family planning services**, other than those services specifically described in the Covered Services sections.

20. **Foot care (routine)**, including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, corns, or calluses, unless determined by HOI to be Medically Necessary.

21. **Hearing aids** (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

22. **Immunizations and physical examinations**, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements; or except immunizations necessary in the course of other medical treatments of an illness or injury.

23. **Infertility treatment** services and associated expenses and any outpatient prescription medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; infertility treatment medications except when used for diagnostic purposes only.

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

25. **Military service-connected medical care** received at military or government facilities.

26. **Non-Prescription drugs or products,** except insulin, including any non-Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

27. **Obesity treatment**, including but not limited to, surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be Medically Necessary.

28. **Oral surgery** for any reason including oral surgery the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided under the Covered Services sections.

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

30. **Penile prosthesis** and surgery to insert penile prosthesis except when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

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

32. **Prescription drugs**, purchased, prescribed, or dispensed while other than an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital, except for immuno-suppressant therapy following a major human organ/tissue transplant, or chemotherapy in connection with a diagnosed malignancy.

33. **Private duty nursing care**.

34. **Rehabilitation services**, including physical, speech, occupational and other rehabilitation therapy, except as described in the Covered Services section. This exclusion includes:

    a. Services or supplies provided to a Member as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, where the admission is primarily to provide rehabilitative services;

b. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Member's Condition within a 62-day period;

c. Services for treatment of abuse of or addiction to alcohol and drugs; or

d. Long term rehabilitation services (i.e., services in excess of 62 days from the first date the Member begins such services).

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

36. **Services or supplies** that are:

a. Determined to be not Medically Necessary;

b. Not specifically listed in the Covered Services sections unless such services are specifically required to be covered by state or federal law. HOI will provide coverage on a primary or secondary basis as required by applicable COB state or federal laws;

c. Court ordered care or treatment, unless otherwise covered;

d. For the treatment of a Condition resulting directly or indirectly from:

1) War or an act of war, whether declared or not;

2) Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;

3) Engaging in an illegal occupation;

4) Services in the armed forces;

5) Intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Member; or

6) A Member being under the influence of alcohol or any narcotic unless taken on the specific advice of a Physician.

e. Received prior to a Member's Effective Date or received on or after the date a Member's Coverage terminates under the Group Plan, unless coverage is extended in accordance with the Extension of Benefits subsection;

f. Provided by a Physician or other health care provider related to the Member by blood or marriage;

g. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;

h. For treatment of non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

i. Supplied at no charge;

j. For elective care, routine care, or any care other than Medically Necessary emergency care, required by a Member while outside of the Service Area; or

k. For normal pregnancy and delivery outside the Service Area, unless the need for such services was not, and reasonably could not have been, anticipated before leaving the Service Area.

37. **Sexual reassignment, or modification services,** including but not limited to any service or supply related to such treatment, including psychiatric services.

38. **Skilled Nursing Facility services** not provided in lieu of hospitalization.

39. **Smoking cessation programs**, including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches).

40. **Sports-related devices** used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

41. **Substance dependency care and treatment services** that are long-term treatment services (i.e., more than the number of outpatient visits set forth on the Schedule of Copayments) for treatment of alcoholism or drug addiction, and including prolonged treatment in a specialized inpatient or residential facility.

42. **Tobacco** or tobacco related products.

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

44. **Transplantation or implantation** services, including the transplant or implant, other than those specifically listed in the Covered Services sections. This exclusion

includes:

a. Any service in connection with the implant of an artificial organ, including the implant of the artificial organ.

b. Any organ which is sold rather than donated to the Member.

c. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in Chapter 10D-127.001 of the *Florida Administrative Code* or covered by Medicare pursuant to a national coverage decision made by the Health Care Financing Administration as evidenced in the most recently published *Medicare Coverage Issues Manual*.

d. Any service in connection with identification of a donor from a local, state or national listing.

45. **Travel** or vacation expenses even if prescribed or ordered by a provider.

46. **Transportation service** that is non-emergency transportation between institutional care facilities, or to and from the Member's residence.

47**.** **Vision care**, including

a. the purchase, examination, or fitting of eyeglasses or contact lenses, except **only the first** glasses or contact lenses following cataract surgery or following an accident;

b. any surgery for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error (e.g., radial keratotomy, myopic keratomelusis); and

c. training or orthoptics, including eye exercises.

48. **Volunteer services** or services which would normally be provided free of charge to a Member including services which would normally be provided free of charge in a Hospice program; services of a person who ordinarily resides in the home of the terminally ill Member, or is a member of the Member's family, or of the Member's spouse's family; or any service not provided through the Hospice program approved by HOI.

49. **Weight control services** including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise programs, equipment or memberships; or surgical procedures.

50. **Wigs or cranial prosthesis**.

51. **Work related condition services** to the extent the Member is covered or required to be covered by Workers' Compensation law. Any service or supply to diagnose or treat any Condition resulting from or in connection with a Member's job or employment will not be covered under the Group Plan, except for Medically Necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

Limitations

The rights of Members and obligations of HOI hereunder are subject to the limitations set forth on the Schedule of Copayments and the following limitations.

Circumstances Beyond the Control of HOI

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of HOI, results in facilities, personnel or financial resources of HOI being unable to arrange for provision of the Covered Services, HOI shall have no liability or obligation for any delay in the provision of, or any failure by any provider to provide, such Covered Services, except that HOI shall make a good faith effort to arrange such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of HOI if HOI cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

SECTION 23: STATEMENT ON ADVANCE DIRECTIVES

> The following information is provided in accordance with the Patient Self-Determination Act to advise you of your rights under Florida law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to formulate an advance directive, and explain the policy of HOI with respect to advance directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make treatment decisions for him or her in the event that such person should be found to be incompetent and suffering from a terminal condition. Advance directives provide patients with a mechanism to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own healthcare decisions.

An "advance directive" is a witnessed oral or written statement which indicates the individual's choices and preferences with respect to medical care made by the individual while he or she is still competent. An advance directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care provider should consult in making treatment decisions.

There are three types of documents recognized in Florida commonly used to express an individual's advance directives: a Living Will, a Healthcare Surrogate Designation and a Durable Power of Attorney for Healthcare.

A Living Will is a declaration of a person's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal condition and is not able to express his or her wishes. It does not become effective until the patient's physician and one other physician determine that the patient suffers from a terminal condition and is incapable of making decisions.

Another common form of advance directive is the Healthcare Surrogate Designation. When properly executed, a Healthcare Surrogate Designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient's wishes. The surrogate's authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions which by law the surrogate cannot make, such as consent to abortion or electroshock therapy, any specific limits on the surrogate's power to make decisions should be clearly expressed in the Healthcare Surrogate Designation document.

Finally, there is the Durable Power of Attorney for Healthcare. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical condition.

A suggested form of Living Will and Designation of Healthcare Surrogate is contained in Chapter 765 of the *Florida Statutes*. There is no requirement that a patient have an advance directive and your health care provider cannot condition treatment on whether or not you have one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. a judicially appointed guardian;
2. a spouse;
3. an adult child or a majority of the adult children who are reasonably available for consultation;
4. a parent;
5. siblings who are reasonably available for consultation;
6. an adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health and religious or moral beliefs;
7. a close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending physician an affidavit stating that he or she is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, religious and moral beliefs.

Deciding whether to have an advance medical directive, and if so, the type and scope of the directive, is a complex understanding. It may be helpful for you to discuss advance directives with your spouse, family, friends, religious or spiritual advisor or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, physician and whomever else will be faced with the task of carrying out those wishes knows what you would want.

It is the policy of HOI to recognize the right of each Member to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an advance directive to guide treatment decisions in the event you become unable to do so. HOI will not interfere with your decision in accordance with the laws of the State of Florida. It is your responsibility to provide notification to your providers that an advance directive exists. If you have a written advance directive, we recommend that you furnish your providers with a copy so that it can be made a part of your medical record.

Pursuant to §765.308 of the *Florida Statutes*, Florida law does not require a health care

provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a provider or facility in the HOI network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another provider or facility.

HOI providers have, in accordance with state law, varying practices regarding the implementation of an individual's advance directive. Therefore, we recommend that you have discussions about advance directives with your medical care givers, family members and other friends and advisors. Your physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical condition or environment.

Complaints concerning noncompliance with advance directives may be submitted to the following address:

Agency for Health Care Administration
Bureau of Managed Health Care
Building 1, Room 311
2727 Mahan Drive
Tallahassee, Florida 32308

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law.

SECTION 24: MEMBER'S RIGHTS AND RESPONSIBILITIES

HOI is committed to arranging for the provision of quality health care coverage at a reasonable cost while maintaining the dignity and integrity of our Members. Consistent with our commitment, and with the recognition that Contracting Providers of services are independent contractors and not the agents of HOI, the following statement of Member's Rights and Responsibilities has been adopted.

Rights

1. To be provided with information about HOI, its services and the affiliated practitioners providing care.

2. To receive medical care and treatment from providers who have met the credentialing standards of HOI.

3. To expect health care providers who participate in HOI to permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-provider relationship requirements.

4. To expect health care providers who participate in HOI to provide treatment, and relevant information about your treatment, with courtesy, respect, and concern for your dignity and privacy.

5. To appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the Group Plan or other procedures adopted by HOI for such purposes.

6. To inform health care providers who participate in HOI that you refuse treatment, and to expect to have such providers honor your decision, if you choose to accept the responsibility and the consequences of such decision.

7. To have access to your medical records, and to have confidentiality of these records maintained, in accordance with applicable law and HOI's rules.

Responsibilities

1. To seek all non-emergency care through your assigned Primary Care Physician (PCP) or a Contracting Physician and to cooperate with all persons providing you care and treatment.

2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.

3. To be responsible for understanding and following instructions concerning your treatment and to ask questions if you do not understand or need an explanation.

4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.

5. To be financially responsible for any Copayments and to provide current information concerning your HOI membership status to any HOI affiliated provider.

6. To follow established procedures for filing a grievance concerning medical or administrative decisions which you feel are in error.

7. To request your medical records in accordance with HOI rules and procedures and in accordance with applicable law.

8. To follow Coverage Access Rules established by HOI.

SECTION 25: COMPLAINT AND GRIEVANCE PROCESS

Introduction

HOI has established a process for reviewing a Member's complaints and grievances. The purpose of this process is to facilitate review of, among other things, a Member's dissatisfaction with HOI, its administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care of any of the independent contracting healthcare providers in the HOI provider network. The HOI Complaint and Grievance Process also permits a Member, or his/her Physician, to expedite HOI's review of certain types of complaints or grievances. (See *Expedited Review of Urgent Complaints or Grievances*). Members must follow the process set forth below in the event of a complaint or grievance.

Under the HOI Complaint and Grievance Process a Member may bring his/her dissatisfaction to HOI's attention either informally or formally. A verbal (i.e., nonwritten) expression of dissatisfaction will be handled informally in accordance with the Informal Review subsection set forth below. A nonwritten expression of dissatisfaction is a complaint. A written expression of dissatisfaction will be handled formally in accordance with the Formal Review subsection set forth below. A written expression of a Member's dissatisfaction is a grievance.

HOI encourages Members to first attempt informal resolution of any dissatisfaction by calling HOI. If HOI is unable to resolve the matter on an informal basis, Members may submit their formal request for review in writing.

Informal Review

Complaints

If a Member is dissatisfied with HOI, the Member should first contact an HOI Customer Service Representative at the local HOI office, either by phone or in person, to advise HOI of the complaint. The telephone number is listed on the Membership Card and the address of the HOI local office is listed below. The Customer Service Representative, working with appropriate personnel, will review the Member's complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction. If the Member remains dissatisfied with HOI's resolution of the complaint, the Member may request a formal review in accordance with the Formal Review subsection below.

Important Note:

The Member must provide to the Customer Service Representative all of the facts relevant to the complaint. Failure of the Member to provide any requested or relevant information may delay HOI's review of the complaint. Consequently, Members are obliged to cooperate with HOI in its review of the matter.

Formal Review

Grievances

A Member, a provider acting on behalf of the Member, or a state agency, may submit a grievance. To submit or pursue a grievance on behalf of a Member, a healthcare provider must previously have been directly involved in the treatment or diagnosis of the Member.

1. Local Office Review

   In order to begin the formal review process, the Member must complete, and submit to the local HOI office, a pink *HOI Grievance Form (Local Office Review)* or a letter explaining the facts and circumstances relating to the grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation. **While a Member is not required to use an *HOI Grievance Form (Local Office Review)*, HOI strongly urges that a Member submit his/her grievance on such a form in order to facilitate logging, identification, processing, and tracking of the grievance through the formal review process. A Member may obtain these or other necessary forms by contacting HOI at the local office number listed on his/her Membership Card.**

   If the grievance results from a coverage determination regarding Medical Necessity, the grievance will be reviewed by a committee consisting of a majority of providers. In this instance, the Member must submit his/her grievance within 30 days of notice of HOI's coverage determination. All other grievances must be filed with HOI within one (1) year of the date of the occurrence that initiated the grievance.

   The Local Office will review a Member's grievance and advise the Member of its decision in writing within approximately 30 days from receipt of the grievance. If the Member remains dissatisfied with the decision of the Local Office, he/she may request reconsideration of the decision by HOI's Corporate Office as set forth below.

2. Corporate Office Review

In order to have the Local Office's decision reconsidered by HOI's Corporate Office, the Member must complete, and submit to the Corporate Office, a green *HOI Grievance Appeal Form (Corporate Office Review)* or a letter explaining why the Member feels that the Local Office's decision was wrong or not appropriate and what the Member would like HOI to do to remedy the matter.

At the Member's request the HOI Corporate Office will review the Local Office decision as quickly as possible and advise the Member of its decision in writing within approximately 30 days from receipt of the HOI Grievance Appeal Form.

3. Statewide Provider and Subscriber Assistance Panel

If the Member is not satisfied with the decision of the Corporate Office, he/she may submit the grievance to the Statewide Provider and Subscriber Assistance Panel within 365 days of the Corporate Office's decision.

Expedited Review of Urgent Complaints or Grievances

If HOI, based on information provided to it, makes a coverage determination that a service, which has yet to be provided to the Member, is not Medically Necessary, the Member, or a provider acting on behalf of the Member, may submit a verbal (i.e., nonwritten) or written request for expedited review. A Member, or a provider acting on behalf of the Member, may request expedited review if the Member or the provider reasonably believes that a delay in reviewing the coverage decision due to the standard timeframes of the Complaint and Grievance Process would seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function, and a healthcare provider has refused or will refuse to provide the service unless coverage or payment will be provided by HOI for the service.

Process for Requesting An Expedited Review

The Member, or a provider acting on the Member's behalf, must specifically request an expedited review. For example, this request may be made by saying: "I want an expedited review."

A request for expedited review will be evaluated by a health care professional which was not involved in the initial decision and which is in the same or similar specialty, if any, as typically manages the medical condition, process, or treatment which the Member or provider are requesting be reviewed.

Information necessary to evaluate an expedited review may be transmitted by telephone, facsimile transmission, or such other expeditious method as is appropriate under the circumstances.

HOI will make a decision and notify the Member, or the provider acting on behalf of the Member, within 72 hours after receipt of the request for expedited review.

If a Member's request for expedited review arises out of a utilization review determination by HOI that a continued hospitalization or continuation of a course of treatment is not Medically Necessary, coverage for the hospitalization or course of treatment will continue until the Member has been notified of the determination.

HOI will provide written confirmation of its decision concerning an expedited review within two (2) working days after providing notification of that decision, if the initial notification was not in writing.

HOI will not honor a request for expedited review which relates to services which have already been performed, rendered, or provided to the Member. Members must submit any such dissatisfaction or dispute to HOI in accordance with the standard complaint and grievance process described in the Informal Review and Formal Review subsections above.

If the Member is not satisfied with the decision, he/she may submit the grievance to the Statewide Provider and Subscriber Assistance Program.

General Rules

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

1. The Member always has the right, at any time, to have a complaint or a grievance reviewed by the Florida Department of Insurance or the Agency for Health Care Administration or the Statewide Provider and Subscriber Assistance Program Panel. Telephone numbers and addresses are listed below. It is advisable that the Member complete the entire Complaint and Grievance Process outlined above before pursuing review by the Panel.

2. A grievance must be filed with HOI within one (1) year of the date of the occurrence that initiated the grievance. In order for grievances concerning coverage determinations of Medical Necessity to be reviewed by a committee consisting of a majority of providers, the Member must submit the grievance within 30 days from the receipt of HOI's coverage determination.

3. A Member must cooperate fully with HOI in its effort to promptly review and resolve a complaint or grievance. In the event the Member does not fully cooperate with

HOI, the Member will be deemed to have waived his or her right to have the complaint or grievance processed within the time frames set forth above.

4. HOI shall offer to meet with the Member if the Member believes that such a meeting will help HOI resolve the complaint or grievance to the Member's satisfaction. The meeting will be held at HOI's Local Office within the Service Area or at such other mutually agreeable location within the Service Area which is convenient to the Member. For the convenience of the Member, and at the Member's option, the Member may elect to meet with HOI representatives in person, by telephone conference call, or by video-conferencing (if facilities are available). Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at the administrative offices of HOI within the Service Area. These arrangements will be made by HOI with no additional charge to the Member. The Member must notify HOI that he/she wishes to meet with HOI representatives concerning the complaint or grievance.

5. HOI will provide to the Member any of the forms necessary with each written decision letter or upon request of the Member. The Member may obtain such forms by contacting an HOI Customer Service Representative at HOI's Local Office.

6. The timeframes set forth herein may be modified by the mutual consent of HOI and the Member, however, any mutually agreed timeframe extension does not preclude the Member from having HOI's decisions reviewed by the Statewide Provider and Subscriber Assistance Program Panel at any time.

7. HOI will resolve a Member's grievance within 60 days after receipt, or within 90 days if the grievance involves the collection of information outside the Service Area. HOI may toll these time periods by notifying the Member, in writing, that additional information is required in order for HOI to complete its review of the grievance. Time is tolled until HOI receives such information. After HOI receives the requested information, the time allowed for completion of the formal process will resume.

Telephone Numbers and Addresses

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

Department of Insurance
Division of Insurance Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399-0322
1-800-342-2762

Agency for Health Care Administration
2727 Mahan Drive, Building 1, Room 301
Tallahassee, Florida 32308
1-850-922-6481
1-800-266-1062

Statewide Provider and Subscriber Assistance Program
2727 Mahan Drive, Building 1, Room 301
Tallahassee, Florida 32308
1-850-921-5458
1-800-266-1062

Local Office Locations

Health Options, Inc.
P. O. Box 44165
Jacksonville, Florida 32231-4165
(800) 734-6656

Health Options, Inc.
3191 Maguire Blvd., Suite 200
Orlando, Florida 32803
(800) 445-1494

Health Options, Inc.
4904 Eisenhower Blvd., Suite 200
Tampa, Florida 33634-6330
(800) 583-9072)

Health Options, Inc.
8400 NW 33rd Street, Suite 100
Miami, Florida 33122-1932
(800) 964-6595

SECTION 26: PRE-EXISTING CONDITIONS LIMITATION

Introduction

An Eligible Employee or Eligible Dependent with Creditable Coverage in effect for a continuous period of 12 months or longer will not be subject to a Pre-existing Condition limitation.

All Eligible Employees and Eligible Dependents enrolled subsequent to the Effective Date of the Group Plan will be subject to Pre-existing Condition limitations, except newborn or adopted dependents who are properly enrolled in accordance with the Group Plan.

Definitions

The following definitions will be referred to for purposes of this Pre-existing Conditions Limitation section:

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Pre-existing Condition means any Condition related to a physical or mental Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately preceding:

1. the first day of the Member's Waiting Period, typically the date full-time employment begins, for initial enrollees; or
2. the Member's Effective Date of coverage under the Group Plan for special and annual enrollees.

The Pre-existing Condition Limitation does not apply to:

1. pregnancy;
2. a newborn child or an adopted newborn child;
3. an adopted child who is covered under creditable coverage;
4. Genetic Information in the absence of a diagnosis of the Condition;

5. routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or
6. Conditions arising from domestic violence.

General

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

Prior health insurers and/or group health plans are required to provide a certification of Creditable Coverage to the Member upon termination of his or her coverage.

There is no coverage under the Group Plan for services or supplies to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until the Member has been continuously covered under the Group Plan for a 12-month period. This 12-month Pre-existing Condition exclusion period begins on the first day of the Waiting Period for initial enrollees; or the Member's Effective Date of coverage under the Group Plan for special and annual enrollees. This limitation also applies to any Prescription Drug that is prescribed in connection with a Pre-existing Condition. Covered Services rendered by the Member's Primary Care Physician are not subject to Pre-existing Condition Limitations.

Members With Creditable Coverage at Initial Enrollment Period

An Eligible Employee and/or an Eligible Dependent who enrolls during the Initial Enrollment Period and has Creditable Coverage will be given credit, beginning on the Enrollment Date, for the creditable portion of the Pre-existing Condition exclusion period if that person has not satisfied a 12-month Pre-existing Condition exclusion period. The Eligible Employee must furnish certification or relevant corroborating evidence of Creditable Coverage.

Members Without Creditable Coverage at Initial Enrollment Period

If an Eligible Employee or Eligible Dependent enrolls during the Initial Enrollment Period and does not have Creditable Coverage, a Pre-existing Condition will not be covered until the Member has been covered under the Group Plan for 12 consecutive months from the Enrollment Date.

Members With Creditable Coverage at Annual Open Enrollment or Special Enrollment Periods

An Eligible Employee and/or an Eligible Dependent who enrolls during the Annual Open Enrollment Period or Special Enrollment Period and has Creditable Coverage will be given credit, beginning on the Effective Date, for the creditable portion of the Pre-existing Condition exclusion period if that person has not satisfied a 12-month Pre-existing Condition exclusion period. The Eligible Employee must furnish certification or relevant corroborating evidence of Creditable Coverage.

Members Without Creditable Coverage at Annual Open Enrollment or Special Enrollment Periods

If an Eligible Employee or Eligible Dependent enrolls during the Annual Open Enrollment Period or Special Enrollment Period and does not have Creditable Coverage, a Pre-existing Condition will not be covered until the Member has been covered under the Group Plan for 12 consecutive months from the Effective Date.