UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No.: 15-cv-61144

ILISSA M. JONES, individually
and on behalf of a class of similarly
situated persons,

Plaintiff

v. JURY TRIAL DEMANDED

UNITED HEALTHCARE SERVICES, INC.,
a Minnesota corporation,
UNITED HEALTHCARE, INC.,
a Delaware corporation, and
NEIGHBORHOOD PARTNERSHIP, INC.,
a Florida corporation,

Defendants.
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AMENDED CLASS ACTION COMPLAINT
FOR DAMAGES AND INJUNCTIVE RELIEF

Plaintiff Ilissa M. Jones, individually and on behalf of a class of similarly situated persons, files this Amended Class Action Complaint for damages and injunctive relief against United HealthCare Services, Inc., United Healthcare, Inc., and Neighborhood Health Partnership, Inc.

NATURE OF THE ACTION

1. This is a class action arising from Defendants' unlawful refusal to provide contractually required, medically necessary coverage for a breakthrough, life-saving treatment for Hepatitis C.

2. Defendants United HealthCare Services, Inc. ("UHCS"), United Healthcare, Inc. ("UHC"), and Neighborhood Health Partnership, Inc. ("NHP")

(collectively, "Defendants" or "United") sell and market their health insurance products (the "Policies") to millions of Policy holders in Florida and across the nation (the "Insureds"), who have the right to rely on Defendants to handle their health insurance claims with the utmost good faith.

3. Defendants, acting in concert with others, are engaged in an unlawful pattern and practice of using undisclosed, fraudulent and pretextual "cost-avoidance" criteria to deny coverage for a miracle cure of a hitherto incurable disease to Plaintiff and other similarly situated Insureds who have Hepatitis C, but have not yet suffered irreversible, life-threatening liver damage from it. Defendants' conduct has not only caused harm, and threatens to cause irreparable harm, to Plaintiff, but also to thousands of similarly situated Insureds (the "Class Members").

4. Hepatitis C causes serious health complications, including severe liver damage, infections, liver cancer, and death. Hepatitis C is the leading cause of cirrhosis—a disease in which healthy liver tissue is replaced with scar tissue, which prevents the liver from functioning properly and can lead to liver failure and liver cancer. Even before suffering irreversible liver damage, persons with Hepatitis C can suffer serious health issues, including a high risk of heart attack, fatigue, depression, joint pain, itchy skin, fever, sore muscles, arthritis, and jaundice.

5. Until recently, there was no effective treatment, let alone cure, for Hepatitis C. In October 2014, the U.S. Food and Drug Administration ("FDA") approved Harvoni, calling it a "breakthrough drug," because it can cure Hepatitis C in a remarkable 95% to 99% of cases. Harvoni is taken once daily in pill form. It can eradicate Hepatitis C and cure the patient in as little as eight weeks with few side effects. Since October

2014, Harvoni has been the medical community's standard of care for treating Hepatitis C. The manufacturer has priced Harvoni at approximately $99,000 for a 12-week treatment in the United States, but at lower prices elsewhere.

6. The fundamental premise of health insurance is that health insurers collect premiums from insureds in exchange for a promise to cover insureds for medically necessary treatment by a treating physician. As a matter of law and logic, medically necessary treatment includes prescriptions for, and treatment administering, medicine that cures a hitherto and otherwise incurable disease.

7. In disclosures to Plaintiff and Class Members that are uniform in all material respects, Defendants consistently and expressly represent that coverage and treatment decisions under the Policies are made on the basis of "medical necessity."

8. Contrary to their express representations, and in furtherance of a common, unlawful scheme, Defendants, acting in concert with others, are and have been intentionally, systematically and continuously misrepresenting and failing to disclose that they will not provide medically necessary coverage for Harvoni treatment prescribed by Plaintiff's and Class Members' physicians, and will deny coverage under inherently fraudulent and pretextual "cost-avoidance" criteria, until Plaintiff and Class Members have suffered severe, irreversible liver damage from Hepatitis C.

9. Defendants, acting in concert with others, are and have been systematically, continuously and uniformly misrepresenting the "medical necessity" of Harvoni treatment for Plaintiff and Class Members, by denying coverage of their treating physicians' prescriptions for Harvoni treatment as not medically necessary, based on inherently fraudulent and pretextual "criteria" that have no valid basis and have been

condemned by the medical society that issued the report from which Defendants deceitfully claim to have derived them. That society—the American Association for the Study of Liver Diseases (the "AASLD")—has instructed insurers to provide coverage for Harvoni treatment to all insureds infected with Hepatitis C, "adamantly disagree[s]" with the insurers' current, unnecessary practice of "treat[ing] the sickest first,"[1] and recently concluded that it would be cost-effective to provide Harvoni treatment to everyone suffering from Hepatitis C, regardless of the degree of liver damage.[2]

10. Defendants' wrongful conduct is causing irreparable harm to Plaintiff and Class Members, by requiring them to suffer severe, irreversible liver damage that can cause cancer and death before Defendants will deign to provide coverage for Harvoni, a medically-necessary, breakthrough treatment that cures a hitherto incurable disease.

11. Lives are at stake here, and Defendants are not selling widgets. They may not simply breach their contracts in order to await a better price, or engage in fraudulent word-mincing with impunity. Plaintiff and many Class Members have suffered for a decade or more, praying that a cure is found before the ravages of Hepatitis C result in irreversible liver damage, cancer, or death. A cure has been found, it is medically necessary by any reasonable definition, and Defendants must provide the coverage they promised to provide, or pay the retail costs of obtaining it. Plaintiff and Class Members have suffered long enough.

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[1] *See AASLD Position on Treating Patients with Chronic Hepatitis C Virus*, http://www.aasld.org/aasld-position-treating-patients-chronic-hcv#sthash.7KlZ3Xqy.dpuf (emphasis added).

[2] http://www.bloomberg.com/news/articles/2015-07-13/gilead-pills-priced-at-1-000-a-day-are-found-cost-effective.

THE PARTIES

12. Plaintiff Jones is and was, at all relevant times, a citizen of Florida, residing within this District, in Pompano Beach, Florida.

13. Defendant United HealthCare Services, Inc., is and was, at all relevant times, a corporation duly organized and existing under the laws of the State of Minnesota that is authorized to transact, and is transacting, the business of insurance in the State of Florida.

14. Defendant United Healthcare, Inc., is and was, at all relevant times, a corporation duly organized and existing under the laws of the State of Delaware that is authorized to transact, and is transacting, the business of insurance in the State of Florida.

15. Neighborhood Health Partnership, Inc., is and was, at all relevant times, a corporation duly organized and existing under the laws of the State of Florida that is authorized to transact, and is transacting, the business of insurance in the State of Florida.

NON-PARTY CO-CONSPIRATORS

16. Defendants have not committed their unlawful practices and activities in isolation, but instead have done so as part of a common scheme and conspiracy, which includes not only the Defendants, but also their Pharmacy Benefits Manager, OptumRx ("Optum"). Optum facilitates Defendants' unlawful practices by developing and implementing what are referred to as "utilization management" programs, which include "prior authorization" procedures. After selling Policies to Plaintiff and Class Members, in which Defendants fraudulently misrepresented the definition of "medical necessity," Defendants deployed Optum to implement their unlawful practice of cost-avoidance through use of fraudulent "utilization management" and "prior authorization" procedures

and guidelines intended to deny Harvoni coverage to all Class Members who have not yet suffered the irreparable harm of irreversible liver damage caused by Hepatitis C.

17. At all relevant times, Defendants and Optum were the agents of each other, and in committing the unlawful acts alleged herein, each acted within the scope of their agency, with the consent, permission, authorization and knowledge of the others and, in furtherance of their individual and collective interests, aided and abetted, and conspired with the others, as set forth below.

JURISDICTION AND VENUE

18. The Class Action Fairness Act of 2005 ("CAFA"), Pub. L. No. 109-2, 119 Stat 4 (codified in various sections of 28 U.S.C.), requires that this action be brought before this Court.

19. This Court has subject matter jurisdiction because the amount in controversy exceeds $5 million and diversity exists between the Plaintiffs (including class members) and Defendants. 28 U.S.C. § 1332(d)(2). Further, in determining whether the $5 million amount in controversy requirement of 28 U.S.C. 1332(d)(2) is met, the claims of the putative class members are aggregated. 28 U.S.C. 1132(d)(6).

20. This Court also has subject matter jurisdiction under 28 U.S.C. § 1331 and 1367, and 18 U.S.C. § 1964.

21. This Court has personal jurisdiction over the Defendants because they are doing business in Florida and have registered with the Florida Secretary of State.

22. The Court also has personal jurisdiction over the Defendants under 18 U.S.C. §§ 1965(b) and (d).

23. Venue is proper in this forum because at all relevant times, Plaintiff resided in the Southern District of Florida, a substantial portion of the practices complained of occurred in the Southern District of Florida, and Defendants have received substantial compensation as a result of doing business in the Southern District of Florida. Moreover, at all times material to the allegations contained herein, Defendants personally or through their agents:

(a) operated, conducted, engaged in, and carried on a business venture in the Southern District of Florida or had an office or agency in the Southern District of Florida; and/or

(b) engaged in substantial activity within this state and district.

24. Venue also is proper in this district pursuant to 18 U.S.C. § 1965(a) and 28 U.S.C. § 1391(b).

25. All conditions precedent to this action have occurred, been performed, or have been waived.

FACTUAL BACKGROUND

A. The Contract of Insurance that Defendants sold to Ilissa Jones

26. Jones is covered by Defendants' policy called "NHP POS DIRECT ACCESS" (the "Policy"). The Policy promises coverage for medically necessary care in exchange for the payment of premiums. A true and correct copy of the Policy is attached hereto as **Exhibit A**. In exchange for the benefits promised by the Policy, Jones pays a monthly premium of more than $190.

27. The Policy defines medically necessary care to be that which:

(1) is appropriate, consistent and necessary for the symptoms, diagnosis or treatment of a medical condition;

(2) is likely to result in demonstrable medical benefit;

(3) is not provided primarily for the convenience of the Member, the Member's family, attending or consulting Physician, or other healthcare provider;

(4) is not custodial or supportive care or rest cures;

(5) is in accordance with standards of good medical practice in the medical community;

(6) is approved by the Food and Drug Administration (FDA) or the appropriate medical body or board for the condition in question; and

(7) is the most appropriate, efficient and economical medical supply, service, level of care or location which can be safely provided to treat the Member.

[*See* Policy at 14].

28. The Policies that Defendants sold to Class Members were uniform and standardized in all material respects that are relevant to Plaintiff's and the Class Members' claims.

29. All Policies that Defendants sold to Class Members contained substantially similar definitions of "medical necessity" set forth in paragraph 27 above, or contained definitions with immaterial differences. All Policies sold to Class Members promised to cover the cost of Hepatitis C treatment where such treatment satisfied the "medical necessity" definition set forth in paragraphs 27 above, or the materially identical definitions in the other Policies.

30. Plaintiffs and the Class Members reasonably relied on Defendants' express and implied representations that they would be covered for medically-necessary services.

B. Jones and Class Members are diagnosed with Hepatitis C

31. The Hepatitis C virus (or "HCV" for short) was first discovered in 1990 and is a contagious virus that attacks the liver. An estimated 2.7 million people in the United States have the disease.[3] It is generally transmitted through contact with the blood of an infected person. In 1992, the United States began screening blood utilized in transplants and transfusions for the presence of Hepatitis C. Before 1992, Hepatitis C often was transmitted through blood transfusions or transplant surgeries.

32. Hepatitis C also can be transmitted from mothers to infants at birth. Several factors influence the likelihood that the virus will be passed from mother to child, including the viral load of the mother, the gender of the newborn, and whether there is premature membrane rupture.

33. Hepatitis C has six different genotypes, or virus classifications, based on the virus's genetic material in RNA strands. Genotype 1 is the most common in the United States, and approximately 75% of Americans with the disease are infected with Genotype 1. All six genotypes of Hepatitis C cause liver deterioration and can be fatal. Even before liver deterioration occurs, patients have a heightened risk of heart attack, and suffer from fatigue, joint pain, depression, sore muscles, arthritis, and jaundice. Statistics kept by the U.S. Centers for Disease Control and Prevention (the "CDC") reveal that up to 70% of patients with Hepatitis C will develop chronic liver disease, 20% will develop cirrhosis, and 5% will develop liver cancer.

34. Like other liver diseases, Hepatitis C progresses in stages. The usual progression is from inflammation of the liver, to fibrosis of the liver, to cirrhosis of the

[3] CDC, *Viral Hepatitis – Hepatitis C Information*, http://www.cdc.gov/hepatitis/hcv/cfaq.htm.

liver. Cirrhosis can lead to liver failure, liver cancer, or death. The extent of fibrosis is described in several stages, ranging from F0 to F4.[4] A normal liver is designated as stages F0 or F1. A patient in stage F2 suffers from significant fibrosis. A patient in stage F3 suffers from severe fibrosis, and a patient in stage F4 suffers from cirrhosis.

35. For ten years since Plaintiff Jones was diagnosed with Hepatitis C in 2005, she has lived with this disease, its deleterious effects, and the well-founded fear that it eventually would destroy her liver and kill her. Like all persons who suffer from this virus, Jones kept alive the hope that medical science would develop an effective treatment before it was too late. That finally happened in October 2014, when the FDA approved Harvoni.

C. The standard of care in the medical community to treat Hepatitis C is Harvoni

36. Following her diagnosis, Jones immediately asked her treating physician, Dr. Barry Migicovsky, about her prognosis and treatment options. He advised her that the then-available treatment options caused unbearable side effects.

37. Specifically, prior to the FDA's approval of Harvoni, the standard of care in the medical community for treating Hepatitis C patients was a three-drug treatment program containing boceprevir, interferon, and ribavirin. The overall cost of this treatment program was $170,000 and provided only a 70% cure rate. In addition, this treatment caused significant adverse side effects, including anemia, insomnia, depression, diarrhea, and memory loss.

[4] A so-called "Metavir score" measures irreversible scarring of the liver in stages, from F0 to F4. Metavir scores are derived from liver biopsies, which themselves are painful and dangerous, especially to persons with Hepatitis.

38. On October 10, 2014, the FDA approved Harvoni, a prescription drug that can dramatically improve the lives of those who suffer from Hepatitis C. Harvoni is a once daily tablet that contains two drugs, ledipasvir and sofosbuvir, and can completely cure the disease in just eight to twelve weeks in 95% to 99% of cases. The length of treatment depends on a patient's condition, particularly the patient's viral load. The viral load refers to the number of viral particles in a person's blood. A patient with a viral load of more than 6 million will remain on Harvoni for twelve weeks. One with a viral load of less than 6 million will remain on Harvoni for eight weeks. A doctor can determine a viral load through a simple blood test.

39. When the FDA approved Harvoni in 2014, that drug treatment became the standard of care in the medical community. Its efficacy had been tested in three clinical trials on more than 1,500 patients. In those trials, Harvoni cured 95-99% of patients within twelve weeks. In one study of 865 patients with Genotype 1, 99% of individuals who received a twelve-week Harvoni regimen were cured (participants were considered cured if the virus was not detected in their blood three months after the conclusion of the last Harvoni treatment). Another study, involving 440 Hepatitis C patients with Genotype 1 who had failed prior treatments, produced astounding results: Harvoni cured 95% of patients without cirrhosis in 12 weeks.

40. This revolutionary cure is not only far more effective than all other treatment options, but eliminates the harmful side effects associated with other available treatments such as Sovaldi, a prescription medication utilized in combination with ribavirin. Other treatment options result in severe, unbearable side effects such as nausea, fatigue, anemia, insomnia, anxiety, diarrhea, low red blood cell count, depression,

memory loss, and muscle, joint, or bone pain. In contrast, the most severe common side effects associated with Harvoni are tiredness and headaches.

41. In light of its high success rate and minimal side effects, the FDA designated Harvoni as a ***"breakthrough therapy"*** on October 10, 2014.[5] The FDA reserves its "breakthrough therapy" designation for drugs that are proven to provide "substantial improvement over available therapies for patients with serious or life-threatening diseases." *Id.*

42. Hepatitis C is only the second disease or condition for which a cure has been discovered within a single lifespan of the disease or condition's discovery. Hepatitis C was discovered in 1990 and the cure was approved in 2014. Hepatitis C could be completely eradicated in a few years as a result of this miracle cure, assuming patients, such as Plaintiffs and Class Members, have access to it.

D. Defendants develop and conceal a cost-avoidance scheme to deny coverage for Harvoni treatment

43. At least six months before the FDA approved Harvoni in October 2014, Defendants already had begun developing secret "management strategies" to "identify program and cost savings opportunities" to elevate profits over the needs of their insureds with Hepatitis C.[6] United's "Hep C Management Strategy" reveals that those discussions began no later than April 2014, and describes a scheme to misuse a report by the AASLD

[5] *FDA approves first combination pill to treat hepatitis C*, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm418365.htm (Oct. 10, 2014).

[6] *See* Case Study: Management Strategies for Hepatitis C at p. 11, found at http://www.cbinet.com/sites/default/files/files/Godwin_Mark_pres.pdf (hereinafter referred to as "Hep C Management Strategy").

(the "AASLD Report") to deny medically necessary treatment in order to "prioritize coverage based on clinical interpretation." *See* Hep C Management Strategy at 12.[7]

44. When the FDA approved Harvoni in October 2014, Defendants began denying coverage for Harvoni treatment based on hidden, cost-avoidance "criteria" purportedly based on a fraudulent interpretation and misrepresentation of the AASLD Report. Internal documents demonstrate that Defendants "assigned to the highest priority" those insureds "with advanced fibrosis (Metavir F3)" or "those with compensated cirrhosis (Metavir F4)." *See* UnitedHealthcare Clinical Pharmacy Program, dated October 2014 (hereinafter referred to as the "October 2014 Clinical Pharmacy Program").[8]

45. Defendants concealed their internal "criteria" from Plaintiff and the Class Members, and instead fraudulently represented that coverage determinations would be made on the "medical necessity" definition found in the Policies. Only after Defendants denied Plaintiff's claim based on their undisclosed cost-avoidance "criteria" did they offer to disclose it, by informing Plaintiff that she could obtain, "upon written request and at no charge, the internal . . . clinical criteria for HARVONI coverage."

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[7] The AASLD has not only condemned this misrepresentation and misuse of its report, but has expressed its intent to issue another report concluding that it would be cost-effective to treat all Hepatitis C patients with Harvoni, regardless of their degree of liver scarring. *See AASLD Position on Treating Patients with Chronic Hepatitis C Virus*, http://www.aasld.org/aasld-position-treating-patients-chronic-hcv#sthash.7KlZ3Xqy.dpuf

[8] As noted above, Metavir scores measure (on a scale from F0 to F4), the irreversible fibrosis and scarring of the liver caused by Hepatitis C. Metavir scores are derived from liver biopsies, which themselves are painful and risky, particularly for persons with Hepatitis. A normal liver is designated as F0 or F1. Severe fibrosis is designated as stage F3, while cirrhosis (which itself can cause death) is designated as stage F4. The Metavir process cannot reliably distinguish between stages F2 and F3.

E. Defendant and its Pharmacy Benefits Manager ("PBM") uniformly carry out a scheme to deny Defendants' Insureds coverage for, and access to, a medically-necessary, miracle cure for Hepatitis C

46. As set forth above, Defendants use a Pharmacy Benefits Manager (or "PBM") named OptumRx to administer pharmacy claims by Insureds. While the Defendants control the process of underwriting and selling the Policies to Class Members, Optum controls and administers the prescription claims for Harvoni submitted by Class Members' treating physicians.

47. At all material times Optum and Defendants were each other's agents. In committing the unlawful acts alleged herein, Defendants acted within the scope of that agency, with the consent, permission, authorization and knowledge of Optum, and in furtherance of their individual and collective interests acted in concert, aided and abetted, and conspired with Optum, as set forth below.

48. As United described in its Hep C Management Strategy, its cost-avoidance scheme involves the use of "utilization management" programs. "Utilization management" is merely opaque verbiage used to obfuscate meaning. It means the use of "cost-avoidance" protocols to minimize costs and maximize profits. A core feature of utilization management is a process Defendants call "prior authorization." Under a "prior authorization" procedure, Defendants will refuse to cover any prescribed treatment or medication unless the treating physician gets its authorization in advance.

49. One legitimate reason for an insurer's "prior authorization" procedure could be to capture a discount it receives on a particular drug, as opposed to a medically-equivalent substitute for which it pays a higher price. Insurers also use the "prior authorization" process to ensure that the prescribed treatment conforms to the applicable

definition of "medical necessity." None of the Class Members' Policies allow Defendants to use the "prior authorization" process to change the contractual definition of medical necessity, or deny coverage for treatment that is medically necessary.

50. Defendants have employed Optum as the enforcer of their cost-avoidance scheme. As that enforcer, Optum polices the prior authorization process, which requires all Class Members to obtain "prior authorization" before obtaining Harvoni. Optum evaluates and denies any requests that do not meet the internal guidelines developed by the Defendants, which are wholly unrelated to, contradict, subvert and undermine the definition of "medical necessity" in the Policies that the Defendants sold to Plaintiff and Class Members. As the Defendants' agent and on their behalf, Optum then issues letters to Plaintiff and Class Members denying their "prior authorization" requests.

51. The prior "authorization procedures" that Optum administers on behalf of Defendants require Plaintiff and Class Members to demonstrate that they have suffered for a sufficiently long time to have developed significant, irreversible liver damage, before Optum will approve their treating physicians' prescriptions for the miracle cure that Harvoni provides.

52. The Defendants and Optum have attempted to disguise their "cost-avoidance" conspiracy by uniformly relying on, and misrepresenting to Plaintiff and Class Members, that their coverage denials are supported by the AASLD Report, which they fraudulently claim supports their denial of coverage for Harvoni treatment to patients with Metavir scores lower than F3.[9] However, the AASLD expressly disavowed insurers' use of its Report as a pretextual basis to force insureds to keep suffering when a

[9] As noted, the Metavir test cannot meaningfully distinguish between stages F2 and F3.

cure is now available. In what amounts to a first-of-its-kind condemnation of the misuse of such a report, the AASLD issued the following statement:

> Unfortunately payers across America are denying treatment when a doctor has prescribed it for their patient. ***We adamantly disagree with this decision***. Our Guidance is not intended to be used by payers to deny access to treatment. In no way does this position contradict the evidence evaluated to produce the Guidance and the recommendation made in the Guidance to treat the sickest first, but ***recognizes need to treat all***.

See AASLD Position on Treating Patients with Chronic Hepatitis C Virus, http://www.aasld.org/aasld-position-treating-patients-chronic-hcv#sthash.7KlZ3Xqy.dpuf (emphasis added).

53. Contrary to Defendants' false representations that the AASLD Report recommends Class Members should suffer irreparable bodily harm and liver damage before receiving treatment, the AASLD Report expressly states that: "[e]vidence clearly supports treatment in all BCV-infected persons, except those with limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions." AASLD, *When and in Whom to Initiate HCV Therapy, Recommendations for Testing, Managing, and Treating Hepatitis C*, http://www.hcvguidelines.org/printpdf/91. In fact, and as noted above, the AASLD recently reaffirmed its position that the evidence supports treating all Hepatitis C patients, and expressly concluded that doing so would be cost-effective.

54. Defendants have ignored the AASLD's express disavowal of their systematic misrepresentation and misuse of the AASLD report, and have continued to require Plaintiff and Class Members to prove significant, irreversible liver damage before they will approve coverage, including demanding that this damage be demonstrated through costly, painful, and dangerous liver biopsies.

55. In fact, following their Hep C Management Strategy and the October 2014 Clinical Pharmacy Program discussed above, which fraudulently misrepresented and purported to rely on the AASLD Report, Defendants, through Optum, have used, now use, and intend to continue using fraudulent cost-avoidance criteria to wrongfully and unlawfully deny coverage for Harvoni treatment to Plaintiff and Class Members. These pretextual "criteria" would breach, violate, and fraudulently purport to change the Policies' definition of "medical necessity," even if they had timely been disclosed to Plaintiff or Class Members (which they were not).

56. Defendants' practice is consistent nationwide. For instance, a United spokesman stated that it uniformly denies Harvoni treatment because the Defendants' "clinical coverage criteria is consistent with clinical evidence to prioritize treatment based upon the progression of the disease, i.e., treating the sickest patients first, and monitoring patients with early stage disease, and treating them if and when they progress."[10] United's statements to the press are a striking admission of an unlawful cost-avoidance scheme to deny Insureds a life-saving cure for a hitherto incurable degenerative disease. Nothing in the Policies (let alone the ethical practice of medicine) would allow Defendants to treat the "sickest patients first" and deny coverage for all others until their disease has caused irreparable harm, when a cure is readily available right now.

F. The Defendants deny Jones' claim for Harvoni treatment

57. On February 3, 2015, Dr. Migicovsky recommended that Plaintiff Jones begin Harvoni treatment and promptly requested prior authorization for the medication.

[10] http://www.kristv.com/story/29582807/port-aransas-man-with-hep-c-fights-insurance-company.

Almost immediately after Dr. Migicovsky's request, Defendants denied coverage because Ms. Jones's liver had not sufficiently deteriorated. In other words, Defendants decided that Ms. Jones hadn't suffered enough, and her liver hadn't been damaged enough, by a disease that causes irreparable harm and death, for which a cure is finally available. Defendants said they would not consider approving Harvoni for Jones until a biopsy demonstrates significant scarring of her liver (severe fibrosis of stage F3 or greater).

58. Dr. Migicovsky and Plaintiff Jones were shocked by Defendants' position. Never in Dr. Migicovsky's 25-plus years of practice would he have thought that an insurer would take the position that a patient's disease must get worse, and cause irreparable harm, before it would approve treatment that could arrest the progression of the disease ***and prevent that harm***.

59. On February 23, 2015, Dr. Migicovsky immediately appealed Defendants' denial. Defendants affirmed their denial in a letter dated February 26, 2015. Defendants claimed that Harvoni treatment was not medically necessary for Jones because her liver did not yet demonstrate stage F3 or F4 damage. No known medical study supports this denial, and nothing in Jones's Policy (or any of the class members' Policies) grants Defendants the right to withhold a potentially life-saving cure, particularly on the perverse and pretextual "basis" that it is not "medically necessary."

60. Nothing in Jones's Policy (or the Policies of class members) permits Defendants to withhold a potentially life-saving cure until a disease has caused irreparable harm, including liver fibrosis or cirrhosis. Defendants' conduct demonstrates that (1) they prefer for their Insureds with Hepatitis C to suffer continuing and irreparable

harm before they will authorize treatment that appears all but guaranteed to cure the disease, and (2) they prefer to put profits ahead of patients.

61. As a result of Defendants' unreasonable and unlawful denial of coverage, Jones has been unable to begin Harvoni treatment, which has demonstrated a 95% to 99% cure rate in cases like hers. At a cost of $99,000 for a 12-week treatment, she is unable to pay for the treatment out-of-pocket.

62. To date, Defendants continue to deny Jones access to this breakthrough treatment, demanding that she wait until her medical condition has worsened to the point that irreparable harm has occurred. Absent judicial intervention, significant, irreversible deterioration to Jones's liver function must occur before Defendants will deign to provide coverage for Harvoni. Specifically, unlike those patients with F0-F2 liver scarring, those who have reached stage F3 or F4 face a higher risk of liver cancer.[11] In fact, the AASLD recommends a patient that has reached F3- or F4-level liver scarring to test for hepatocellular carcinoma (i.e. liver cancer) every 6 months for the rest of her life.[12] In other words, instead of treating all Hepatitis C patients regardless of liver deterioration, United is forcing its patients to develop a type of liver scarring that, even if cured, will require a lifetime of medical monitoring.

63. Nothing in Plaintiff's Policy, or the Policies of Class Members, permits Defendants to deny coverage for a potentially life-saving cure until a disease has caused irreparable harm, including liver fibrosis or cirrhosis. Moreover, no clinical criteria

[11] http://www.hcvguidelines.org/full-report/monitoring-patients-who-are-starting-hepatitis-c-treatment-are-treatment-or-have.
[12] *Id.*

supports "prioritizing" treatment based on how much an Insured has suffered from an otherwise incurable disease, let alone the price of a proven miracle cure for that disease.

64. Defendants and Optum have not committed the above-described, unlawful practices and activities in isolation, but instead have done so as part of a common scheme and conspiracy. Other participants in the scheme and conspiracy may be revealed through the pendency of this action.

65. Each member of the conspiracy, with knowledge and intent, agreed to the overall objective of the conspiracy, and agreed to commit, and committed, acts of fraud intended to deprive Plaintiff and Class Members of coverage for a medically necessary, life-saving cure for Hepatitis C.

66. For the fraudulent scheme described above to be successful, it was necessary for Defendants and Optum to agree to enact and utilize the same fraudulent tactics against Plaintiff and the Class Members.

67. Numerous common facts and similar activities, which reflect the above-described scheme and demonstrate the existence of the conspiracy, exist among the Defendants and Optum, including:

(a) Optum's implementation and monitoring of a "cost-avoidance" scheme that relies on the use of "utilization management" techniques, including fraudulent "prior authorization" requirements, to deny coverage for Harvoni treatment to all of Defendants' Insureds who had not already suffered irreversible liver damage;

(b) Defendants' Hep C Management Strategy, which was developed as early as April 2014 and fraudulently represents that the AASLD Report

recommends prioritizing treatment to those with advanced fibrosis (Metavir F3) or compensated cirrhosis (Metavir F4);

(c) Defendants' October 2014 Clinical Pharmacy Program, which fraudulently represents that the AASLD recommends covering only those patients "assigned to the highest priority," which were those with "with advanced fibrosis (Metavir F3)" or "those with compensated cirrhosis (Metavir F4);" and

(d) Optum's immediate implementation of the Hep C Management Strategy and the October 2014 Clinical Pharmacy Program as a basis to issue uniform denial-of-coverage letters to Plaintiff and Class Members, and its fraudulent use of cost-based "criteria" to deny coverage of Plaintiff's and Class Members' prescriptions for Harvoni treatment.

68. During the past year the conspiracy has been conducted and implemented through the sharing and dissemination of claims-processing and utilization-management techniques that Defendants and Optum share with each other directly or indirectly, including, but not limited to, the Hep C Management Strategy, described in Paragraph 43, and the October 2014 Clinical Pharmacy Program described in Paragraph 44.

69. In short, Defendants, through Optum, continue to unlawfully use irreversible liver damage as a pretextual pre-condition for denying coverage of Harvoni treatment to the vast majority of its Insureds who suffer from Hepatitis C, when there is no basis to prioritize coverage for Harvoni treatment based on the severity of permanent liver damage, because (1) there is no lack of supply of Harvoni and, (2) the AASLD—which wrote the Report that Defendant fraudulently misrepresents as "guidelines" for

denying coverage—expressly states that health insurers should not "prioritize" treatment in any way. The AASLD instead recognizes the "need to treat all" and notes that the "[e]vidence clearly supports treatment in all BCV-infected persons . . . ." *See AASLD Position on Treating Patients with Chronic Hepatitis C Virus*, http://www.aasld.org/aasld-position-treating-patients-chronic-hcv#sthash.7KlZ3Xqy.dpuf.

70. At bottom, Plaintiff Jones's Policy, consistent with those of Class Members, promises to provide coverage for medically necessary treatment. The Policy contains a definition of medical necessity, which is the only criteria Defendants disclosed to Plaintiffs and Class Members before sending them letters denying coverage for Harvoni treatment.

71. Harvoni treatment unquestionably satisfies the operative definition of medical necessity. Nothing in the Policies (or the law) requires Class Members to allow their medical condition to deteriorate to the point of suffering irreparable fibrosis of the liver before their doctor-prescribed Harvoni treatment becomes "medically necessary."

72. The Policies' contractual standard of "medical necessity" is not the standard Defendants applied in denying Plaintiff's claim (and the claims of Class Members) for Harvoni treatment. Instead Defendants applied an undisclosed and much more restrictive standard (that was inherently fraudulent), which plainly was created to increase profits by limiting Class Members' access to this life-saving medication. Defendants continue to use their pretextual cost-avoidance "criteria" to deny the claims of Class Members.

73. Until Jones received Defendants' (and Optum's) letters denying coverage, she had no notice that coverage could be determined by anything outside of her Policy, or that Defendants would place arbitrary restrictions on her access to medically necessary treatment, let alone restrictions based on the price of treatment, disguised as having anything to do with anything else. The same is true for all the Class Members.

74. As a matter of law, Defendants were required to rely on the plain language of the Policies to determine coverage eligibility for Harvoni treatment. Defendants flagrantly breached their duties by ignoring that Policy language and denying coverage based on undisclosed criteria, which served only to elevate profit-seeking over their duties to Plaintiff and Class Members.

75. The Policies by which Defendants insure Plaintiff (and similarly situated Class Members) are substantially similar in all material respects, are the complete expression of the agreement, and contain materially identical definitions of "medical necessity," or definitions with immaterial differences.

76. By relying on inherently fraudulent and pretextual, purported "medical criteria" to deny Plaintiff's and Class Members' claims for coverage for Harvoni treatment, Defendants have breached and are breaching their Policies with Plaintiff and Class Members.

RICO ALLEGATIONS

A. The Enterprise

77. Plaintiff, Class Members, Defendants, and Optum are "persons" within the meaning of 18 U.S.C. § 1961(3).

78. Based on Plaintiff's current information, the following persons constitute a group of individuals associated in fact that Plaintiff refers to as the "Enterprise," within the meaning of 18 U.S.C. § 1962(c): (1) Defendant UHCS; (2) Defendant UHC; (3) Defendant NHP; and (4) Optum.

79. The Enterprise is an ongoing organization which engages in, and whose activities affect, interstate commerce.

80. While Defendants and Optum participate in and are members and part of the Enterprise, they also have an existence separate and distinct from the Enterprise.

81. In order to successfully deny the Class Members access to a medically necessary, potentially life-saving Harvoni cure in the manner set forth above, Defendants needed an organizational framework that would allow them to systematically and uniformly process and deny coverage for prescriptions that the Class Members' treating physicians write for their patients, and conceal the manner in which that process is carried out. The Enterprise provides Defendants with that system and ability, and control of and participation in it is necessary for the successful operation of the scheme. Defendants control and operate the Enterprise as follows:

(a) By sharing and disseminating claims-processing and utilization-management information through meetings with each other;

(b) By developing purported "clinical criteria" guidelines, based on hidden criteria of financial expediency, to use as a basis for systematically denying claims without regard to medical necessity;

(c) By agreeing to use and using those guidelines, which are based on hidden criteria of financial expediency,

(d) By engaging and paying Optum to implement "clinical criteria" guidelines that are based on hidden criteria of financial expediency;

(e) By agreeing to use the cost-based criteria to deny medically necessary treatment; and

(f) By participating in, and supporting the use of, Optum as a PBM to assist Defendants in processing (and denying) doctors' prescriptions (including prescriptions for Harvoni treatment) in a coordinated fashion.

82. In short, the Defendants underwrite and sell insurance policies to the Class Members and develop, in coordination with Optum, "utilization management" programs to deny coverage for what otherwise would be medically necessary treatment. Optum then implements these techniques through procedures such as "prior authorization" to ensure that Defendants' unlawful and fraudulent cost-avoidance goals are achieved.

B. The Predicate Acts

83. Section 1961(1) of RICO provides that "racketeering activity" includes any act indictable under 18 U.S.C. § 1341 (relating to mail fraud) and 18 U.S.C. § 1343 (relating to wire fraud). As set forth below, Defendants and the other Enterprise members have committed and continue to commit acts of mail and wire fraud in furtherance of the scheme.

84. In addition, in order to make the scheme effective, each of the Enterprise members sought to and did aid and abet the others in violating the above laws within the meaning of 18 U.S.C. § 2. As a result, their conduct is indictable under 18 U.S.C. §§ 1341 and 1343, on this additional basis.

85. For the purpose of executing and/or attempting to execute the above described scheme to defraud or obtain money by means of false pretenses, representations or promises, the Defendants and the other Enterprise members, in violation of 18 U.S.C. § 1341, placed in post offices and/or in authorized repositories matter and things to be sent or delivered by the Postal Service, caused matter and things to be delivered by commercial interstate carrier, and received matters and things from the Postal Service or commercial interstate carriers, including but not limited to the Policy, any modifications to the Policy, descriptions and explanations of Policy benefits, premium invoices and payments, correspondence relating to premiums, acceptance of premiums, requests for coverage, and denials of coverage.

86. For the purpose of executing and/or attempting to execute the above described scheme to defraud or obtain money by means of false pretenses, representations or promises, Defendants and the other Enterprise members, also in violation of 18 U.S.C. § 1343, transmitted and received by wire, matters and things which include but are not limited to the Policy, any modifications to the Policy, descriptions and explanations of Policy benefits, guidelines recommending the use of cost-based criteria to deny medically-necessary treatment, premium invoices and payments, correspondence relating to premiums, acceptance of premiums, requests for coverage, and denials of coverage.

87. The matter and things sent by Defendants and the other Enterprise members via the Postal Service, commercial carrier, wire or other interstate electronic media include, inter alia: (a) material containing false and fraudulent misrepresentations that coverage determinations under the Policies will be made in accordance with the

medical necessity definition in the Policies; and (b) denials of coverage of the Plaintiff's and Class Members' doctors' prescriptions for Harvoni treatment that falsely or fraudulently claimed to have been made in accordance with the medical necessity definition in the Policies.

88. For example, and without limitation, the medical necessity definition in the Policy was itself a willful misrepresentation in that Defendants, through Optum, knowingly used undisclosed cost-based "criteria," in addition to or in place of the Policy's medical-necessity definition, to deny claims for a medically-necessary, potentially life-saving, miracle cure for Hepatitis C. The representations in the Policy that coverage determinations would be based on the medical necessity definition in the Policy was therefore false, inaccurate and misleading. The wrongful use of cost-based criteria was not grounded in medical necessity under the Policy, and had the purpose and effect of improperly denying contractually-owed medically-necessary treatment.

89. The Enterprise's undisclosed cost-based criteria for denying claims for Harvoni coverage are uniformly based on considerations unrelated to the definition of medical necessity in Class Members' Policies. Thus, these undisclosed cost-based "criteria" are designed to improperly prevent Class Members from obtaining coverage for medically-necessary Harvoni treatment.

90. The Enterprise concealed their cost-based "criteria" through denial letters including, but not limited to, those in Paragraphs 57-59, which are substantially similar in all material respects to the denial letters sent to other Class Members. In those letters, the Enterprise falsely represented that their denials of coverage for Harvoni prescriptions written by Class Members' physicians were based on medical necessity when, in fact,

they were based on undisclosed cost-based "criteria" in service of a cost-avoidance scheme.

91. The Enterprise further attempted to conceal their secret, cost-based "criteria" through statements to the press. For instance, when confronted with their cost-avoidance scheme, the Defendants falsely represented that their use of "clinical coverage criteria [to deny Harvoni coverage] is consistent with clinical evidence to prioritize treatment based upon the progression of the disease, i.e., treating the sickest patients first, and monitoring patients with early stage disease, and treating them if and when they progress."[13]

92. In addition to the above-described matters and things, other matters and things sent through or received from the Postal Service, commercial carrier or interstate wire transmission by the Enterprise included false or fraudulent information or communications in furtherance of the scheme, or that were necessary to effectuate it.

93. The above misrepresentations, acts of concealment and failures to disclose were knowing and intentional, and were made for the purpose of deceiving Plaintiff and the Class Members, wrongfully denying coverage for medically necessary treatment under the Policies, and wrongfully obtaining Plaintiff's and Class Members' property for the Defendants' and other Enterprise members' gain.

94. Defendants either knew or recklessly disregarded the fact that the misrepresentations and omissions described above were material, and that Plaintiff and the Class Members reasonably relied on them.

[13] http://www.kristv.com/story/29582807/port-aransas-man-with-hep-c-fights-insurance-company.

95. As a result, Defendants wrongfully denied Plaintiff's and Class Members' claims for medically necessary treatment, and wrongfully obtained money and property belonging to Plaintiff and Class Members. Plaintiff and the Class Members have been injured in their business or property by reason of the Enterprise's overt acts of mail and wire fraud, conspiracy to commit acts of mail and wire fraud, and aiding and abetting each other's acts of mail and wire fraud.

C. Pattern of Racketeering Activity

96. Defendants and the Enterprise have engaged in a pattern of racketeering activity, as defined by 18 U.S.C. § 1961(5), by committing or aiding and abetting in the commission of at least two acts of racketeering activity, i.e., indictable violations of 18 U.S.C. § 1341 and 1343 as described above, within the past ten years. Each act of racketeering activity was related, had a similar purpose, involved the same or similar participants and method of commission, had similar results and impacted similar victims, including Plaintiff and the Class Members. The similar result was to fraudulently induce persons to purchase, and continue to pay premiums on, the Policies, thereby permitting the Defendants to reap, keep, and share millions of dollars in premiums with Optum, while systematically denying contractually-promised coverage for medically-necessary Harvoni treatment.

97. The multiple acts of racketeering consist of those described in Paragraphs 85-95. Specifically, since at least 2013, the Enterprise has repeatedly delivered or caused to be delivered to Class Members, by means of the Postal Service, documents containing material misrepresentations and omissions concerning coverage for Harvoni treatment, as well as misrepresentations that such coverage determinations would be based on medical

necessity. Those documents include (a) the Policies, (b) any and all modifications to the Policies, (c) denial letters, and (d) press releases. The Enterprise members also repeatedly delivered or caused to be delivered to each other documents containing inherently fraudulent "guidelines" and "criteria" that contained material misrepresentations of the AASLD Report, which the Enterprise intended to use, and is using, to deny claims for Harvoni treatment, none of which were provided to Plaintiff and Class Members. All of these documents contained material misrepresentations in that they misrepresented or failed to disclose that Defendants would base Harvoni coverage decisions not on "medical necessity" but, instead, on undisclosed, cost-based "criteria" in furtherance of a cost-avoidance scheme. Thus, the representations that Defendants made in the Policies that such coverage would be decided based on "medical necessity" were materially false, inaccurate and misleading.

98. Furthermore, Defendants and the Enterprise continue to engage in these unlawful, predicate acts causing harm to the Class Members on a daily basis, which establishes a threat of long-term racketeering activity and evidences the continuity of the Enterprise's open-ended pattern of racketeering activity.

D. Rico Violations

1962(a)

99. Section 1962(a) of RICO provides that "it shall be unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity . . . in which such person has participated as a principal within the meaning of 2, title 18, United States Code, to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in the acquisition of any interest in, or

the establishment or operation of, any enterprise which is engaged in, or the activities of which affect interstate or foreign commerce."

100. As set forth above, Defendants received income from their participation as principals in an extensive pattern of racketeering activity.

101. That income is reinvested to finance future racketeering activity, and the future operation of the Enterprise. In addition, Defendants use the income to buy additional health insurance companies or plans, which increases the scope and size of the Enterprise, the reach of their fraudulent scheme, and the power to perpetuate and enforce it.

1962(c)

102. Section 1962(c) of RICO makes it unlawful "for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce."

103. As detailed above, Defendants agreed to participate, directly or indirectly, in the conduct of the affairs of the Enterprise through a pattern of racketeering activity comprised of numerous acts of mail fraud and wire fraud, and did so in violation of 18 U.S.C. § 1962(c).

104. Defendants and the Enterprise committed a pattern of racketeering activity that was intended to, and did, fraudulently deny coverage for medically necessary treatment and keep money obtained from the Plaintiff and Class Members for their own use, in violation of 18 U.S.C. § 1962(c).

105. Defendants further agreed to use or invest, directly or indirectly, part of the income derived from the Enterprise's acts of mail fraud and wire fraud, which constituted a pattern of racketeering activity, in the establishment, operation and expansion of the Enterprise, and has been done so in violation of 18 U.S.C. 1962(c).

1962(d)

106. Section 1962(d) of RICO makes it unlawful "for any person to conspire to violate any of the provisions of subsection (a), (b) or (c), of this section."

107. Defendants conspired with other members of the Enterprise to obtain and keep money obtained from the Plaintiff and Class Members for their own use and deny coverage for Harvoni treatment through the fraudulent scheme described above, which violates 18 U.S.C. § 1962(d).

CLASS ALLEGATIONS

A. Class Definition

108. Plaintiff brings this action against Defendants under Rule 23 of the Federal Rules of Civil Procedure on behalf of herself and all other similarly situated persons, and seeks to represent the following class:

> All persons who are, or were, insured by Defendants or their affiliates, subsidiaries, agents, or entities, and (1) have Hepatitis C and Stage F0, F1, or F2 fibrosis, (2) have received a prescription from their treating physician for Harvoni, and (3) have been denied Harvoni treatment by Defendants or their affiliates, subsidiaries, agents, or entities because they do not have Stage F3 or F4 fibrosis (the "Class," whose members are "Class members"). Excluded from the Class are Defendants, their

affiliates, subsidiaries, agents, board members, directors, officers, and/or employees.

109. Plaintiff reserves the right to modify or amend the definitions of the proposed Class before the Court determines whether certification is appropriate.

110. Defendants subjected Plaintiff and Class members to the same harm and in the same manner. The conduct described above constitutes Defendants' standard business practice.

B. Rule 23(a)(1) – Numerosity

111. The individual Class members are so numerous that their individual joinder is impracticable. The Defendants sell numerous health insurance policies in the state of Florida and throughout the country and, as a general business practice, have failed to comply with applicable law. Moreover, the individual Class members easily can be identified from Defendants' business records. On information and belief, the number of Class members is in the thousands. Their precise number will be determined through discovery, but they are too numerous to be consolidated in one complaint, and it is impractical for each to bring an individual action.

C. Rule 23(a)(2) – Commonality

112. There are questions of law and fact that are common to Plaintiff's and Class members' claims. These common questions predominate over any questions that might apply particularly to the claim of any individual Class member. Common questions of law and fact include, but are not limited to, the following:

(a) Whether Defendants are engaging in a pattern and practice of denying coverage for Harvoni treatment to Class members suffering from stage F0, F1, or F2 liver fibrosis;

(b) Whether Defendants' pattern and practice of denying coverage for Harvoni treatment to Class members suffering from stage F0, F1, or F2 liver fibrosis constitutes a breach of the Policies;

(c) Whether Defendants' pattern and practice of denying coverage for Harvoni treatment to Class members suffering from stages F0, F1, or F2 liver fibrosis constitutes a breach of the implied covenant of good faith and fair dealing in the Policies;

(d) Whether Defendants' pattern and practice of denying coverage for Harvoni treatment to Class members suffering from stages F0, F1, or F2 liver fibrosis is procedurally and substantively unconscionable, because the Policies do not contemplate or authorize Defendants to derive hidden financial benefits by denying coverage based on undisclosed or hidden guidelines;

(e) Whether the Class Members are entitled to specific performance, and/or injunctive relief and damages by reason of Defendants' refusal to provide coverage required by the Policies for medically necessary treatment;

(f) Whether Defendants conspired and/or aided and abetted each other in furtherance of the unlawful acts alleged herein;

(g) Whether Defendants have engaged in mail and wire fraud;

(h) Whether Defendants have engaged in a pattern of racketeering activity;

(i) Whether Defendants and Optum constitute an enterprise within the meaning of 18 U.S.C. § 1961(4);

(j) Whether Defendants have used or invested income from their racketeering activities to establish or operate the Enterprise in violation of 18 U.S.C. § 1962(a);

(k) Whether Defendants conducted or participated in the affairs of the Enterprise through a pattern of racketeering activity in violation of 18 U.S.C. § 1962(c);

(l) Whether Defendants' overt and/or predicate acts in furtherance of the conspiracy and/or aiding and abetting and/or direct acts in violation of 18 U.S.C. § 1962(a) and (c) proximately caused injury to the Plaintiff's and the Class Members' property;

(m) Whether Defendants are acting and/or refusing to act on grounds generally applicable to the Plaintiff and the Class Members; and

(n) Whether Defendants have fraudulently concealed their scheme.

D. Rule 23(a)(3) – Typicality

113. Defendants' own records demonstrate that Plaintiff is a member of the Class. Plaintiff's claims are typical of the claims of the Class because they are based on the same legal theory, arise from the similarity, uniformity, and common purpose of Defendants' unlawful conduct, and are not subject to any unique defenses. Each Class member has sustained, and will continue to sustain, damages in the same manner as Plaintiff as a result of Defendants' wrongful conduct.

E. Rule 23(a)(4) – Adequacy of Representation

114. Plaintiff is an adequate representative of the Class and will fairly and adequately protect the interests of the Class. Plaintiff is committed to the vigorous prosecution of this action, and has retained competent counsel who are experienced in litigation of this nature to represent her. There is no conflict or antagonism between the interests of Plaintiff and the unnamed Class Members.

115. To prosecute this case, Plaintiff has chosen the law firm of Rivero Mestre LLP, and is obligated to pay a fee for that representation. This firm is experienced in class action litigation and possesses the financial and legal resources to deal with the costs and legal issues inherent in this action.

F. Requirements of Fed. R. Civ. P. 23(b)(3)

116. Questions of law or fact common to the Plaintiff's and Class Members' claims predominate over any questions of law or fact affecting only individual Class members. All claims by Plaintiff and the unnamed Class Members arise from Defendants' common course of unlawful conduct, in breach of the Policies and violation of Florida law. The predominating questions of law and fact include those set forth above in Paragraph 112.

117. Common issues predominate where, as here, liability can be determined on a class-wide basis, even if there might be the need for some individualized damages determinations. As a result, in determining whether common questions predominate, courts focus on the liability issue, and if the liability issue is common to the class, as it is in this case, common questions will be held to predominate over individual questions.

G. Superiority

118. A class action is superior to individual actions, in part because of the following, non-exhaustive list of factors:

(a) Individual joinder of all Class Members would impose extreme hardship and inconvenience on them, because they reside all across the nation;

(b) Individual claims by Class Members are impractical because the cost of pursuing an individual claim could exceed its value. As a result, individual Class Members have no interest in prosecuting and controlling separate actions;

(c) There are no known Class Members who are interested in individually controlling the prosecution of separate actions;

(d) The interests of justice will be served by resolving the common disputes of all Class Members in one forum;

(e) Judicial and party resources will be conserved by resolving the common disputes of all Class Members in one forum;

(f) Individual claims would not be cost effective or economically feasible to pursue through individual actions; and

(g) The action is manageable as a class action.

H. Requirements of Fed. R. Civ. P. 23(b)(1)(a) & 23(b)(2)

119. The prosecution of separate actions by (or against) individual Class Members would create a risk of inconsistent or varying adjudications with respect to individual Class Members that would establish incompatible standards of conduct for Defendants and any other party opposing the Class.

120. Defendants have acted or failed to act in a manner generally applicable to the Class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

121. Defendants have combined and conspired among themselves and with others as an association-in-fact enterprise within the meaning of 18 U.S.C. 1962(c), and have conducted the affairs of that enterprise through a nationwide pattern of racketeering activity in violation of the federal RICO statute, 18 U.S.C §§ 1961-1968. Defendants' pattern of racketeering is comprised of hundreds (if not thousands) of continuous and ongoing predicate acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343. Plaintiff and the Class have been, are being, and will continue to be damaged by reason of these predicate acts and the pattern of racketeering activity they comprise. As a result, Plaintiff and the Class are entitled to injunctive relief and to recover three times their actual damages, including the fees and costs of this action, pursuant to 18 U.S.C. §§ 1964(a) and 1964(c).

COUNT I
Breach of Contract

122. Plaintiff re-alleges paragraphs 1 through 120, as if fully set forth herein.

123. Defendants materially breached the materially identical terms of Plaintiff's and Class Members' Policies by:

(a) denying coverage to Plaintiff and Class Members for treatment that is covered by the Policies;

(b) requiring that Plaintiff's and Class Members' medical condition and health deteriorate—resulting in irreversible damage and irreparable

harm—before providing coverage for Harvoni treatment prescribed by their doctors;

(c) failing and refusing to provide coverage for Harvoni treatment to Plaintiff and Class Members, with knowledge that Harvoni was medically necessary and with knowledge that these claims for coverage were valid claims under the Policies;

(d) failing to evaluate Plaintiff's and Class Members' claims for coverage of Harvoni treatment based on the criteria and standards required by the Policies, including the Policies' definition of "Medical Necessity."

124. Defendants' denial of coverage for Harvoni treatment to Plaintiff and Class Members is procedurally and substantively unconscionable, because the law forbids Defendants from deriving hidden financial benefits by denying coverage based on hidden or undisclosed guidelines.

125. On information and belief, Defendants have breached the terms and provisions of the materially identical Policies it sold to Plaintiff and Class Members by other acts and omissions of which Plaintiff is presently unaware, which will be shown according to proof at the time of trial.

126. Plaintiff and the Class have a clear right to specific performance of Defendants' contractual obligation under the Policies to provide coverage for medically necessary Harvoni treatment, which justice requires, because further delay in treatment will cause irreparable harm to their health and well-being, for which money damages are an inadequate remedy.

127. As a direct and proximate result of Defendants' material breaches of its contractual obligations, Plaintiff and the Class have suffered damages that include the retail cost of Harvoni treatment and incidental damages, together with interest, and such other relief as the law provides, including compensation or reimbursement of their attorneys' fees pursuant to Fla. Stat. §§ 627.428, 641.28, and other applicable laws.

COUNT II

Breach of implied covenant of good faith and fair dealing

128. Plaintiff re-alleges paragraphs 1 through 120, as if fully set forth here.

129. The implied covenant of good faith and fair dealing is an element of every contract and imposes upon each party a duty of good faith and fair dealing in its performance. Common law calls for substantial compliance with the spirit, not just the letter, of a contract in its performance.

130. All Policies that Defendants sold to Plaintiff and Class Members contained an implied covenant of good faith and fair dealing, whereby Defendants agreed to perform their obligations under the Policies in good faith, to deal fairly with Plaintiff and the Class, and to not unreasonably deny coverage.

131. Defendants breached their duty of good faith and fair dealing in at least the following respects:

(a) Unreasonably delaying and denying coverage for Plaintiff's and Class Members' doctors' prescriptions for Harvoni treatment;

(b) Unreasonably failing to give at least as much consideration to Plaintiff's and Class Members' interests and welfare in the investigation and handling of their claims as they gave to their own interests;

(c) Unreasonably deriving hidden financial benefits by denying coverage based on hidden or undisclosed guidelines;

(d) Unreasonably requiring Plaintiff's and Class Members' health to deteriorate before providing coverage for medically necessary treatment;

(e) Unreasonably compelling Plaintiff and Class Members' to institute this litigation to obtain benefits due under the Policies.

132. Plaintiff and the Class have a clear right to specific performance of Defendants' contractual obligation under the Policies to provide coverage for medically necessary Harvoni treatment, which justice requires, because further delay in treatment will cause irreparable harm to their health and well-being, for which money damages are an inadequate remedy.

133. As a direct and proximate result of Defendants' breaches of its duty of good faith and fair dealing, Plaintiff and the Class have suffered damages that include the retail cost of Harvoni treatment and incidental damages, together with interest and such other relief as the law provides, including compensation or reimbursement of their attorneys' fees pursuant to Fla. Stat. §§ 627.428, 641.28, and other applicable laws.

COUNT III

Violations of RICO, 18 U.S.C. §§ 1962(a) and (c)

134. Plaintiff and the Class Members re-allege paragraphs 1 through 120 as if fully set forth here.

135. This claim for relief arises under 18 U.S.C. 1964(a) and (c).

136. As set forth above, Defendants have violated 18 U.S.C. 1962(a) by investing and reinvesting income derived, directly or indirectly, from the Enterprise's pattern of racketeering to operate, expand and perpetuate the Enterprise.

137. As set forth above, Defendants have violated 18 U.S.C. 1962(c) by conducting, or participating directly or indirectly in the conduct of, the affairs of the Enterprise through a pattern of racketeering.

138. By reason of Defendants' reinvestment in the Enterprise of income derived from the Enterprise's pattern of racketeering, and by reason of Defendants' conducting, or participating in the conduct of the affairs of the Enterprise through a pattern of racketeering, Plaintiff and Class Members have been proximately harmed in their business or property, both by the predicate acts that comprise the pattern of racketeering activity and the investment and reinvestment of income therefrom to operate, expand and perpetuate the Enterprise.

139. Pursuant to 18 U.S.C. 1964(c), Plaintiff and the Class Members have a right to recover three times their actual damages, together with attorney's fees and costs.

COUNT IV

Violation of RICO, 18 U.S.C. § 1962(d) by Conspiring to Violate 18 U.S.C. §§ 1962(a) and (c)

140. Plaintiff and the Class Members re-allege paragraphs 1 through 120 as if fully set forth here.

141. This claim for relief arises under 18 U.S.C. § 1964(d).

142. In violation of 18 U.S.C. § 1962(d), Defendants have conspired to violate: 18 U.S.C. § 1962(a) by using and investing income received from a pattern of racketeering, directly or indirectly, to establish and operate the Enterprise, which is

engaged in, and whose activities affect, interstate commerce; and 18 U.S.C. § 1962(c) by conducting, or participating directly or indirectly in the conduct of, the affairs of the Enterprise through a pattern of racketeering.

143. By reason of Defendants' reinvestment in the Enterprise of income derived from the Enterprise's pattern of racketeering, and by reason of Defendants' conducting, or participating in the conduct of the affairs of the Enterprise through a pattern of racketeering, Plaintiff and Class Members have been proximately harmed in their business or property, both by the predicate acts that comprise the pattern of racketeering activity and the investment and reinvestment of income therefrom to operate, expand and perpetuate the Enterprise.

144. Pursuant to 18 U.S.C. 1964(c), Plaintiff and the Class Members have a right to recover three times their actual damages, together with attorney's fees and costs.

COUNT V

Declaratory and Injunctive Relief Under 18 U.S.C. § 1964(a)

145. Plaintiffs and the Class Members re-allege paragraphs 1 through 120 as if fully set forth here.

146. This claim arises under 18 U.S.C. § 1964(a), which authorizes this Court to enjoin violations of 18 U.S.C. § 1962, and under 28 U.S.C. § 2201, which authorizes associated declaratory relief.

147. As set forth in Counts III and IV, Defendants have violated 18 U.S.C. §§ 1962 (a), (c), and (d), and, unless enjoined, will continue to do so in the future.

148. Enjoining the Defendants from committing these RICO violations in the future and declaring their invalidity is appropriate, because Plaintiff and Class Members

have no adequate remedy at law, and will suffer irreparable harm in the absence of declaratory and injunctive relief.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff on their own behalf and on behalf of all similarly situated persons (as defined above), demand judgment against Defendants as follows:

(1) Declaring (a) that this action is a proper class action maintainable under Rule 23(a), and one or more of Rules 23(b)(1)(a), 23(b)(2), and 23(b)(3) of the Federal Rules of Civil Procedure, and (2) that Plaintiffs shall serve as Class representatives and their attorneys shall serve as Class counsel;

(2) Ordering specific performance of Defendants' contractual obligation under the Policies to provide coverage to Plaintiff and the Class for medically necessary Harvoni treatment;

(3) Awarding injunctive relief preventing Defendants from using hidden, cost-based "criteria" to deny coverage of medically-necessary Harvoni treatment in furtherance of a cost–avoidance scheme;

(4) Awarding damages sustained by Plaintiff and the Class as the result of Defendants' material breach of the terms of the Policy, together with pre-judgment interest and such other relief as the law provides, including attorneys' fees pursuant to Fla. Stat. §§ 627.428, 641.28, and other applicable laws;

(5) Awarding damages sustained by Plaintiff and the Class as a result of Defendants' breach of the implied covenant of good faith and fair dealing, together with pre-judgment interest and such other relief as the law

provides, including attorneys' fees pursuant to Fla. Stat. §§ 627.428, 641.28, and other applicable laws.

(6) Ordering injunctive and declaratory relief from Defendants' RICO violations;

(7) Awarding threefold the actual damages Plaintiff and the Class have sustained by reason of Defendants' RICO violations, together with attorneys' fees and costs of suit;

(8) Awarding Plaintiff and the Class their costs and disbursements, and reasonable allowances for expert fees and reimbursement of expenses; and

(9) Awarding such other and further relief as the interests of justice require.

DEMAND FOR JURY TRIAL

Plaintiff and the Class request a trial by jury of any and all Counts for which a jury trial is permitted by law.

Respectfully submitted on July 30, 2015

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Florida Bar No. 108573

CERTIFICATE OF SERVICE

I certify that on July30, 2015, I electronically filed this document with the Clerk of the Court using CM/ECF.

s/ Andrés Rivero
ANDRÉS RIVERO

EXHIBIT

A

Member Handbook

Neighborhood Health Partnership – 2015

NHP Handbook SB 11/14

UnitedHealthcare®
Neighborhood Health Partnership

Please call Customer Service at 1-877-972-8845 for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Note: Call Customer Service at the telephone number on your ID card, or check our website www.myNHP.com to determine appropriate providers to contact in the case of emergency and other information regarding emergency services within the community. In some cases, the most cost effective action may be to visit an Urgent Care Center. Check your Summary of Benefits to determine the copayment or coinsurance for a visit to the Urgent Care Center or your Physician's office, rather than seeking care at an emergency room in a hospital.

Our website www.myNHP.com also includes plan details, such as copayments and coinsurance for various services, any required deductible and the status of your maximum out-of-pocket.

Notice: Examine your provider's itemized statements. If you believe you have been billed for procedures or services you did not receive, please notify us. If we determine you were improperly billed, we will reduce the amount of payment to the provider accordingly and we will pay you 20% of the reduction up to $500. This payment only applies in the event you notify us of possible improper billing.

This health benefit plan may contain a deductible.

Neighborhood Health Partnership

Table of Contents

IMPORTANT INFORMATION

Neighborhood Health Partnership

7600 Corporate Center Drive
Miami, FL 33126

Mailing Address
PO Box 025680
Miami, Fl. 33102-5680

Customer Service
1-877-972-8845
TTY 711

Monday through Friday between 8am and 6pm

Online directory and member information www.myNHP.com

YOUR RIGHTS AND RESPONSIBILITIES

NHP is committed to provide you with quality healthcare. It is important that you know your rights and responsibilities under this Member Handbook (referred throughout as the Handbook).

Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by Neighborhood Health Partnership personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy
- Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan or the care provided to you.
- Receive timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access to doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Receive and make recommendations regarding the organization's rights and responsibilities policies.
- Receive information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your health plan ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Log in to myNHP.com, or call Customer Care when you have a question about your eligibility, benefits, claims and more.
- Log in to myNHP.com or call Customer Care before receiving services, to verify that your doctor or health care professional participates in the UnitedHealthcare network.

YOUR RIGHT TO DECIDE

All adult individuals in healthcare facilities such as Hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations, have certain rights under Florida law.

You have a right to fill out a form known as an "advance directive." The form stipulates what kind of treatment you want or do not want for special or serious medical conditions. For example, if you were taken to a healthcare facility in a coma, would you want the facility staff to know your wishes about decisions affecting your treatment?

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a written or oral statement which is made and witnessed prior to a serious illness and injury. It says how you want medical decisions made. Two forms of advance directives are:

- A Living Will
- Healthcare Surrogate Designation

An advance directive allows you to state your choices about healthcare or to name someone to make those choices for you, in the event you are not able. For more information, contact Customer Service.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Q. Whom do I call for assistance or if I need information in another language?

A. Call Customer Service at the phone number on your NHP ID Card. Language assistance is available through Customer Service.

Q. Does NHP have a website, and can I e-mail my questions?

A. Our website address is www.myNHP.com. Our website offers helpful information about NHP and your coverage. The NHP homepage offers a useful link for contacting us (click on "contact us"), with e-mail addresses and telephone numbers for other NHP departments.

Q. What's included on the NHP website?

A. NHP's website provides members with useful tools and guidelines. The website contains Members Rights & Responsibilities Statement, Notice of Privacy Practices, Preventive Health Guidelines, Preferred Drug List, Behavioral Health Benefit Information, and Provider Lookup. If you would like a summary of the tools and/or guidelines, please contact Customer Service at the phone number on your NHP health ID Card.

Q. How do I order a new ID card, change my Primary Care Physician (PCP) or order a new Provider Directory?

A. Please call Customer Service at the phone number on your NHP health plan ID Card or access www.myNHP.com.

Q. How can I add a dependent to my NHP coverage?

A. You need to coordinate adding dependents through the HR department of the employer group through which you are covered. Your HR department can provide you with an NHP enrollment form. There are special rules regarding when dependents can be added. Your HR department can help you with this.

Q. How do I obtain a referral?

A. Unless your health benefit plan includes a Direct Access Rider, you must coordinate all of your care through your PCP. You will need a referral from your PCP to visit a NHP specialist. However, you can see the following specialties without a referral from your PCP:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits)
- Gynecology
- Alcohol/substance use treatment (services must be provided by NHP's Behavioral Health Network)
- Mental Health (services must be provided by NHP's Behavioral Health Network)

Q. What is included in a referral?

A. A referral is a written recommendation from your Primary Care Physician (PCP) for you to see a specialist or receive certain healthcare services. Your PCP must issue the referral through NHP's automated referral system or by contacting NHP directly prior to your visit. Please discuss with your practitioner the tests and services which are included in the referral.

Test and services not included in the referral or performed outside the specialist's office may require a separate authorization.

Q. Whom do I contact if I have a complaint?

A. If you have an inquiry or complaint about the service you received, your coverage or a provider, you may call Customer Service at the phone number on your NHP health plan ID Card.

Q. What if I'm still not satisfied with the resolution of the complaint?

A. If you are not satisfied with the resolution of your complaint you may file a formal written appeal within 180 days of the occurrence of the incident. Written appeals must be mailed to:

Neighborhood Health Partnership, Inc.
PO Box 5210
Kingston, NY 12402-5210
Attention: Appeal Coordinator

If you need assistance preparing your appeal, you may call Customer Service at the phone number on your NHP health plan ID Card.

Q. How do I add my newborn baby to my coverage?

A. Please complete and return an NHP enrollment form within 60 days of your baby's date of birth, even if you already have family coverage. You may obtain enrollment forms through your employer group's HR department. If NHP receives your baby's enrollment form within 30 days of birth, NHP will not charge an additional premium for the first 30 days of coverage. NHP must receive your completed enrollment form within 60 days of your baby's date of birth.

Q. Does NHP have a Quality Improvement program?

A. To request a summary of the NHP Quality Improvement program's progress and achievements, you may call Customer Service at the phone number on your NHP health plan ID card, Monday through Friday between 8:00 am and 6:00 pm. For the hearing impaired (TTY), call the National Relay Center at 1-800-828-1120.

Q. What drugs generally are not covered?

A. In general, the following categories of drugs are either excluded, or have limitations:

- Appetite suppressants
- Erectile dysfunction drugs
- Infertility drugs
- Drugs used for cosmetic purposes
- Smoking cessation products,
- Some injectables

Q. How do I get care after my doctor's office hours?

A. If it is not an emergency, you may call your doctor's office and work with his/her answering service to put you in contact with your doctor. If you are sick or injured, and you're not sure if you should go to the emergency room, visit an urgent care center, make a doctor's appointment or use self-care, call Nurseline Services. An experienced Nurseline nurse can give you information to help you decide and provide you information, support and education for any health-related question or concern. You can call the 1-866-780-9857 Nurseline toll free number anytime.

If you have an emergency, go to the nearest emergency room. If you need urgent care services (minor injuries or illnesses that require immediate attention, but are not severe enough to go to the emergency room), go to one of the urgent care centers in NHP's network. If you are not sure you are experiencing an emergency, go to the nearest emergency room or call 911.

Q. Does NHP have a Utilization Management program?

A. NHP has a Utilization Management (UM) program to ensure that utilization decisions affecting the members' healthcare are done in a fair, impartial and consistent manner. The UM components are prior authorization, concurrent review, retrospective review and case management. The UM program is designed to make healthcare services available to members medically appropriate, accessible, and cost-effective by evaluating service and care, and making decisions regarding benefit coverage.

The following are brief summaries of each component:

Prior authorization is the process of health services being reviewed before services are approved through the referral process.

Concurrent Review is the process of continuous medical monitoring while the member is in an inpatient facility or under a plan of care. This review assures that all the days in the facility are medically appropriate. If services are needed after discharge, NHP assists with the coordination of care in an alternative setting.

Retrospective Review is the review of care rendered to a member without providing NHP appropriate clinical data. NHP reviews clinical information obtained from the provider or facility. The review assures that services provided would have been approved as through the prior authorization process.

Case Management is the process whereby medical cases that are serious or medically complex are flagged and reviewed to assure that appropriate care is rendered to the member through a plan of treatment and the status of the member's condition is updated. Close communication with the practitioner and the member is maintained.

The NHP Medical Management staff is accessible to practitioners and members to discuss UM issues, including UM decisions and questions about the program and process.

The Medical Management staff is available during normal business days. Calls received after hours, weekends and holidays are forwarded to an after-hours line. You may also call Customer Service at the phone number on your NHP ID card.

Q. How can I get copies of my medical records?

A. You may request copies of your medical records from your PCP and your other providers.

Q. What are the rules for changing my PCP?

A. You may change your PCP once every month, and the change will be effective the first of the month following the request of the change.

Q. How does NHP make sure that all of my Protected Health Information (PHI) stays confidential?

A. NHP takes many steps to ensure that your Protected Health Information (PHI) remains confidential. Our routine notifications of our privacy practices includes: our commitment to your privacy; how NHP uses and discloses your PHI; other uses and disclosures permitted or required by law; your rights regarding your PHI; how to obtain further information; and how to file a complaint. NHP must ask for your authorization before disclosing your PHI for non-routine purposes. NHP also allows you

access to your PHI upon written request.
Employees of NHP receive education and training to ensure that your written, oral and electronic PHI is kept confidential. PHI transmitted electronically is encrypted and any documents containing your PHI are stored in a secure area with access limited to designated individuals. NHP uses, discloses and requests only the minimum amount of information necessary. NHP does not disclose PHI to your employer for employment-related purposes without your authorization, but may disclose PHI for plan administrative purposes. To obtain a complete Privacy Notice outlining all of NHP's privacy practices, call Customer Service at the phone number on your NHP health plan ID card or at www.myNHP.com.

Q. How does NHP evaluate new technology for inclusion as a covered benefit?

A. UnitedHealthcare Medical Technology Assessment Committee evaluates the strength of clinical evidence supporting the use of new and existing health services. Conclusions of this committee help to determine whether new technology and health services will be covered**.**

Q. How do I obtain information about practitioners that participate in the NHP network (i.e. professional qualifications, specialty, and address)?

A. Call Customer Service at the phone number on your NHP health plan ID Card or at www.myNHP.com.

Q. Does NHP provide incentives for Utilization Management decisions?

A. NHP does not use incentives that encourage barriers to care and/or service, or that reward inappropriate restriction of care. Rather, NHP encourages appropriate utilization while discouraging any under-utilization. NHP affirms that utilization management decision-making is based only on appropriateness of care and services and existence of coverage. NHP does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage of service or care. No incentives are offered to encourage decisions that might result in under-utilization.

Q. Why have an Advance Medical Directive?

A. You can plan ahead by writing an Advance Medical Directive, also called an Advance Directive. This statement outlines the medical treatment you would want, or names the person you would want, to make healthcare decisions for you if you can no longer express your wishes. You can obtain additional information by contacting your Primary Care Physician's office or by calling our Customer Service at the phone number on your NHP health plan ID Card.

ARTICLE I – DEFINITIONS

For purposes of the Handbook, the following terms will have the following meanings:

ADOPTED CHILD means a child who is adopted by the Subscriber in accordance with Chapter 63, Florida Statutes or the applicable laws of the state where the adoption was finalized.

ADVERSE DETERMINATION means a coverage determination by NHP that an admission, availability of care, continued stay, or other healthcare service or healthcare supply has been reviewed and, based upon the information provided, does not meet NHP's requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

APPEALS means a written Complaint submitted by or on behalf of a Member to NHP regarding:

1. availability, coverage for the delivery, or quality of healthcare services, including a Complaint regarding an Adverse Determination made pursuant to utilization review;
2. claims payment, handling, or reimbursement for healthcare services; or
3. matters pertaining to the contractual relationship between a Member and NHP.

Only those providers who have been directly involved in the treatment or diagnosis of the Member relating to the Appeal may submit an appeal on behalf of a Member.

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

AUTISM SPECTRUM DISORDER - any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

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

CALENDAR YEAR means a period of one year starting on January 1 and ending on December 31.

COMPLAINT means any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provisions of services, which relate to the quality of care provided by a provider. Members may submit a Complaint to NHP or to a State Agency. A complaint is part of the informal steps of an appeal procedure and is not part of the formal steps of an appeal procedure unless it is a Appeal as defined in this Article.

COPAYMENT means a specified dollar amount which the Member must pay directly to the Network Provider for specified Covered Services at the time services are rendered. Copayment amounts are set forth in the Summary of Benefits and are subject to Out-of-Pocket Maximum established by NHP.

COVERED SERVICES means those Medically Necessary services and supplies described in this Handbook that are not otherwise excluded or limited. To be a Covered Service, a service must be provided by a Network Provider in accordance with NHP's referral and approval procedures described in this Handbook, except in the case of an Emergency Medical Condition or as otherwise expressly stated in Article V. Services provided by a Non-Network Provider are not Covered Services unless receipt of services from such provider was approved in advance by NHP or in the case of an Emergency Medical Condition.

CUSTODIAL CARE means care that serves to assist an individual for the purpose of meeting personal needs and which could be provided by persons without professional skills or training. Custodial Care includes assistance with 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. 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.

DOMESTIC PARTNER - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

ELIGIBLE DEPENDENT or DEPENDENT - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child placed for foster care.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A newborn child of an Enrolled Dependent. The newborn child may be covered from birth to 18 months of age.

The definition of Dependent also includes parents and grandparents or such other sponsored Dependents as agreed upon by us and the Group.

To be eligible for coverage, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent is a child under 26 years of age.
- A Dependent includes a dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

In the event the Subscriber has a Dependent who meets the following requirements, extended coverage is available for that Dependent up to the age of 30. Contact your Group for details. To be eligible for extended coverage, a Dependent must satisfy the following:

- Is unmarried and does not have dependent of his or her own;
- Is a resident of Florida or a Student, and
- Does not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If such a Dependent's coverage is terminated at the end of the month in which the Dependent reached age 26, the child is not eligible to be covered unless the Dependent was continuously covered by Creditable Coverage without a gap in coverage of more than 63 days.

A child who is covered under extended coverage provisions set forth above ceases to be eligible as a Dependent on the last day of the calendar year following the child's attainment of the limiting age or when the child no longer meets the requirements.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

ELIGIBLE EMPLOYEE means a person employed with the Group who works or resides in the Service Area and is eligible to enroll as a Subscriber. An individual is considered to work within the Service Area when the physical location from which he/she performs substantially all of his/her work-related activities is physically located within the Service Area.

Note: If an Eligible Employee is currently residing in a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, this notice applies to that person. You may request to be referred to that facility's skilled nursing unit or assisted living facility.

An Eligible Employee does not include any person:

- who spends more than 90 days (consecutive or non-consecutive) in any Calendar Year outside the United States for any reason;
- who is a seasonal or temporary employee;

- who no longer works or resides in the Service Area; or
- who is unable to receive routine care within the Service Area due to any reason.

ELIGIBLE EXPENSES means the amount NHP pays Non-Network Providers, including those who are Facility-based Physicians or providers. They will be reimbursed as follows:

For Covered Services provided by a Network Provider, Members are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Services provided by a Non-Network Provider (including Emergency Health Services or services otherwise arranged by NHP), the Member will not be responsible to the Non-Network Provider for any amount billed that is greater than the amount NHP determines to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with NHP's reimbursement policy guidelines, as described in this Agreement.

Eligible Expenses are based on the following:

- When Covered Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Services are received from a Non-Network Provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by state law.

- For Covered Services received on a non-Emergency basis at a Network Hospital from a non Network Emergency care Physician, radiologist, anesthesiologist, pathologist, consulting Physician, neonatologist, intensivist, assistant surgeon and surgical assistant or at a Network clinic or Physician office by a non-Network Emergency care Physician, radiologist, anesthesiologist or pathologist, the Eligible Expense is based on 120% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.

  When a rate is not published by *CMS* for the service, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc*. If the *Ingenix, Inc*. relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.

  When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

- For Emergency Health Services delivered by a Non-Network Provider, the Eligible Expense is based on the higher of:

  - The median amount negotiated with Network Providers for the same service

  - The amount calculated pursuant to Florida state statute 641.513

  - 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service in the locality in which the service was provided.

EMERGENCY MEDICAL CONDITION 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 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, an emergency Medical Condition also means:
   a. that there is inadequate time to affect safe transfer to a Network Hospital prior to delivery :
   b. that such 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 medical screening, examination, and evaluation by a Physician or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a Physician, to determine if any Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Physician necessary to relieve the Emergency Medical Condition, within the service capability of a Hospital.

ENROLLED DEPENDENT means an Eligible Dependent who is properly enrolled for coverage under

the Agreement.

ENROLLMENT DATE means the date of enrollment of the individual covered under the Agreement or, if earlier, the first day of the Waiting Period of such enrollment.

ENROLLMENT FORM means the enrollment application completed and signed by the Subscriber providing necessary information for NHP, listing all Eligible Dependents who are to become Members on the Individual Effective Date, and showing the Members' choices of Primary Care Physicians.

EXPERIMENTAL OR INVESTIGATIONAL SERVICE(S) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing clinical trial that meets the definition of a Phase II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

Clinical trials for which Benefits are available as described in Article III. If you are not a participant in a qualifying clinical trial, as described in Article III, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

GENERAL PATIENT INFORMATION means routine medical, clinical and demographic information about Members. Examples of General Patient Information include, without limitation, clinical information on claims forms, any Member information loaded and maintained in computer systems, telephone logs, demographic information from Groups, medical histories, and information obtained about Members from Network Providers and Non-Network Providers.

GROUP means a Small Employer as defined in this section.

HOME HEALTH CARE means Home Health Services provided by a Home Health Care Agency for the care and treatment of the patient who is confined to home and under the direct care and supervision of a Physician.

HOME HEALTH CARE AGENCY means an organization duly licensed as a Home Health Care Agency under the laws of the state in which it is located. An agency operated by state or local government, which provides Home Health Care in the home in accordance with applicable laws, is also considered a Home Health Care Agency.

HOSPICE means an agency or organization that is licensed, accredited or approved under the laws of the jurisdiction in which services are provided, to provide counseling and medical services (and may include room and board) to a Terminally Ill person.

HOSPITAL means an institution that:

1. is licensed and operated as a hospital under the laws of the state where it is located; and
2. is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organization or by the American Osteopathic Association.

In no event will the term "Hospital" include a convalescent nursing home or any institution, or part thereof, which is used primarily as a convalescent facility, rest facility or nursing facility for the aged, an ambulatory surgery center, a facility for the care and treatment of mental disorders, alcoholism and drug dependency, or a facility which primarily provides custodial or rehabilitative care.

IDENTIFICATION CARD means the document of identification issued to Members by NHP.

ILLNESS means a physical, mental or nervous disorder, pregnancy or any condition determined by the United States Center for Disease Control (CDC) to be predictive of an immune disorder, including all related or resulting diseases and conditions.

INDIVIDUAL EFFECTIVE DATE means the first date as of which a Member is entitled to obtain Covered Services.

INITIAL ENROLLMENT PERIOD means the first 30 day period for which an individual is eligible to enroll for coverage, whether or not such individual chooses to enroll.

INJURY means an accidental bodily injury sustained by the Member that is the direct cause of the need for Covered Services. Such injury must be independent of disease, bodily infirmity or other cause.

INPATIENT or INPATIENT HOSPITAL SERVICE means admission to a Hospital for bed occupancy for the purpose of receiving Medically Necessary Inpatient Hospital Services. A Member is considered a Hospital Inpatient if formally admitted to the Hospital as an Inpatient by a Physician's order.

MEDICALLY NECESSARY means a Covered Service that NHP determines: (1) is appropriate, consistent and necessary for the symptoms, diagnosis or treatment of a medical condition; (2) is likely to result in demonstrable medical benefit; (3) is not provided primarily for the convenience of the Member, the Member's family, attending or consulting Physician, or other healthcare provider; (4) is not custodial or supportive care or rest cures; (5) is in accordance with standards of good medical practice in the medical community; (6) is approved by the Food and Drug Administration (FDA) or the appropriate medical body or board for the condition in question; and (7) is the most appropriate, efficient and economical medical supply, service, level of care or location which can be safely provided to treat the Member. When used in relation to Hospital Inpatient Service, Medically Necessary services only include those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, as an outpatient, or a facility of lesser intensity. Medical Necessity, when used in relation to services or supplies, will have the same meaning as Medically Necessary.

MEMBER means the Subscriber and if dependant coverage is in force, his or her Enrolled Dependents.

MENTAL AND NERVOUS DISORDERS means mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.

NETWORK - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

NETWORK HOSPITAL means a Hospital that has a written contract in force with NHP to render Covered Services to Members.

NETWORK PHYSICIAN means a Physician who has a written contract in force with NHP to render Covered Services to Members.

NETWORK PHYSICIAN OFFICE(S) means the offices and clinical facilities operated by or for Network Physicians to provide Covered Services to Members under the Agreement.

NETWORK PROVIDER means Hospitals, Physicians, and other providers of healthcare goods and services who have written contracts in force with NHP to render such goods and services that they are licensed, certified or otherwise authorized by NHP to provide to Members. Network Providers may also include the following Providers licensed under Florida Statutes: psychologists licensed pursuant to Chapter 490, mental health counselors licensed pursuant to Chapter 491, marriage and family therapists licensed pursuant to Chapter 491, clinical social workers licensed pursuant to Chapter 491, optometrists licensed under Chapter 463, certified nurse anesthetists and nurse midwives licensed under Chapter 464, nurse practitioners licensed under Chapter 464, and physician assistants licensed under Chapter 458, Florida Statutes.

NETWORK SPECIALIST means a Specialist who has a written contract in force with NHP to render Covered Services to Members, and to whom a Member is referred for consultation or treatment by the Member's Primary Care Physician or NHP.

NEWBORN means the first 60 days of life from and including the date of birth.

NON-NETWORK PROVIDER means a Hospital,

Physician or other provider of healthcare goods and services that is not a Network provider at the time the healthcare service or supply is provided.

OPEN ENROLLMENT PERIOD for a Small Employer means a 30-day time period immediately prior to the anniversary date of the Effective Date. During the Open Enrollment Period, Eligible Employees and Eligible Dependents who have not previously enrolled with NHP may enroll. The Open Enrollment Period occurs at least once every 12 months.

OUT OF POCKET MAXIMUM means a specified limit to the amount of Copayments for a Member or a Member's family, as listed in the Summary of Benefits.

OUTPATIENT or OUTPATIENT SERVICES means Covered Services that are not Inpatient Hospital Services. A Member is considered to be an Outpatient when he/she is a patient of an organized medical facility or distinct part of such facility and, in the judgment of NHP, is expected to receive professional services, including observation services, on an outpatient basis up to a 72-hour period, regardless of the time of admission, whether or not a bed is used.

PHYSICIAN means an individual who is duly licensed to provide medical services by the states in which he or she is practicing and who is acting within the scope of such license. A Physician will include a doctor of medicine licensed under Chapter 458, a doctor of osteopathy licensed under Chapter 459, a doctor of podiatry licensed under Chapter 461, an ophthalmologist licensed under Chapter 458 or Chapter 459, and a chiropractic physician licensed under Chapter 460, Florida Statutes.

PHYSICIAN'S SERVICES means professional services or medical care rendered by a Physician when Medically Necessary for the diagnosis or treatment of an Illness or Injury. To the extent a Physician employs or engages a nurse practitioner or physician assistant to provide services under the Physician's supervision, directly or indirectly, these providers may provide Covered Services consistent with their scope of practice.

PLAN MEDICAL DIRECTOR means a Physician employed by NHP, or his or her appointed designee.

PRIMARY CARE PHYSICIAN is a Network Physician who has a written contract in force with NHP and is responsible for providing, prescribing, authorizing and coordinating the medical are and treatment of the Member.

PRIOR AUTHORIZATION means that NHP has determined that the admission, surgery, care, treatment or other service or supply is Medically Necessary and appropriate for the diagnosis and condition of the patient and is eligible for coverage. Prior Authorization does not, however, guarantee or confirm benefits under the Agreement. Benefits are subject to eligibility at the time charges are actually incurred and all other terms, provisions, exclusions and limitations in this Handbook. Prior Authorization decisions are decisions concerning reimbursement and do not replace nor are they intended to influence the treatment decisions of the Member's Physician.

SCHOOL means a public or private secondary school, accredited college or university, or licensed trade school.

SERVICE AREA means those counties approved under Chapter 641 Florida Statutes and enumerated on the Health Care Provider Certificate of NHP.

SHARED SAVINGS PROGRAM - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

SKILLED NURSING FACILITY means an institution that:

1. is licensed by the state laws where it is located and operated as a Skilled Nursing Facility as defined by those state laws;
2. provides skilled nursing services and is not primarily a place for rest, Custodial Care, senility care, drug addiction, alcoholism, substance use disorders, intellectual disability, psychiatric disorders, or chronic brain syndromes, nor a nursing home or place for the aged; and
3. is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of

Healthcare Organizations, as a Certified Acute Rehabilitation Facility, or approved by Medicare.

SMALL EMPLOYER means, in connection with a health benefit plan with respect to a calendar year and a plan year:
1. For a grandfathered health plan, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.
2. For a non-grandfathered health plan, any employer that has its principal place of business in this state, employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. As used in this subparagraph, the terms "employee" and "employer" have the same meaning as provided in s. 3 of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. s. 1002.

SPECIALIST means a Physician who specializes in a particular field of medicine.

STUDENT means a person who is enrolled in and attending School. A Registrar's letter of status confirmation must be provided upon NHP's request. Student status is determined in accordance with the standards set forth by the School. A person is no longer a Student and coverage may terminate at the end of the calendar year in which the person graduates or is otherwise no longer enrolled and in attendance at the School. A person continues to be a Student during periods of vacation as established by the School.

SUBSCRIBER means the eligible Employee who has enrolled for coverage.

TERMINALLY ILL means that the Member has a medical prognosis, as certified by a Network Physician, of a life expectancy of six months or less.

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

URGENT CARE SERVICES means services for an unforeseen illness, injury, or condition (not an Emergency Medical Condition) that, (i) could result in serious injury or disability unless medical attention is received or (ii) substantially restricts the member's activities.

ARTICLE II - INDIVIDUAL ENROLLMENT, EFFECTIVE DATE AND TERMINATION OF COVERAGE AND CONTINUATION

A. ELIGIBLE ENROLLEE AND DEPENDENT ENROLLMENT AND EFFECTIVE DATE

1. During the Initial Enrollment Period prior to the Individual Effective Date, in order to enroll for coverage, all Eligible Employees must accurately complete and sign an Enrollment Form listing Eligible Dependents. Upon request by NHP, during the Initial Enrollment Period, Eligible Employees will provide additional information needed by NHP to determine eligibility.

2. All statements on the Enrollment Form must be accurate and complete. Providing false or misleading information or omitting required information in the enrollment process or at any other time gives rise to termination of the Eligible Employee's coverage.

3. Eligible Employees and their Eligible Dependents whose Enrollment Forms are received by NHP:
   i. within 30 days prior to or for 30 days after the date such individual first becomes eligible for coverage: or
   ii. during an Open Enrollment Period, will become effective on the Individual Effective Date, as provided in paragraph 4 below.

4. The Individual Effective Date will be the first day of the Premium Month after the date the individual first becomes eligible for coverage. Covered Services rendered to Members on or after the Individual Effective Date and prior to termination of the Members' coverage are subject to Article VI - Exclusions and Limitations and all other terms and conditions in this Handbook.

5. ***Late Enrollment***. A Late Enrollee may only enroll for coverage during an Open Enrollment Period.

6. ***Special Enrollment***. An individual is not a Late Enrollee if:
   a) the individual was covered under another employer health plan during his or her Initial Enrollment Period: and:
      i. the individual lost coverage under such plan as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of the employer contributions toward such coverage or lost eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*; and
      ii the individual requests to enroll and the Enrollment Form is submitted to NHP either within 30 days after termination of his or her prior coverage or within 60 days if prior coverage was *Medicaid* or *Children's Health Insurance Program (CHIP)*;

   OR

   b) the person was covered under a COBRA continuation provision or continuation of coverage pursuant to Section 627.6692, Florida Statutes, and the coverage under such provision was exhausted, and the Enrollment Form is submitted to NHP within 30 days of such exhaustion;

   OR

   c) the person becomes a dependent through marriage, birth, adoption, or placement for adoption and submits an Enrollment Form to NHP within 30 days of such marriage, birth, adoption, or placement for adoption;

   OR

   d) in the case of the birth or adoption of a child, the individual or spouse submits an Enrollment Form to NHP within 30 days of such birth or adoption, if such person is otherwise eligible for coverage;

   OR

   e) the person previously declined coverage but becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage begins after we receive an Enrollment Form and any required premium within 60 days of the date of determination of subsidy eligibility.

7. ***Adopted Children***. All benefits applicable to children will also be payable with respect to a Subscriber's Adopted Child. Coverage for an Adopted Child begins when the child is placed in the residence of the Subscriber in compliance with Florida law, if a written agreement to adopt such child has been entered into by the Subscriber prior to the birth of the child. Coverage for a newborn Adopted Child begins at the moment of birth whether or not such contract is enforceable.

However, coverage is not available for an Adopted Child if the child is not ultimately placed in the residence of the Subscriber in Compliance with Chapter 63, Florida Statutes. The Subscriber must enroll such child within 30 days of the birth or placement of the Adopted Child.

8. ***Newborn Children***. All benefits applicable for children will be payable with respect to a child born to the Subscriber or the Subscriber's Enrolled Dependents after the Individual Effective Date. Coverage for a Newborn Child will begin as of the date of birth if a completed and signed enrollment form is received by NHP within 30 days following the date of birth (the "Birth Notice Period"). If timely notice is given, NHP will not charge an additional premium for the 30-day Birth Notice Period. If the enrollment request is not received by NHP within 60 days of the birth of the child, such child will be a Late Enrollee and subject to the provisions of Late Enrollment described in this Article. Coverage for an enrolled Newborn Child of a Member, other than the Subscriber's spouse, will automatically terminate 18 months after the birth of such Newborn Child.

9. ***Marriage***. Upon a marriage under the laws of the state in which the marriage occurred, the spouse of a Subscriber must submit an Enrollment Form within 30 days of the marriage. If the Enrollment Form is timely submitted, the Individual Effective Date will be the date of the marriage. If the spouse is not enrolled during this period, the spouse may be enrolled during the next Open Enrollment Period.

10. ***Non-Discrimination***. NHP will not expel, refuse to renew the coverage of, or refuse to enroll any Eligible Employee or Eligible Dependents on the basis of race, color, creed, marital status, sex or national origin. Moreover, NHP will not expel or refuse to renew the coverage of a Member on the basis of such Member's age, health status, healthcare needs or expected cost of healthcare services of the Member.

B. RE-ENROLLMENT AFTER TERMINATION. A Subscriber and/or Enrolled Dependent(s) whose coverage is terminated by such Subscriber will be entitled to apply for re-enrollment only during an Open Enrollment Period.

C. TERMINATION OF COVERAGE. The coverage of any Member will terminate:

1. at the end of the Premium Month during which a Member no longer qualifies as an Eligible Employee or Eligible Dependent. The Group must notify NHP within 30 calendar days of the date a Member no longer qualifies as an Eligible Employee or Eligible Dependent. If notice is not given to NHP within 30 calendar days, then termination of such individual will become effective at the end of the Premium Month in which notice is received by NHP. The Group is responsible for payment of any required Premiums until the end of the Premium Month in which notice was received. Coverage will terminate automatically and without notice.

2. at the end of the Premium Month for which the last Premium was paid in full by the Group to NHP, if the Premium was not paid by the end of the Grace Period. The Group will be responsible for providing notice to Members.

3. on the last day of the Premium Month during which NHP has terminated the Member's coverage for cause. Cause for termination will include, but is not limited to: i) fraud or intentional misrepresentation or omission of material fact in applying for eligibility or seeking any benefits; ii) disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior towards a healthcare provider or administrative staff that, in NHP's sole discretion, impairs NHP's ability to arrange for Covered Services; iii) failure to pay, upon notice, fees or Copayments which are the responsibility of the Member: iv) misuse of the identification Card by any person; v) a Member's refusal to follow his or her Physician's treatment plan; vi) failure to provide any signed releases, consents, assignments, or other documents and information reasonably requested by NHP; or vii) failure to cooperate with NHP in the administration of the Handbook, including failure to abide by utilization review and case management. NHP will notify the Member in writing 45 days prior to the date of termination: provided, however, when the grounds for termination are based upon fraud or intentional misrepresentations or omission of material fact or when Members may not be lawfully covered under the Agreement, coverage will be cancelable by NHP retroactive to the Individual Effective Date of the Member . NHP may recover from Member any and all amounts paid on behalf of Member for this period.

4. on the last day of the Premium Month during which the Member becomes eligible for coverage under Medicare, Title XVII1 of the Social Security Act, as amended.

No Member will have his/her coverage terminated under this provision because of the amount, variety or cost of services required by such Member.

D. EXCEPTIONS TO TERMINATION OF COVERAGE

1. NHP will not terminate a Subscriber's coverage solely due to
   a. absence from work due to Illness or Injury. In such event, the Subscriber's coverage can be continued for up to 12 months if the Group continues to make Premium payments for the Subscriber's coverage,; or
   b. absence from work due to a temporary lay-off or leave of absence approved by the Group. In such event, the Subscriber's coverage can be continued for up to 2 months, if the Group continues to make Premium payments for the Subscriber.
2. If coverage for an Enrolled Dependent child would terminate because of that child's attainment of the applicable Limiting Age but at such time, the child is incapable of self-support due to intellectual disability or physical disability and is chiefly dependent upon the Subscriber for support and maintenance, that child's coverage may be continued during such incapacity as long as:
   a. Premiums are paid for such child's coverage;
   b. the Subscriber's coverage remains in effect;
   c. when a claim is denied due to the child's attainment of the Limiting Age, NHP is provided with required proof of such child's incapacity and dependence for support and maintenance and
   d. all other requirements of the Handbook are met.
3. If coverage for an Enrolled Dependent child would terminate because of that child's attainment of the applicable Limiting Age, that child's coverage may be continued to the end of the calendar year in which the Enrolled Dependent child reaches the Limiting Age.

E. COBRA COVERAGE CONTINUATION. A Group subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (i.e. Groups with 20 or more employees) is required to provide the Member a notice of continuation of coverage rights under COBRA. The Group is responsible for meeting all of the obligations under COBRA, including, without limitation, notifying all Members of their rights under COBRA. If the Group fails to meet its obligations under COBRA, NHP will not be liable for any claims incurred by a Member following the termination of coverage.

The following is a brief summary of the Member's rights under COBRA and the general conditions necessary to qualify for such COBRA continuation benefits.

A Member may be entitled to elect continuation of coverage under COBRA in the event of the occurrence of any of the following "qualifying events" where such event results in the Member's loss of coverage under the Agreement:

1. Termination of the Subscriber's employment for any reason other than gross misconduct.
2. A reduction in the Subscriber's work hours.
3. The Subscriber's death.
4. The Subscriber's divorce or separation.
5. The Subscriber's or Enrolled Dependent's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare").
6. The Subscriber's enrolled Dependent Child ceasing to be an Eligible Dependent as defined in the Agreement.

The Member must elect to continue coverage under COBRA within the election period determined by the Group. An election period must be for at least 60 days. It will begin no later than the date the Member would have otherwise lost coverage under the Agreement due to a qualifying event. A Member who elects COBRA continuation of coverage is subject to all the same terms and conditions of the Agreement as a Member who has not had a qualifying event.

Such continuation of coverage will be made available at the Premium specified in the Agreement, which will not exceed: (1) 102%; or (2) 150% for allowed extensions after the 18-month continuation period, of the total Premium charged for such period of coverage for a similarly situated Member who has not had a qualifying event. The Member must pay any required Premiums directly to the Group.

If the qualifying event is due to termination of employment or reduction of hours, the maximum COBRA continuation period is 18 months. The maximum COBRA continuation period is 29 months if disabled at time of the qualifying event or if the disability arises within the first 60 days of COBRA continuation. For all other qualifying events the maximum COBRA continuation period is 36 months.

F. CONTINUATION RIGHTS FOR GROUPS WITH 19 OR FEWER EMPLOYEES.

Each Member who would lose coverage under the Agreement due to a qualifying event, as defined below, is entitled to elect continuation coverage without evidence of insurability. The following is a brief summary of the Member's rights and general conditions necessary to qualify for such continuation

coverage.

A Member may be entitled to elect continuation coverage in the event of the occurrence of any of the following qualifying events where the qualifying event results in the Member's loss of coverage under the Agreement:

1. Termination of the Subscriber's employment for any reason other than gross misconduct.
2. A reduction in the Subscriber's work hours.
3. The Subscriber's death.
4. The Subscriber's divorce or separation.
5. A Member's entitlement to benefits under either Part A or Part B of Title XVII of the Social Security Act ("Medicare").
6. An Enrolled Dependent Child ceasing to be an Eligible Dependent as defined in the Agreement.
7. A retired Subscriber or the Enrolled Dependent spouse or child of a retired Subscriber losing coverage within one year before or after commencement of a bankruptcy proceeding under Title XI of the United States Code by the employer from whose employment the Subscriber retired.

The Member must elect to continue coverage in writing within the 63-day election period as set out in Section 627.6692, Florida Statutes. It is the Member's responsibility to notify NHP in writing of his/her desire to elect continuation coverage. Unless otherwise specified, notice by one Member constitutes notice on behalf of all Members residing in the same household who remain eligible for coverage. The written notice must include: (1) the identity of the employer; (2) the Group health plan number; and (3) the name and address of all Members. Within 14 days of receipt of written notice by NHP, NHP will send each Member an election and Premium notice form. A Member who wishes to elect continuation coverage must do so in writing and pay the initial Premium within 30 days from receipt of the election and Premium notice form. The election period will begin on the date the Member would have otherwise lost coverage due to a qualifying event. A Member who elects continuation coverage under this section is subject to all the same terms and conditions of the Agreement as a Member who has not had a qualifying event.

Such continuation coverage will be made available at the premium specified in the Agreement, which in no event will exceed: (1) ll5%; or (2) 150%, for allowed extensions after the 18-month continuation period, of the total Premium charged for such period of coverage for a similarly situated Member to whom a qualifying event has not occurred. The Member must pay the Premium amount required on the first of the month directly to NHP, to continue benefits. The maximum period for continuation of coverage will be 18 months. If disabled at the time of the qualifying event, the maximum period for continuation of coverage is 29 months.

G. EXTENSION OF BENEFITS

In the event the Agreement is terminated, coverage for benefits end as of the termination date, except as set forth below.

For any Illness or Injury that commenced while the Agreement was in force which results in the continuous total disability of the Member, there will be an extension of benefits beyond the date that coverage under the Agreement terminates for Covered Services necessary to treat the disabling condition only. A Member who is pregnant as of the termination date of the Group is also entitled to an extension of benefits for Covered Services necessary to treat the pregnancy only, so long as the pregnancy commenced while the Member was covered under the Agreement.

1. ***Due to total disability.*** The extension of benefits due to total disability is limited to the first to occur of the following events: (i) the expiration of 12 months from the date of termination of the Agreement; (ii) such time as the Member is no longer totally disabled; (iii) a succeeding carrier provides replacement coverage without limitation as to the disability condition; or (iv) the maximum benefits payable under the Agreement have been paid.

   For the purposes of this section, a Member is totally disabled if the Member has a condition resulting from an Illness or Injury that prevents the Member from engaging in any employment or occupation for which the Member is or may become qualified by reason of education, training, or experience is not in fact engaged in any employment or occupation for wage or profit; and is under the regular care of a Physician.

2. ***Due to pregnancy.*** An extension of benefits due to pregnancy is limited to Covered Services relating to such pregnancy. An extension of benefits does not include coverage for services relating to the Newborn. Benefits will continue until the first to occur of the following events: (i) the end of such pregnancy; or (ii) the date the Member becomes covered under another plan and the succeeding carrier assumes liability for such pregnancy coverage.

3. ***Due to Student's leave of absence.*** Coverage for an Enrolled Dependent child who is a Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

   - One year after the medically necessary leave of absence begins.
   - The date coverage would otherwise terminate under the Contract.

   Coverage will be extended only when the Enrolled Dependent is covered under the Agreement because of Student status at a post-secondary school immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Student status meets all of the following requirements:

   - The Enrolled Dependent is suffering from a serious Sickness or Injury.
   - The leave of absence from the post-secondary school is medically necessary, as determined by the Enrolled Dependent's treating Physician.
   - The medically necessary leave of absence causes the Enrolled Dependent to lose Student status for purposes of coverage under the Agreement.

   A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

   For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment at the post-secondary school that causes the loss of Student status.

4. ***Exceptions to Extension of Benefits.*** No Member is entitled to an extension of benefits, as provided in Article II the Agreement, if NHP has terminated the Agreement for any of the following reasons: (i) fraud or misrepresentation or omission of material fact in applying for coverage or any benefits under the Agreement; (ii) disenrollment for cause. as described in Article II of the Agreement; (iii) the Member has left the Service Area with the intent to relocate or establish a new residence outside the Service Area.

H. BENEFIT ELIGIBILITY

Prior Authorization for services by NHP does not guarantee or confirm benefits under the Agreement. Benefits are subject to eligibility at the time services are rendered and to all other terms, provisions, conditions, exclusions, and limitations of the Agreement.

ARTICLE III - HOSPITAL AND RELATED SERVICES

The following hospital and related services must be medically necessary and must be provided or arranged by the PCP and prior authorized by NHP, except in the case of an emergency medical condition. Services provided by Non-Network Providers are described in the definition of "Eligible Expenses" in Article I. Other services provided by Non-Network Providers are not covered unless prior authorization from NHP is obtained. This does not apply to services provided for an emergency medical condition. It is the member's responsibility to determine if a provider is a Network provider before services are rendered. Services that do not receive prior authorization from NHP as required and which were not referred by the member's Primary Care Physician or as specified above will be at the member's own expense. Any service, care or supplies which are not medically necessary, as determined by NHP, are not covered services.

Coverage is subject to any applicable copayment and to all terms, conditions, exclusions and limitations under the Agreement.

All benefits available under the Agreement are subject to Article VI, Exclusions and Limitations.

A. HOSPITAL SERVICES

1. Hospital Services provided on an inpatient or outpatient basis may include the following:
   a. semi-private room and board:
   b. use of specialized units within the facility to include operating, recovery, delivery rooms, intensive care and nursery;
   c. anesthesia services, administration and supplies;
   d. laboratory services;
   e. diagnostic services, including x-rays, nuclear medicine, sonography, and magnetic resonance imaging;
   f. medical and surgical services and supplies including medications, intravenous therapy, radiation therapy, supplies and dressings, and blood and blood products when participation in a blood replacement program is not available and administration by the Hospital;
   g. rehabilitation and therapeutic services (including physical therapy as described in Article III), respiratory therapy, cardiac therapy, occupational therapy and speech therapy. in connection with a Covered Service; and
   h. nursing care provided by hospital staff.
2. Hospital Services must be provided by a Network Hospital, unless otherwise approved in advance by NHP, or when Emergency Services or Care is necessary.

B. CLINICAL TRIALS

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer
- Cardiovascular disease (cardiac/stroke)
- Surgical musculoskeletal disorders of the spine, hip and knees.
- Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

Be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:

  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).*)
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Agreement.

C. HOME HEALTH SERVICES

Home Health Services include:

1. part-time or intermittent skilled nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
2. part-time or intermittent home health aide services provided by a certified home health aide in the home under the supervision of a registered nurse (R.N.) or a physical, speech, or occupational therapist;
3. physical, occupational, or speech therapy: and
4. medical supplies, drugs, medicines and related pharmaceutical and laboratory services that are prescribed by a Physician and provided in connection with covered Home Health Services. Drugs or nutrients taken by mouth or self-administered by injection are not covered.

The Agreement covers all Home Health Services combined, including the services of social workers and dieticians when the Member is confined to home and requires skilled nursing services. See your Summary of Benefits for limits. All Home Health Services must be performed by a Network Home Healthcare Agency. Benefits are only available for Members confined to their homes for conditions which, in the opinion of the Network Physician, can be satisfactorily treated on such basis. A Home Healthcare treatment plan must be established in writing and approved by NHP. No Home Health Services will be provided under the Agreement beyond the date upon which, in the opinion of a Network Physician and NHP, continued Home Health Services are no longer Medically Necessary. For purposes of determining this benefit, all or part of one hour will equal one Home Healthcare visit. Services or training for activities of daily living, domiciliary care, Custodial Care or care provided for the Member's convenience are not covered. Medical supplies, drugs, medicines and related pharmaceutical and laboratory, services provided by the Network Home Healthcare Agency will not be covered as Home Health Services. The Home Health Services benefit does not provide coverage for Home Infusion Therapy; that coverage is described below.

D. HOME INFUSION THERAPY

Home Infusion Therapy is the administration of drugs or nutrients using specialized delivery systems in Member's home by a Network Home Care Provider which otherwise would have required the Member's hospitalization. Drugs, medical supplies and related pharmaceutical supplies for the home infusion are covered. Drugs or nutrients taken by mouth or self-administered injectables are not covered.

E. HOSPITALIZATION AND ANESTHESIA FOR DENTAL TREATMENT

Hospitalization and general anesthesia in the delivery of Necessary dental treatment or surgery are covered only under the following conditions: 1) a Member under 8 years of age who is determined by a licensed dentist and the Member's Primary Care Provider to need Necessary dental treatment or surgery in a Hospital or ambulatory surgical center due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proved to be ineffective; or 2) whose medical condition(s) would create significant or undue medical risks if Necessary dental treatment or surgery is not rendered in a Hospital or ambulatory surgical center. Dental care, treatment or surgery is excluded from coverage.

For purposes of this benefit, "Necessary" means the necessary dental surgery or treatment where the dental condition would likely result in a medical condition if left untreated.

F. HOSPICE CARE

The Agreement covers inpatient and/or outpatient Hospice Care for a Terminally Ill Member when requested by a Network Physician. Hospice Care is palliative care (pain control and symptom relief), rather than curative care. Hospice Care must be provided by a Network Provider. See your Summary of Benefits for limits.

G. MENTAL HEALTH AND NERVOUS DISORDERS

The Agreement covers the treatment of Mental Health and Nervous Disorders. Benefits include mental health evaluations and assessment, diagnosis, treatment planning, referral services, medication management, inpatient, partial hospitalization/day treatment, intensive outpatient treatment, services at a residential treatment facility, individual, family and group therapeutic services and crisis intervention.

Depending on where the Covered Services are provided, Benefits for outpatient Mental Health and Nervous Disorders will be the same as those stated under Physician Services. Benefits for inpatient/intermediate Mental Health and Nervous Disorders will be the same as those stated under Hospital Services.

H. NEUROBIOLOGICAL DISORDERS - AUTISM SPECTRUM DISORDER SERVICES

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Habilitative services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include services provided on an outpatient basis for Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

I. OUTPATIENT SURGERY SERVICES

Outpatient surgery services are covered services when provided by a Network Provider (i.e. an outpatient department of a Network Hospital or a Network free standing ambulatory surgery center). If Member has Outpatient Surgery Services, Member's coverage is the same as would be provided if Member was an inpatient, except semi-private room and Inpatient rehabilitation services are not covered.

J. PHYSICAL REHABILITATION

The Agreement covers Physical Rehabilitation services during a hospital stay, portion of a hospital stay, a Skilled Nursing Facility stay, or a portion of a Skilled Nursing Facility stay which is primarily for restorative physical therapy. Such services must be

provided by a Network Provider, unless otherwise approved in advance by NHP.

The services must be for restorative physical rehabilitation for a condition which is subject to significant clinical improvement through relatively short term therapy, as determined by Member's Network Provider. More extensive specialized physical medicine and inpatient rehabilitation services, including physical therapy and physical rehabilitation, may be covered, subject to Medically Necessity review by NHP.

Any limits for physical rehabilitation are included in and part of the limits applicable to Skilled Nursing Facility Services, described in Article III. See your Summary of Benefits for any applicable limits.

K. SKILLED NURSING SERVICES includes services provided in a Skilled Nursing Facility that meet all of the following conditions:
1) ordered by and under the supervision of a Network Physician; 2) sufficiently medically complex to require supervision, assessment, planning, or intervention by a Registered Nurse (R.N.);
3) required to be performed by, or under the direct supervision, of a Registered Nurse for safe and effective performance;
4) required on a daily basis;
5) Medically Necessary to treat the Injury or Illness; and
6) consistent with the nature and severity of the Member's condition.

L. SUBSTANCE USE DISORDER SERVICES include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

Depending on where the services are provided, Benefits for outpatient Substance Use Disorders will be the same as those stated under Physician Services. Benefits for inpatient/intermediate Substance Use Disorders will be the same as those stated under Hospital Services.

M. TRANSPLANT SERVICES

For the purposes of this section, "Transplant Services", including Bone Marrow Transplants, mean pre-transplant (i.e. evaluation), transplant and post-transplant services, and treatment of complications resulting from the transplantation. A Bone Marrow Transplant is the administration of human precursor cells to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent. Bone Marrow Transplant includes ablative and non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood or a combination of bone marrow and circulating blood, if chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term “bone marrow transplant” includes both the transplantation and the chemotherapy.

Transplant Services are Covered Services only if NHP has separately approved the evaluation, transplant and post-transplant services. The Member or the Member's Primary Care Physician must notify NHP in advance of the Member's initial evaluation for the transplant procedure. Such notice must be sufficient to allow NHP a reasonable amount of time to determine if the transplant evaluation services are Covered Services under the Agreement. For approval of the transplant itself, NHP must be given a reasonable period of time and the opportunity to review the clinical results of the evaluation. If approval is not given, coverage will not be provided for the transplant procedure. The Agreement will not cover Transplant Services pursuant to this section if they are determined to be Experimental/Investigational by the American Medical Association DATA panel, UHC Medical Technology Assessment, any department or agency of the federal government authorized to make such determinations, or otherwise deemed not Medically Necessary by NHP. Post-transplant services and complications resulting from the transplantation are not covered if the transplant procedure was not a Covered Service.

If the transplant procedure is approved, NHP will advise the Member's Physician of those facilities that are approved for the type of transplant procedure involved. A facility must meet criteria established by the National Institute of Heart, Blood and Lung or the National Institutes of Health to be approved by NHP Coverage is available only if the pre-transplant services, the transplant procedure, and post transplant services are performed in approved facilities.

Subject to applicable conditions, exclusions and limitations of the Agreement, only the following services are covered for approved transplant procedures and related complications in approved facilities:

1. Hospital Services and Physician Services under the same terms and conditions as provided for the care and treatment of any other covered Injury or Illness under the Agreement.
2. Medical costs associated with organ acquisition and donor cost. However: (1) medical donor costs are not covered if payable, in whole or in part, by any other group plan, insurance company, organization, or person other than the donor's family or estate: (2) Non-medical organ acquisition costs and donor costs are not covered under the Agreement, unless otherwise specified: and (3) the Agreement will not cover any donor costs related to the removal of an organ from a Member for the purposes of transplantation into a recipient who is not a Member. Notwithstanding the above, donor costs associated with Bone Marrow Transplants are covered to the same extent as such services are covered for the Member receiving the Bone Marrow Transplant from the donor.
3. Transportation and lodging costs are only covered when the transplant procedure is performed in a facility which is outside the Service Area. Coverage for transportation and lodging costs are limited to any overall dollar maximum of $5,000 per transplant. This includes any related complications and follow-up visits. Transportation and lodging benefits only include: 1) round-trip coach class air fare for the Member receiving Transplant Services and one family member; and 2) lodging expenses for the Member who is the transplant recipient up to $65 per day. In the event the Member is the recipient of a bone marrow transplant, transportation and lodging cost include: 1) round trip coach class air fare for the bone marrow donor and one family member, and 2) lodging expenses for a bone marrow donor, up to the current daily limit. The Member is required to provide detailed invoices and receipts documenting such expenses to NHP in order to obtain reimbursement.
4. Bone Marrow Transplants that are specifically listed in Chapter lOD-127.001 of the Florida Administrative Code. This includes coverage for the bone marrow donor as described in items 1-3 above. Coverage for the costs for a bone marrow donor search is limited to costs associated with searches relating to immediate family members and the National Bone Marrow Donor Program.

ARTICLE IV - MEDICAL, SURGICAL AND RELATED SERVICES

The following hospital and related services must be medically necessary and must be provided or arranged by the primary care physician and prior authorized by NHP, except in the case of an emergency medical condition. Services provided by Non-Network Providers are described in the definition of "Eligible Expenses" in Article I. Other services provided by Non-Network Providers are not covered unless prior authorization from NHP is obtained. This does not apply to services provided for an emergency medical condition. It is the member's responsibility to determine if a provider is a Network provider. If you have a Point of Service plan, it is your responsibility to insure that NHP's prior authorization is obtained before services are rendered. Services that do not receive prior authorization from NHP as required and which were not referred by the member's primary care physician or as specified above will be at the member's own expense. Any service, care or supplies which are not medically necessary, as determined by NHP, are not covered services.
Coverage is subject to any applicable copayment and all terms, conditions and exclusions under the Agreement.

All benefits provided under the Agreement are subject to Article VI, Exclusions and Limitations.

Every Member must select a Primary Care Physician who is a Network Physician. Network Physicians, including Primary Care Physicians, are listed in the Network Provider Directory which is updated from time to time by NHP. If the Member fails to select a Primary Care Physician, NHP will assign one to the Member. Specialists must be selected from those Network Specialists listed in the Network Provider Director). A referral from the Primary Care Physician must be obtained before services are rendered by a Network Specialist, except as set forth below.

Except when Emergency Services and Care are required, services of Non-Network Providers are covered only when Prior Authorization is received from NHP. **It is the member's responsibility to determine if a Provider is a Network Provider and whether Prior Authorization was obtained for use of a Non-Network Provider. Non-Network Provider services that do not receive Prior Authorization from NHP and Network Provider services which were not referred by the Member's Primary Care Physician will be at the Member's own expense.**. The Member may, however, receive services from a Network Chiropractor, Network Podiatrist, Network Gynecologist and Network Dermatologist without a PCP referral, subject to the terms and conditions stated in the Agreement.

On or after the Individual Effective Date, a Member is entitled to the following services and care for the diagnosis or treatment of an Illness or Injury:

A. PHYSICIAN'S SERVICES

1. Consultation, examination and treatment by a Network Physician at the Hospital or Skilled Nursing Facility where the Member is confined, or at the Network Physician's Office.
2. Periodic health assessment, to include well-child care from birth, adult health examinations and immunizations, medical history, physical examination, laboratory, x-ray and other screening or diagnostic tests as indicated by the age, sex, medical history or physical examination of the Member ordered by a Network Physician in accordance with NHP's Preventive Healthcare Guidelines (which are provided to Members by NHP). Travel vaccines and immunizations are not covered.
3. A female Member may choose a Network Gynecologist as her PCP. An annual gynecological exam including manual breast exam, pelvic exam and Pap smear ("well woman exam") is covered. Medically Necessary follow-up care for conditions detected during the well woman exam may be obtained from the same Network Gynecologist. Referrals to a Network Gynecologist are not required.
4. Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:
    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
    - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
    - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
    - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services*

Administration.

5. Pregnancy will be treated the same as any other condition.
6. Allergy testing and desensitization therapy to alleviate allergies, including the cost of hyposensitivity serum.
7. Benefits for treatment and services of Emergency medical conditions received from Non-Network Providers will be paid in accordance with the definition of "Eligible Expenses" in Article I. All claims and supporting documentation must be submitted to NHP in English.

B. SURGICAL SERVICES. Surgical services, including preoperative care, postoperative care and the administration of anesthesia. Services of physician operative assistants are covered according to NHP's coverage criteria for surgical assistants.

C. AMBULANCE SERVICES. Emergency ambulance services are covered. Non-emergency ambulance services required to transfer Member from a non-Network facility to the nearest Network Hospital are covered. Non-emergency ambulance services require prior authorization by NHP. Prior authorization is not required when NHP authorizes a transfer to a Network facility.

D. ANESTHESIA. Administration of anesthesia in connection with surgery or maternity care covered under the Agreement if in NHP's judgment, the nature of the procedure requires anesthesia.

E. BLOOD. Blood and blood derivatives, including administration fees, excluding blood provided through a replacement program.

F. BONES OR JOINTS OF THE JAW AND FACIAL REGION. Benefits are provided for diagnostic and surgical procedures involving bones or joints of the jaw and facial region to treat conditions caused by congenital or developmental deformity, Sickness or Injury. Please note that Benefits are not available for care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes. This Benefit includes evaluation and treatment of temporomandibular joint syndrome (TMJ) when related to congenital, developmental deformity, injury or disease.

G. BREAST PUMPS. Benefits include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

H. CHIROPRACTIC SERVICES. Chiropractic Services performed by a Network Chiropractor for conditions that are medically recognized and accepted as being appropriately treated by such therapy. In addition, a Member may receive services from a Network Chiropractor without a referral from a Primary Care Provider.. Refer to your Summary of Benefits for any specific limits per Calendar Year.

I. CLEFT-LIP/CLEFT-PALATE. Treatment and services for cleft-lip and cleft-palate for Members under the age of 18 years. Benefits for cleft-lip or cleft-palate are subject to the same terms, conditions, and limitations as all other Covered Services under the Agreement.

J. DERMATOLOGY. A Member may receive the first 5 visits per Calendar Year from a Network Dermatologist for office visits and for the provision of minor procedures only, without a referral from the Primary Care Physician. All other services must be upon the referral of the Primary Care Physician and receive Prior Authorization from NHP. Dermatological procedures which are primarily cosmetic in nature are not covered.

K. DIABETES. Equipment, supplies, and services including outpatient self-management training and educational services used to treat diabetes obtained from a Network Provider. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a Network diabetes educator or Network endocrinologist. Nutrition counseling must be provided by a licensed Network dietician. Coverage for insulin pumps is limited to the most cost effective pump which meets the Member's medical needs, as determined by NHP. Equipment and supplies, including insulin pumps and pump supplies, are not subject to the DME maximum set forth in Subsection L. Request for replacement pumps will be subject to medical necessity review. Routine upgrades and replacements may not be considered medically necessary

L. DIALYSIS. Treatment and services for renal disease, including equipment, training and supplies required for effective dialysis obtained from a Network Provider.

M. DURABLE MEDICAL EQUIPMENT (DME) and DISPOSABLE MEDICAL SUPPLIES. Durable medical equipment is covered when provided in connection with or as the result of a Covered Service. Disposable medical supplies necessary for use in connection with covered DME are covered. All **DME** and disposable medical supplies must provide medical and therapeutic service and must be provided by a designated Network Provider. Repair or replacement of damaged equipment and the purchase or rental of duplicate equipment is not covered under the Agreement. DME is defined as equipment that meets all the following criteria:

1. Can stand repeated use.
2. Primarily and customarily used to serve a

medical purpose rather than being primarily for comfort or convenience.
3. Usually not useful to a person in the absence of sickness or Injury.
4. Appropriate for home use.
5. Related to the patient's physical disorder.
6. Certified in writing by a Network Physician as Medically Necessary.

Benefits for DME and disposable medical supplies are subject to the limits on your Summary of Benefits. NHP may, at its option, authorize the purchase of DME if the rental price is projected to exceed the purchase price of the equipment.

N. ENTERAL FORMULA The Agreement covers enteral formulas for home use which are prescribed by your Physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein, for individuals, through the age of 24.

O. EYE EXAMINATIONS. Benefits include **e**ye examinations for diseases of the eye. Initial glasses or contact lenses following cataract surgery are covered. Physician services are also covered to treat an injury or disease of the eyes.

P. FACILITY BASED PHYSICIANS. Services provided by a Facility Based Physician or provider in a Hospital or facility when in support of the primary Covered Service are covered under the Agreement. For purposes of this Section, Facility Based Physicians or providers include, but are not limited to, pathologists, radiologists, anesthesiologists and emergency room physicians when providing services at a Hospital, ambulatory surgery center, or other similar setting.

Q. FAMILY PLANNING. Family planning limited to voluntary surgical sterilization, prescription, fitting and insertion of implantable contraceptives and intrauterine birth control devices, including the device or appliance.

R. HEARING AIDS. Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Network Physician and obtained from a Network Provider. Benefits are provided for the hearing aid and for charges for associated fitting and testing. See your Summary of Benefits for any applicable limits.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids may be covered under the applicable medical/surgical categories in this Agreement only for Members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

S. HEARING EXAMS. One hearing exam per calendar year for children through age 19 is covered when performed by the Primary Care Physician for the primary purpose of determining the need for hearing correction.

T. IMPLANTS. Implants to restore routine function required as a result of acquired Illness, Injury or surgery such as cardiac defibrillators and pacemakers and cochlear implants, except as excluded in Article VI. Coverage for implants is limited to the most cost effective implant device which meets the Member's medical needs, as determined by NHP.

U. MAMMOGRAPHY SCREENING.
Mammography screening performed on dedicated equipment for diagnostic purposes, as follows:
1. One baseline mammogram for women ages 35 through 39.
2. One mammogram for women ages 40 and over, every one to two years.
3. One or more mammograms a year based upon a Network Physician's recommendation for a woman who is at risk for breast cancer because: (i) there is a family history of breast cancer; (ii) there is a history of biopsy-proven benign breast disease; (iii) a mother, sister, or daughter has had breast cancer, or (iv) the woman has not given birth before the age of 30.

V. MASTECTOMY SERVICES. Mastectomy services for breast cancer treatment and outpatient post surgical follow up in accordance with prevailing medical standards. Mastectomy means the removal of all or part of the breast of a Member for Medically Necessary reasons as determined by a Network Physician. Breast reconstructive surgery following Mastectomy to establish contralateral symmetry between the breasts is covered. Breast reconstructive surgery does not include surgery on an otherwise healthy breast to change its size, shape, or appearance, except as stated in the preceding sentence.

X. MATERNITY SERVICES. Service and supplies

for maternity related Covered Services are treated the same as any other Illness and/or Injury. Subject to applicable law, services may be provided by certified nurse-midwives, licensed midwives, and birth centers licensed pursuant to Florida law, who are also Network Providers. Coverage includes services for a normal pregnancy, including routine office visits for prenatal and post-delivery care for a mother and her Newborn infant including a postpartum assessment and Newborn assessment and may be provided at the Hospital, at the attending Physician's office, at an outpatient maternity center, or in the home by a qualified licensed healthcare professional trained in mother and baby care. The services include physical assessment of the Newborn and mother, and any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards. Coverage for the length of a maternity and newborn stay in a Hospital or for follow-up care outside the Hospital will be for the period of time that such care is determined to be Medically Necessary. Medical Necessity will be determined by NHP in accordance with prevailing medical standards and consistent with guidelines for prenatal care of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the treating obstetrical care provider or pediatric care provider. Services received from lactation consultants are not covered. The Newborn Child must be enrolled under the Agreement in accordance with Article II, in order for benefits for the Newborn Child to be paid under the Agreement.

X. NEWBORN CHILDREN. Services for Newborn Children consist of well baby care and diagnosis and treatment of Injury or Illness. This includes the care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and transportation costs of the Newborn to and from the nearest Network facility with the appropriate staff and equipment necessary to protect the health and safety of the Newborn Child. The Newborn Child must be enrolled under the Agreement in accordance with Article II in order for benefits for the Newborn Child to be paid under the Agreement.

Y. ORTHOTICS. Medically Necessary custom-made orthotics for the leg, arm, back and neck. Replacement custom-made orthotics for the leg, arm, back and neck are covered when the Member's Primary Care Physician determines that replacement is necessary to respond to the needs of a growing child.

Z.OSTEOPOROSIS. Diagnosis and treatment of osteoporosis for high-risk individuals is covered. High risk individuals include: (i) estrogen deficient individuals who are at clinical risk for osteoporosis; (ii) individuals who have vertebral abnormalities; (iii) individuals who are receiving long-term glucocorticoid (steroid) therapy or other medications that may case osteoporosis; (iv) individuals who have primary hyperparathyroidism; and (v) individuals who have a family history of osteoporosis.

AA. OUTPATIENT DIAGNOSTIC SERVICES. Outpatient diagnostic services, including radiology, ultrasound, laboratory, pathology, and imaging.

BB. OUTPATIENT RADIATION THERAPY and **I.V. CHEMOTHERAPY.** Radiation therapy and Intravenous (I.V.), Intramuscular and Subcutaneous Chemotherapy is covered when prescribed by or with the concurrence of a Network Physician and may be subject to Prior Authorization.

CC.OUTPATIENT REHABILITATION AND THERAPIES. Outpatient physical, respiratory, speech, cardiac or occupational therapies for purposes of rehabilitation due to an acquired Illness or Injury that are expected to result in significant improvement within 2 months of the start of treatment are covered. See your Summary of Benefits for limits per Calendar Year. Multiple therapies received on the same day will be counted as one visit for each therapeutic discipline received.

Outpatient Rehabilitation and Therapies include habilitative services and those services are subject to the requirements stated below.

Covered Services are provided for habilitative services provided on an outpatient basis those with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental, Investigational or Obsolete Services.

This Covered Service does not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a

result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this Covered Service, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

DD. PODIATRIC SERVICES. Podiatric services performed by a Network Podiatrist are covered without the need for a referral, except for services excluded in Article VI.

EE. PREVENTIVE CARE SERVICES. Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

FF. PROSTHETIC DEVICES. Prosthetic devices to restore normal function required as a result of acquired Illness, covered surgery or Injury, including artificial limbs and eyes to replace natural limbs or eyes lost by a Member while covered under the Agreement and prosthetic devices incident to Mastectomy are covered. Prosthetic devices (except for prosthetic devices incident to Mastectomy) are limited to one permanent prosthesis (including a temporary prosthesis when Medically Necessary) prescribed for the Injury, Illness or surgery, except that replacement of prosthetic devices which are functionally necessary to respond to the needs of a growing child are covered. Replacement of damaged or lost prosthetic devices is excluded from coverage. Coverage for Prosthetic Devices is limited to the most cost effective prosthetic device which meets the Member's medical needs, as determined by NHP. Bionic devices are not covered.

GG. RECONSTRUCTIVE SURGERY. Reconstructive surgery required to correct a functional abnormality resulting from trauma, acquired disease or congenital deformity.

HH. SECOND MEDICAL OPINION. If you dispute our response or a Network Physician's opinion to the reasonableness or necessity of surgical procedures or you are subject to a serious Sickness, you may obtain a second opinion from one of the following:

- Network Physician listed in our provider directory or by going to www.myNHP.com or by calling *Customer Service* at the telephone number on your ID Card.
- A Non-Network Physician located within our Service Area.
- In the case of a second opinion from a Network Physician, such second opinions are considered Covered Health Services. In the case of a second opinion from a Non-Network Physician, Covered Health Services shall be limited to 60% of Eligible Expenses. If the Non-Network Physician requires any tests during the second opinion process, you must have such tests performed by a Network provider.

  In the event that you seek more than three second opinion referrals in a year and we determine that you are unreasonably over-utilizing the second opinion privilege, we may deny reimbursement of expenses incurred after three referrals.

II. TEMPOROMANDIBULAR JOINT SERVICES.

- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.
- Diagnosis: Examination, radiographs and applicable imaging studies and consultation.
- Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.
- Benefits are provided for surgical treatment if the following criteria are met:
- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.
- Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations

JJ. URGENT CARE SERVICES when provided by a Network Provider in the Service Area or a Non-Network Provider outside the Service Area and when it is not reasonable or practical to wait to see the Primary Care Physician.

KK. **VISION SCREENING**. One Vision screening per calendar year for children through age 19 when performed by the Primary Care Physician.

ARTICLE V - EMERGENCY MEDICAL CONDITIONS IN OR OUT OF THE SERVICE AREA

A. EMERGENCY SERVICES AND CARE. Emergency Services and Care in or out of the Service Area are covered under the Agreement subject to the applicable Copayment. Emergency Services and Care provided to a Member in an emergency situation that does not permit treatment through Network Providers are covered under the Agreement without prior notification to or approval of NHP. Benefits for treatment and services of Emergency medical conditions received from Non-Network Providers will be paid in accordance with the definition of "Eligible Expenses" in Article I. All claims and supporting documentation must be submitted to NHP in English.

B. NOTIFICATION UPON HOSPITALIZATION. If a Member is hospitalized with an Emergency Medical Condition, the Member, or the Subscriber in the case of a minor Member, should notify NHP within 48 hours of the Member's hospitalization. In the case of a Member who, by reason of medical condition, is unable to communicate, notification is required as soon as reasonably possible once the Member regains the ability to communicate. If a Member fails to notify NHP within 48 hours after the emergency occurred when it was reasonably possible to do so, coverage will be denied.

C. HOSPITAL, MEDICAL AND SURGICAL SERVICES. Treatment and services as described in the Agreement are covered for Emergency Medical Conditions.

D. AMBULANCE SERVICES. Ambulance service to the nearest Network facility as a result of an Emergency Medical Condition is a Covered Service.

E. EMERGENCY ROOM. Emergency room services for Emergency Medical Conditions are covered subject to applicable Copayment amounts. The Copayment is waived if the Member is admitted to the Hospital as a result of the Emergency Medical Condition.

F. HOSPITAL TRANSFER. NHP may elect to transfer the Member to a Network Hospital if the Member is hospitalized in a non-Network Hospital as soon as the Member is medically stable after the Emergency Medical Condition. NHP may further elect to transfer the Member between Network Hospitals if NHP determines such transfer to be medically appropriate under the circumstances. If a Member refuses transfer that is otherwise medically appropriate, then all charges incurred for provision of services to Member as of the requested transfer date will be at the Member's own expense.

G. FOLLOW-UP CARE. Care in follow-up to Emergency Services and Care must be received, prescribed, directed or Prior Authorized by the Member's Primary Care Physician

ARTICLE VI EXCLUSIONS AND LIMITATIONS

No benefits or coverage are provided for the following:

A. **EXCLUSIONS**

1. Services that are not provided, arranged or Prior Authorized by a Primary Care Physician and/or NHP, except in the case of an Emergency Medical Condition, or for services set forth in Article V for which direct access to Participating Providers is expressly permitted.
2. Services that are not Medically Necessary.
3. Non-emergency health services received from Non-Network Providers not Prior Authorized by NHP.
4. Any expenses related to a Member staying in a Hospital, Skilled Nursing Facility or other facility past the discharge time or date set by NHP or a Network Physician, after notice to the Member.
5. Any service or supply received in connection with a facility or program operated, or for which payment is made, by federal or state government or any agency or subdivision and/or when a Member has no legal obligation for payment, or to the extent that payment has been made in accordance with Article VII, Coordination of Benefits.
6. Services for personal comfort or convenience of the Member including, but not limited to television, newspaper, or telephone.
7. Private Hospital room unless Prior authorized by NHP. In circumstances where the private room is not Prior authorized, NHP will not be responsible for the private room surcharge.
8. Corsets, foot orthotics, shoes (including without limitation orthopedic shoes and diabetic footwear), shoe inserts, oral appliances, cranial molding helmets, and over-the-counter cam boots and cam walkers or similar prefabricated devices. Replacement custom-made orthotics due to loss or damage are not covered.
9. Items or services that are primarily Custodial Care, training or supervision in personal hygiene, and other forms of self-care to a Member who does not require skilled medical or nursing *services*, including services provided in or by rest homes, companions, sitters, domestic maids, home mothers or respite care, except for Hospice Services.
10. Medication, supplies and equipment which Member takes home from the Hospital or other facility:
11. Any medical or surgical treatment or related services the primary purpose of which is to improve appearance, such as cosmetic surgery, including but not limited tattoos, liposuction, ear piercing, care and treatment of complication(s) resulting from services that are not otherwise covered:
12. Keloid removal, radiation, injection or any form of treatment for keloids.
13. Ambulance services, except as expressly authorized in Article IV and V.
14. Autopsy.
15. Dental evaluation and/or treatment, including any services or supplies involving repair, replacement or removal of teeth, the care of gums or other supporting structures of teeth, the preparation of the mouth for dentures, intraoral prosthetic devices, improvement of dental occlusion, or surgical procedures that are cosmetic in nature. This exclusion does not apply to accidental injury to sound natural teeth or Cleft Lip or Cleft Palate Treatment Services described in Article IV.
16. Counseling for family or marital problems.
17. Treatment or evaluation (including, without limitation, speech, physical and occupational therapy) of learning disabilities, intellectual disabilities, and developmental disorders or delay including, but not limited to, learning disorders, motor skills disorders, communication disorders, and autistic disorders.
18. Vision care, including examinations in connection with corrective lenses, or for the purchase of' eye glasses, or contact lenses, or for services relating to radial keratotomy or lasik or other surgical procedure to correct myopia (nearsightedness), hyperopia (farsightedness) or stigmatic error, or training or orthoptics. Intraocular lenses at the time of cataract surgery are limited to traditional lenses. Premium lenses are not covered.
19. Items or services determined to be Investigational, Experimental or Obsolete. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication and published within a standard reference compendium or recommended in medical literature.
20. Examinations for insurance, employment, flight physical, travel or School, unless the service is within the scope of, and coincides with, a periodic health assessment as provided in Article IV, or services provided to evaluate scholastic and/or occupational ability, performance or potential.
21. Treatment, services or supplies related to a work

related Illness or Injury are excluded to the extent the Member is covered by Workers' Compensation, except for Medically Necessary services (not otherwise excluded) for a Member who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by the Member.

22. Reversals of voluntary sterilizations.

23. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Excluded infertility treatments include but are not limited to artificial insemination, In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transport; surrogate parenting; donor semen: semen collection and preparation costs; or infertility medications and surgical procedures to correct infertility or other methods of assisted fertilization. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

24. Termination of pregnancy unless Medically Necessary for the physical health of the mother or in the presence of documented fetal abnormalities.

25. Long term physical (including without limitation, chest physiotherapy), respiratory, occupational, cardiac or speech therapy, other than limited visits for Physical Rehabilitation as described in your Summary of Benefits. Therapy for chronic conditions or maintenance therapy is not covered. In addition, therapy for a condition(s) that has not shown significant improvement in a relatively short time is not covered.

26. Any items or services ordered by a court of law, unless otherwise covered under the Agreement.

27. Items or services incurred as a result of voluntary participation in an assault, felony, insurrection or riot or arising during a period of detainment by law enforcement officers or incarceration.

28. Vision screening, except for children through age 19 when performed by the Primary Care Physician.

29. Bone anchored hearing aids except when either of the following applies:
    - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

    More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under this Agreement.

    Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

30. Complementary/Alternative healing methods, including but not limited to acupuncture, colonic irrigations, acupressure, massage, hypnosis, biofeedback, homeopathy, environmental medicine, thermography, mind-body interactions such as meditation, imagery, yoga, dance and art therapy, manual healing methods, herbal therapies or other alternative medicine as determined by NHP.

31. Any medical or surgical treatment whose primary purpose is to correct complications as a result of the Member's willful and knowing failure to follow the treatment plan of the Physician.

32. Services whose primary purpose is for routine foot care including, but not limited to the trimming of corns, calluses, nails or bunions; treatment of flat feet, fallen arches, chronic foot strain, or supplies, including shoes, orthopedic shoes, arch supports, orthotics or similar supplies for the support of feet.

33. Services for cessation of smoking or educational programs to assist in health maintenance or improvement, unless such services are pre-approved by NHP or are for diabetes outpatient self-management training or diabetes educational services.

34. Pre-natal or childbirth classes.

35. Services, including psychiatric services, whose primary purpose is the treatment of sexual dysfunction, gender change, sexual reassignment treatment or modifications or treatment for gender identity disorders or medical or surgical treatment to improve or restore sexual function.

36. Care, treatment or services performed by a resident of the Member's household or from anyone related to the Member by blood or marriage.

37. Inpatient Hospital Services for substance use treatment unless for detoxification and treatment of acute withdrawal symptoms.

38. Private or special duty nursing care. For the purposes of this exclusion, private duty nursing care includes services for Members who require more individual and continuous care than is available from a visiting nurse through a Home Health Care Agency. Private duty nursing services are provided where durations of longer skilled nursing care (typically more than 4 hours) are required and may include shift

care or continuous care in certain settings.

39. Emergency room and related medical services for Illness or injury that are not for an Emergency Medical Condition.

40. Services or treatment provided by a person or facility that is not properly approved or licensed as required by applicable law.

41. Charges for out-of-network or out-of-Service Area services that exceed Eligible Expenses.

42. The purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, whirlpools, jacuzzis, swimming pools, water beds, motorized transportation equipment, escalators, elevators, or other similar items or equipment or sports related devices.

43. Services for the treatment of obesity, including but not limited to, surgical operations and medical treatment.

44. Any services not specifically stated as a Covered Service in the Agreement, unless such services are specifically required to be covered by state or federal law.

45. Medical or surgical treatment and/or evaluation of complications arising from any non-covered services including but not limited to physician and facility charges.

46. Travel or lodging expenses of any kind, unless related to organ transplant services that are approved in advance and in writing by NHP.

47. Charges incurred prior to the Effective Date of coverage or on or after the date coverage is terminated, except as specifically stated under Extension of Benefits, Article II.

48. Treatment of any Illness or Injury due to war or any act of war, declared or undeclared, and any Illness or Injury due to service in the armed forces. For purposes of the Agreement, war does not include terrorism.

49. Pre-conception or genetic testing or counseling, except for genetic testing and/or counseling performed during pregnancy for suspected fetal abnormality when Prior Authorized by NHP. Genetic testing is not covered when the results will not directly impact the diagnosis or treatment of the covered member.

50. Confinement, treatment, service or supply for which a Member has no financial liability or that would be provided at no charge in the absence of insurance.

51. Prescription medications or items for outpatient treatment, over-the-counter drugs, medicines, supplies, vitamins, enteral formulas, nutritional supplies or food; or any other equipment , including but not limited to, heating pads, blood pressure cuffs and compression stockings, except for coverage of Enteral Formula as described in Article III.

52. Illness or Injury resulting from participation in the following hazardous recreational activities including but not limited to bungee jumping, sky diving, scuba diving at depths below 60 feet or scuba diving without prior professional certification (such as PAD1), hang-gliding, auto racing, mountain climbing, and rock climbing.

53. Drugs prescribed for uses other than approved by the United States Food and Drug Administration (FDA).

54. Weight control, weight loss, health and fitness programs, gastric stapling, gastric bypass, gastric banding, gastric bubbles, and other procedures for the treatment of obesity, morbid obesity, or any other diagnoses co-morbid with obesity or morbid obesity.

55. Outpatient vestibular therapy, brain injury therapy, cognitive therapy, or visual therapy.

56. Nutritional consultants, except for Diabetes as set forth in Article IV.

57. Circumcision, except for circumcisions performed within 30 days of birth or when medically necessary.

58. Medical or surgical treatment for gynecomastia related to weight, hormonal, or growth development.

59. Replacement of damaged or lost prosthetic devices.

60. Bionic devices.

61. Costs associated with the surgical or medical care and treatment of erectile dysfunction, including penile implants/ prosthesis and surgery to insert penile implant/prosthesis, regardless of cause of such erectile dysfunction. Replacement, removal or repair of a previous implant or prosthesis is excluded from coverage.

62. Family planning, except as otherwise expressly covered in this Handbook.

63. Wigs or other cranial prosthetics.

64. Services received while on active military duty and services for treatment of military service-related disabilities, when the Covered Person is legally entitled to other coverage and facilities are reasonably available.

65. Orthomolecular therapy, nutrients and food supplements.

66. Treatment of a condition or complications from a condition resulting, directly or indirectly, from a Member being under the influence of alcohol or due to illegal drug use.

67. Transplant services when: (a) NHP is not contacted for authorization within a reasonable time prior to referral for transplant evaluation for the procedure; (b) when the transplant procedure is performed in a facility that has not been designated by NHP as an approved transplant facility; (c) when expenses related to the transplant are eligible for reimbursement under any private or public research fund, government program or other funding program; or (d) when the transplant is for a non-human organ or tissue. Donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not a Member are not covered.

68. Work or travel vaccines and immunizations.

69. Benefits for treatment and services of Emergency medical conditions received from Non-Network Providers will be paid in accordance with the definition of Eligible Expenses in Article I. All claims and supporting documentation must be submitted to NHP in English.

70. Personal Care, Comfort or Convenience. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

B. LIMITATIONS. The following limitations are in addition to any limitation or exclusion described in the Agreement or the Summary of Benefits.

1. ***Major Disasters***

In the event of any major disaster, epidemic, war, riot or civil insurrections, the Network Physicians will render medical services and arrange for hospital services insofar as practical according to their best judgment, within the limitation of such facilities and personnel as are then available. Neither NHP nor its Physicians will have any liability or obligation for delay or failure to provide medical services or arrange for hospitalization due to lack of available facilities or personnel if such lack is the result of conditions arising out of the social or environmental disturbances specified in this paragraph.

ARTICLE VII – COORDINATION OF BENEFITS AND SUBROGATION

A. COORDINATION OF BENEFITS APPLICABILITY

lf a Member is covered by more than one group health plan or insurance program (plan or program referred to as "plan(s)"), then this Coordination of Benefits provision controls which plan or insurance carrier will be the primary payer and which will be secondary payer.

When coordinating benefits, one of the two or more plans involved is the primary plan which is required to pay its full benefit and the other plan is the secondary plan (or tertiary plan, as the case may be). Payments from secondary/tertiary plans are coordinated so that the total of the payments from all plans are not more than 100% of the amount owed by NHP for benefits under the Agreement (i.e. the amount NHP would have paid if primary).

Any plan without a Coordination of Benefits provision is automatically designated as the primary plan. Where the applicable plans all have coordination of benefits provisions, NHP will determine the order of benefits by using the first of the following rules that applies:

1. The benefits of the plan covering the person as an employee are determined before those of the plan covering the person as a Dependent.

2. For Employers with 20 or more employees, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as an active employee or Dependent, the order of benefit determination is:
   a. First, benefits of a plan covering a person as an employee, member, or subscriber.
   b. Second, benefits of a plan of an active worker covering a person as a Dependent.
   c. Third, Medicare benefits.

3. Except as provided in paragraph 4, when more than one plan covers the same child as a Dependent of different parents, the following applies:
   a. The benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls earlier in the year are determined before the benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls later in that year; but
   b. if both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.

   However, if a policy or plan subject to the rule based on the birthdays of the parent coordinates with an out of state policy or plan which contains provisions under which the benefits of a police or plan which covers a person as a Dependent of a male are determined before those other policy or plan which covers the person as a Dependent of a female, and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan determine the order of benefits.

4. Where two or more plans cover a Dependent child of divorced or separated parents, the benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;

b. Second, the plan of the spouse of the parent with the custody of the child; and
c. Finally, the plan of the parent who does not have custody of the child.

However, if the terms of a court decree stipulate that one of the parents is responsible for the child's healthcare expenses, and if the entity obliged to provide benefits under the plan of that parent has actual knowledge of the terms of such decree, the benefits of' that plan are determined first. This order of benefits does not apply to any claim determination period or plan year when benefits are actually paid or provided before the entity has actual *knowledge* of the terms of the court decree.

5. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's Dependent, are determined before those of a policy or plan which covers the person as a laid-off or retired employee or as the employee's Dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph does not apply.

6. If rules 1-5 do not determine the order of benefits, the benefits of a plan covering an employee, Dependent, member, or subscriber for a longer period of time are determined before those of the plan covering the shorter time.

7. If a person is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 99-272), and also under another group plan, the following order of benefits applies:
   a. First, the plan covering the person as an employee or as the employee's Dependent;
   b. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employees Dependent pursuant to the provisions of COBRA.
8. NHP may coordinate benefits under the following types of contracts:
   a. any group or group-type insurance or HMO;
   b. any plan or insurance policy, including automobile insurance policy, provided that such plans contain coordination of benefits provisions;
   c. Medicare, as allowed by law.
9. NHP will not coordinate benefits against indemnity-type policy (regardless of whether such indemnity-type policy is an individual policy, group blanket policy or group franchise policy), an excess insurance policy as defined in Florida Statutes, Chapter 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.
10. The Coordination of Benefit rules set forth above apply whether or not the Member files a claim under the plans.

The Covered Services rendered pursuant to the Agreement are primary to any services for which a Member may be eligible to receive under the Medicaid program.

B. RIGHT TO RECOVER

NHP is entitled to recover from the Member amounts that are overpaid to him or for him for medical services provided under the Agreement.

C. TIME LIMIT FOR PAYMENT

Payment of benefits due under any plan, subject to this Article, will be made in accordance with the time frames listed in Section 641.3155, Florida Statutes, unless NHP provides the claimant a clear and concise statement of a valid reason for further delay which is in no way caused by the existence of a COBRA provision nor otherwise attributable to NHP claiming delay.

D. FACILITY OF PAYMENT AND RECOVERY

1. Whenever payments that should have been made

under the Agreement have been made under any other plans, NHP will have the right to pay that amount to the organization that made such payments. That amount will then be treated as though it was a benefit paid under the Agreement. NHP will not have to pay that amount again. The term "payment" includes providing benefits in the form of services, in which case "payment" means reasonable cash value of the benefits provided in the form of services.

2 If the amount of the payment made by NHP, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the Agreement, it may recover the excess payments from among one or more of the following, as the Agreement will determine: 1) any persons to or for or with respect to whom such payments were made; and 2) any other insurers, service plans or any other organizations.

E. SUBROGATION AND REIMBURSEMENT.

1. ***Subrogation and Reimbursement*.** Generally, in the event that the Member recovers damages from a third party or first party insurer (i.e. uninsured motorist coverage) due to any negligent act or omission of the third party. NHP will, to the extent of medical benefits or payments provided to or on behalf of the Member, retain a right of reimbursement or be subrogated to the Member's rights of recovery arising out of any claim or cause of action related to such third party's negligent act or omission, including the proceeds of first party coverage.

2. ***Filing a Claim Against a Third Party and Other Action.*** In the event that a Member files a claim, lawsuit or otherwise seeks to recover damages from any party arising from the negligent act or omission of a third party, the Member will include in such lawsuit a claim for the medical benefits or payments provided to or on behalf of the Member by NHP. A Member will take such action, furnish such information and assistance and execute and deliver all instruments to NHP or such other party as NHP may require to enforce its reimbursement and/or subrogation rights under the Agreement.

3. ***Allocation of Proceeds***. To the extent that a Member which NHP has provided medical benefits or payments to, or on behalf of, due to injury, disease, or illness by virtue of the intentional or negligent act or omission of a third party, recovers any monies as a result of judgment, settlement or otherwise from any party, including first party insurer. NHP will be entitled to reimbursement or subrogation in accordance with Florida law and the applicable allocation of proceeds that appear below, or such other allocation as the Member may adopt, whichever is greater. For purposes of the Agreement, any settlement or judgment received by a Member is deemed full and complete compensation for any injury disease, or illness suffered as virtue of the negligent act or omission of a third party.
   (a) If the total amount recovered from all such third party recoveries is less than or equal to 150% of the amount of medical benefits or payments provided by NHP to or on behalf of the Member, the Member will designate a portion of any such settlement, judgment or other third party recovery among such medical benefits or payments and other reasonable damages sustained by the Member according to the proportion that medical benefits or payments provided by NHP to, or on behalf of, the Member bears to the total amount of the Member's recovery for purposes of determining NHP's entitlement to reimbursement or subrogation.
   (b) If the total amount recovered from all recoveries is greater than 150% of the amount of medical benefits or payments provided by NHP to or on behalf of the Member, the Member specifically agrees to designate a portion of any such recovery sufficient to fully reimburse NHP for the amount of medical

benefits or payments provided by NHP to or on behalf of the Member for purposes of determining NHP's entitlement to reimbursement or subrogation under Florida law.

4. ***Attorneys' Fees and Other Costs.*** In the event that NHP engages an attorney or other agent for purposes of enforcing its subrogation or reimbursement rights as stated in this provision against a Member's failure to cooperate with NHP, the prevailing party in any legal action or other proceeding brought to enforce such rights will be entitled to an award of its costs, including, without limitation, reasonable attorneys' fees associated with enforcement of its subrogation or reimbursement rights.

5. Survival of Rights. In the event that any or all of NHP's subrogation or reimbursement rights as set forth in the Agreement are found by a court to be unenforceable for any reason, such a finding will not affect the validity or enforceability of any provision of the Agreement not specifically addressed by such Court, nor will such a finding affect NHP's rights to reimbursement or subrogation under Florida law.

6. Notice Right of Intervention. The Subscriber will provide NHP with timely written notification in the event that the Subscriber or any Member related to the Subscriber suffers injury, disease, or illness by virtue of the negligent act or omission of a third party. Such a notice must inform NHP: (i) of the nature of the injury, disease, or illness; (ii) of the name(s) and addresses (if available) of the third party(ies); (iii) of the names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Member; (iv) a description of the accident or occurrence that the Member reasonably believes was responsible for the injury, disease, or illness at issue and the approximate date(s) upon which such accident or occurrence occurred; and (v) the name of any legal counsel retained by a Member in connection with any such accident or occurrence. In the event that a Member brings a lawsuit, counterclaim, cross-claim or any other action in connection with any such accident or occurrence, Member or Member's counsel is required to notify NHP if the Member intends to claim damages from the third party for the injuries or illness. NHP will be provided with copies of all pleadings, notices and other documents and papers that relate to NHP's rights of reimbursement or Subrogation under the Agreement. NHP reserves the right to intervene in any proceeding in which a Member is a party to the extent that such intervention is reasonably necessary to protect NHP's rights of reimbursement or subrogation under the Agreement.

F. Members will fully cooperate with NHP regarding the NHP's exercise of its rights to Coordination of Benefits and Subrogation, and will cooperate with NHP's actions to administer benefits. Member will execute and submit such consents, releases, assignments and other documents as may be requested by NHP. Failure to provide such documents will be a basis for termination of the Agreement.

ARTICLE VIII - COMPLAINTS AND APPEALS, PRIOR APPROVALS AND CLAIMS

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact Customer Service at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer service at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted. If you are unable to attend, you will be notified of the decision within 15 days from receipt of the second level request.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and

you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Group Service Agreement for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received our decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization* (*IRO*). We have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

Within the applicable timeframe after receipt of the request, we will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating claims assignments among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing

the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Claims When You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

Claims When You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information for Claims

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

ARTICLE IX – GENERAL PROVISIONS

Covered Services provided by the Network Provider will be paid directly to the Network Provider of service. If Member has already paid Network Provider, Member must seek reimbursement from such Provider for Covered Services paid to Network Provider by NHP. Benefits will not be paid directly to any Members except reimbursement for payments made by the Member to a Non-Network Provider for which NHP was liable at the time of payment. As soon as practical, the person making claim for cash reimbursement for benefits provided under provisions of the Agreement will give to NHP written proof of claim including full particulars of the nature and extent of the Illness, Injury or condition and treatment received, and any other information that may assist NHP in determining the amount due and payable.

A. NHP may use and disclose certain General Patient Information for routine purposes in accordance with NHP's confidentiality policy and pursuant to the Member's routine consent for the use and disclosure of General Patient Information which is provided when the Member signs the Enrollment Form. Such routine purposes will include, but are not limited to application of the coordination of benefits rules and determination of payment obligations under such rules; payment of claims; coordination of care; risk management; peer review procedures; quality assessment, measurement and improvement; utilization management, and case management.

The Member or Subscriber will provide NHP with all information needed to determine NHP's payment obligations under the coordination of benefits rules within a reasonable time frame from NHP's request. NHP may also obtain the necessary information from other organizations or persons. Further, NHP may disclose this information to any other organization or person as necessary to apply the coordination of benefit rules, without obtaining additional consent from the Member, Subscriber or any other person.

Each Member claiming benefits under the Agreement must also give NHP any other information it needs to pay claims or to administer benefits under the Agreement. NHP reserves the right to decline coverage for any claim for which it has requested and not received such necessary information.

B. Member must complete NHP Appeal process before Member may bring an action at law or in equity. Such action will not be brought prior to the expiration of 64 days following a final appeal in accordance with requirements of the Agreement. No such action may be brought after the expiration of the applicable statute of limitations. The statute of limitations applicable to any action relative to this appeal will commence from the date services or supplies are rendered giving rise to the action.

C. No interest in the Agreement is assignable without prior written consent of NHP.

D. No person other than a Member is entitled to any benefit under the Agreement.

E. When applying for benefits or services under the Agreement, the Member will present the ID Card provided by NHP.

F. Any notice required or permitted under the Agreement will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as set forth below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.
   1. If to NHP, mailed to the address printed on the Application.
   2. If to a Member, mailed to the most recent address provided by the Member or to the Subscriber's most recent address on file with NHP.
   3. If to Group, mailed to the most recent address provided by the Group to NHP.

G. Unless federal law is applicable, the Agreement will be governed by and construed in accordance with the laws of the State of Florida and the exclusive and sole venue for any action will be in Miami-Dade County, Florida.

H. The Agreement in writing, together with the Application and any attached endorsement, constitute the entire Agreement between NHP and the Group. No agent of NHP other than a corporate officer of NHP is authorized to establish, change or waive any of the provisions of the Agreement. No change or amendments to the Agreement will be valid unless evidenced by an endorsement, rider or amendment to the Agreement and is signed by an authorized representative of NHP.

I. Time Limit on Certain Defenses. Relative to a misstatement in the Application, after two years from the date of issue, only fraudulent misstatements in the Application may be used to

void the policy or deny any claim for loss incurred or disability starting after the two year period.

J. Any provision of the Agreement which on its effective date is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered is hereby amended to conform to the minimum requirements of such statutes and regulations.

K. NHP is not responsible for the judgment or conduct of any Network Provider who treats or provides a professional service or supply, but rather each Network Provider is an independent contractor who is not the agent, servant, or employee of NHP. Under the Agreement, NHP makes benefit determinations only relating to Covered Services and does not provide healthcare services or make medical decisions on behalf of Members. Network Providers exercise independent medical judgment on Members' behalf.

L. Members will participate in the development of alternative treatment plans and cooperate with NHP's case management of services they are receiving. In addition to the benefits specified in the Agreement, NHP may provide benefits for services furnished not otherwise covered under the Agreement pursuant to an alternative treatment plan as part of NHP's case management of Member's care. NHP may provide alternative benefit(s) when, in NHP's judgment, alternative services are Medically Necessary, cost effective and feasible and that the total benefits paid for such alternative services do not exceed the total benefits to which Member would otherwise be entitled under the Agreement in the absence of alternative benefits. If NHP elects to provide alternative benefits for a member in one instance, it will not obligate NHP to provide the same or similar benefits for another Member in any other instance, nor will it be construed as a waiver of NHPs right to administer the Agreement thereafter as to the Member receiving alternative benefits in strict compliance with its expressive terms. If benefits under an alternative treatment plan are to be terminated, NHP will provide at least 10 days written notice of the termination to Member.

M. NHP may develop or adopt standards which describe in more detail when NHP will make or will not provide coverage or make payments under the Agreement and administrative rules pertaining to enrollment and other administrative matters. NHP will have all the powers necessary or appropriate to enable NHP to carry out its duties in connection with the administration of the Agreement, including without limitation, the power to conduct utilization review, quality review and case management, the power to construe the Agreement, to determine all questions arising under the Agreement and to make and establish (and therefore change) rules and regulations and procedures with respect to the Agreement. If a Member has a question about the standards which apply to a particular benefit or the administrative rules, Member may contact NHP and NHP will explain the standards or rules.

N. Members may obtain information regarding performance outcomes and financial data for Neighborhood Health Partnership published by the State of Florida Agency for Health Care Administration by accessing the Neighborhood Health Partnership website, www.myNHP.com. This website includes the link to Florida Health Stat where this information is published or Members can go directly to www.floridahealthsstat.com

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Member Handbook* and *Summary of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for Group Service Agreements that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the *PPACA* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the Group Service Agreement and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the Group Service Agreement is subject to the statute known as *Michelle's Law*. This law amends *ERISA,* the *Public Health Service Act,* and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

- Retroactive rescission of coverage under the Group Service Agreement is permitted, with 45 days advance written notice, only in the following two circumstances:

  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.

- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:

  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

  If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or Neighborhood Health Partnership for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call Neighborhood Health Partnership at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from Neighborhood Health Partnership will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call Neighborhood Health Partnership at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call Neighborhood Health Partnership at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call Neighborhood Health Partnership at the number listed on your health plan ID card. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact Neighborhood Health Partnership at the number listed on your health plan ID card for assistance.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (http://www.dol.gov.ebsa/healthreform/ -click link for Consumer Assistance Programs)

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Mental Health/Substance Use Disorder Parity

Effective for Group Service Agreements that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Group Service Agreement must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for

Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Group Service Agreement are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Group Service Agreement, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could

cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Group Service Agreement for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2015

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, we will post the revised notice on your health plan website, such as www.myuhc.com or www.uhcwest.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

[1]*This Medical Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group:*

ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Co., Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, LLC.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York;

UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person or the public by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.

Additional Restrictions on Use and Disclosure

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and

- Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a “Federal and State Amendments” document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your health information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you have the right to have the denial reviewed. We may charge a reasonable fee for sending any copies.
- **You have the right to ask to amend** certain health information we maintain about you if you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com or www.uhcwest.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please **call the toll-free member phone number your health plan ID card** or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-633-2446.

- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, at the following address:

  UnitedHealthcare
  Customer Service - Privacy Unit
  PO Box 740815
  Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2015

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and

To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please **call the toll-free phone number on your ID card** or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on page IX of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan

of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUPHEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2015

The first part of this Notice, which provides our privacy practices for Medical Information (pages IX-XIV), describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- show the categories of health information that are subject to these more restrictive laws; and
- give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV

Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written request.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT

Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you may be entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration.*

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description.* The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card.*

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above

rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor,* or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA,* or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,* 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*