**YOUR BENEFITS**

# Cover Florida

## *UnitedHealthcare* - Cover Florida Standard Plan

This plan pays a portion of your costs when you receive covered medical services. The purpose of this document is to summarize:

- Services the Cover Florida Standard Plan pays for,
- Services the Cover Florida Standard Plan does not pay for,
- The percentage or dollar amount you must pay.

As you read through this Benefit Summary, please note:

- Only certain Physicians, Hospitals and other providers have agreed to be part of the Network.
- If you choose to seek care outside the Network, the plan does not provide benefits for Non-Network providers and it is your responsibility to pay those charges.
- You may obtain treatment with any Network provider without a referral.

**The Cover Florida Standard Plan is a limited health benefit program which does not encompass all required benefit mandates as provided for under Florida law. Please consider your other coverage options carefully and compare them to the benefits available in this program.**

# **Cover Florida Standard Plan** Benefit Summary

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|
| This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.<br><br>**This plan provides only Network Benefits. Non-Network Benefits are not available.** | **Annual Deductible:** No Annual Deductible.<br><br>**Out-of-Pocket Maximum:** No Out of Pocket Maximum.<br><br>**Maximum Policy Benefit:** $500,000 per lifetime. | **Non-Network Benefits are not provided.** |
| **(1) Hospital – Inpatient Stay**<br>Services, supplies and room and board in a Semi-private Room during an Inpatient Stay. | Not covered. | No benefit. |
| **(2) Outpatient Diagnostic Services**<br>Services received on an outpatient basis at a Hospital or Alternate Facility include lab and radiology/X-ray (such as CT scans, PET scans, and MRI), mammography testing, electrocardiograms (ECG) and electroencephalograms (EEG). | Not covered. | No benefit. |
| **(3) Outpatient Surgery**<br>Outpatient surgery received at a Hospital or Alternate Facility include the facility charge, the charge for required services, supplies and equipment and the Facility-Based Physician fees. | Not covered | No benefit. |
| **(4) Preventive Care Services**<br>Benefits are provided for charges from a Physician, Outpatient Hospital Department or Alternate Facility for preventive care services. Services include exams, lab and radiology/X-ray, and surgery (including anesthesia).<br>**Annual Benefit Maximum:**<br>**Office Services**<br>Included in the Annual Benefit Maximum for Physician's Office Services.<br>**Outpatient Services**<br>Limited to $600 in Eligible Expenses per Covered Person per Policy year for services provided at an Outpatient Hospital or Alternate Facility. | We pay 100% of Eligible Expenses. | Not benefit. |

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|
| **(5) Physician's Office Services**<br>Benefits are provided for the diagnosis and treatment of Sickness or Injury and for preventive care. Services include lab and radiology/X-ray, surgery (including anesthesia) performed in a Physician's office.<br>**Annual Benefit Maximum:**<br>Limited to $450 in Eligible Expenses per Covered Person per Policy year. | You pay $10 per visit. | No benefit. |
| **(6) Professional Fees for Surgical and Medical Services - Inpatient**<br>Professional Fees for Surgical and Medical Services provided during an Inpatient Stay in a Hospital. | Not covered. | No benefit. |
| **(7) Emergency Services**<br>Services provided in an emergency department located in a hospital. | Not covered. | No benefit. |
| **(8) Urgent Care Center**<br>Services provided at an Urgent Care Center for the diagnosis and treatment of Sickness or Injury. | Not covered. | No benefit. |
| **(9) DME and Prosthetics**<br>Durable Medical Equipment and medical supplies include insulin pumps, and prosthetic devices.<br>**Annual Benefit Maximum:**<br>Limited to $500 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | No benefit. |
| **(10) Diabetic Supplies**<br>Benefits for medical supplies used in the treatment of diabetes include needles, syringes, lancets, test strips and blood glucose monitoring devices.<br>**Annual Benefit Maximum:**<br>Limited to $100 in Eligible Expenses per Covered Person per Policy year. | You pay $25 per item for up to a 31 day supply. | Not covered |
| **(11) Mental Health Services**<br>Outpatient services provided for the diagnosis and treatment of mental health conditions. Excludes substance abuse conditions.<br>**Annual Benefit Maximum:**<br>Outpatient limited to five visits per Covered Person per Policy year. | You pay $40 per visit for outpatient services. | Not covered. |

| **Prescription Drug Coverage**<br>**Annual Benefit Maximum:**<br>Benefits for Prescription Drug Products are limited to $500 per Covered Person per Policy year. | **Retail Network Pharmacy**<br>For up to a 31 day supply | **Home Delivery Network Pharmacy**<br>For up to a 90 day supply | **Retail Non-Network Pharmacy**<br>For up to a 31 day supply |
|---|---|---|---|
| **Generic** | $10 | $25 | $10 |
| **Brand, other than Diabetic** | No benefit. | No benefit. | No benefit. |
| **Diabetic Brand Name Drugs (including oral and self injectables)** | $45 | $112.50 | $45 |

# Medical Exclusions

The information below describes medical services that are *not* covered by Cover Florida Standard Plan.

**Preexisting Conditions** are not covered by your plan. A preexisting condition is a sickness or Injury that was: (a) diagnosed or treated within 6 months prior to the start of this coverage, or (b) a condition or Injury for which medications were prescribed or taken within 6 months prior to the start of this coverage. Benefits for the treatment of a Preexisting Condition are excluded until you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

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| **Alternative treatments** such as acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, or other forms of alternative treatment. |
| **Comfort or convenience items** such as TV, phone, beauty/barber service, guest service, air conditioners, air purifiers or filters, batteries or battery chargers, dehumidifiers or humidifiers, or devices and computers to assist in communication or speech. |
| **Dental** care of any kind. |
| **Drugs: Prescription drug products** for outpatient use that are filled by a prescription order or refill. Self-injectable medications, non-injectable medications given in a Physician's office except as required in an emergency, **over-the-counter drugs** and treatments, and **allergy injections**. |
| **Emergency Services** provided on an outpatient basis at an Alternate Facility or Hospital emergency room. |
| **Experimental, investigational or unproven services** are excluded, except for medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in the medical literature. |
| **Foot care** if it is not related to an Injury or illness, such as removal of corns/calluses, soaking/cleaning of feet, nail trimming, application of skin creams in order to maintain skin tone, treatment of flat feet, treatment of subluxation of the foot, or shoe orthotics. |
| **Home health care** or other care provided by a home health agency. |
| **Hospice care** including bereavement counseling. |
| **Inpatient** services including, but not limited to, care at a **hospital, nursing home, a skilled nursing facility, or inpatient rehabilitation facility.** |
| **Medical equipment, supplies and appliances** used as safety items, sports-performance enhancing items, orthotic appliances that straighten or reshape a part of the body (including cranial banding and braces), and oral appliances for snoring. |
| **Mental Health/Substance Abuse services** for the inpatient treatment of mental health conditions and any treatment of substance abuse and chemical dependency. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. |
| **Nutrition:** Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups; enteral feedings and other nutritional and electrolyte supplements, including formula and donor breast milk. |
| **Outpatient rehabilitation services** including, but not limited to, physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy and cognitive therapy. **Outpatient therapeutic services** including, but not limited to, dialysis, nuclear medicine, intravenous chemotherapy and other intravenous infusion therapy; this exclusion does no apply to outpatient therapeutic services provided in the Physician's office for Benefits available as described under Physician's Office Services. Physician Services provided on an outpatient basis for non-facility-based Physicians; this exclusion doe not apply to services provided in a Physician's office for benefits available as described under Physician's Office Services. |
| **Physical Appearance: Cosmetic procedures** including, but not limited to, pharmacological regimens, nutritional procedures or treatments, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Breast implant replacement if the earlier breast implant was for cosmetic rather than medical reasons. **Physical conditioning programs and medications** for athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. **Weight loss programs. Wigs**, regardless of the reason for hair loss. |

**Providers:** Services from a provider who is a family member by birth or marriage or services performed by a provider with the same legal address as you. This includes services that a provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a physician. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services that are ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility when that Physician or other provider has not been actively involved in your medical care prior to ordering the service or who is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing.

**Reproduction** including **infertility treatments, surrogate parenting,** and the **reversal of voluntary sterilization**, health services and associated expenses for elective abortion, contraceptive supplies and services, fetal reduction surgery and health services associated with the use of non-surgical or drug-induced Pregnancy termination.

**Services provided under another plan:** Health services paid under arrangements by federal, state or local law to be purchased or provided through other arrangements including, but not limited to, coverage paid by worker's compensation or no-fault automobile insurance. Health services for treatment of **military** service-related disabilities if you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

**Transplants:** This plan does not cover health services for solid organ, bone marrow and stem cell transplants and transplant evaluations. This plan does not cover health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person.

**Travel/Transportation:** This plan does not cover health services provided in a foreign country. This plan does not cover travel or transportation expenses (including emergency and non-emergency ambulance) even when prescribed by a physician.

**Vision and Hearing:** Routine refractive eye examinations, eye exercise therapy and surgery to help you see better without glasses, including radial keratotomy, laser, and other refractive eye surgery is not covered. Purchase cost and fitting of eyeglasses, contact lenses, or hearing aids are not covered.

**Other exclusions under this plan:**

- Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered by the plan when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services received after the policy ends.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Services for the evaluation and treatment of temporomandibular joint syndrome **(TMJ)**, whether the services are considered to be medical or dental in nature.
- **Jawbone surgery** (upper and lower), except as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea.
- Surgical and non-surgical treatment of **obesity** (including morbid obesity).
- **Growth hormone therapy**.
- Sex transformation operations.
- Treatment of benign breast enlargement in males.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment of snoring.
- Custodial care, domiciliary care, respite care, rest cures or private duty nursing.
- Psychosurgery.
- Charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
- Charges for services, supplies or equipment advertised by the provider as free.
- Charges prohibited by federal anti-kickback or self-referral statutes.

## Prescription Drug Exclusions

The information below describes prescription drug services that are not covered by your Cover Florida Standard Plan.

*Exclusions from coverage listed in the Certificate also apply to this Outpatient Prescription Drug Coverage. In addition, the following exclusions apply:*

Brand prescription drugs, except where specified in section "Prescription Drug Coverage".

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to e experimental, investigational or unproven.

Prescription Drug Products furnished by the local, state, or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to generic Depo Provera and other generic injectable drugs used for contraception.

Durable Medical Equipment.

General vitamins, except the following which require a Prescription Order or Refill: generic prenatal vitamins, generic vitamins with fluoride, and single entity generic vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Prescription Drug Products when prescribed to treat infertility.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in the over-the-counter form or equivalent.

Prescription Drug Products for smoking cessation.

Compounded drugs that contain one or more brand drugs.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

## Glossary

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|---|---|
| Alternate Facility | A health care facility that is not a Hospital, but provides surgical services and laboratory or diagnostic services on an outpatient basis. |
| Continuous Creditable Coverage | Health care coverage during which there was a break in coverage of no more than 63 days. A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage. |
| Covered Health Services | Services that the plan pays either completely or partially for are called "Covered Health Services". A Covered Health Service is a health care service or supply described in "Section 1: What's Covered – Benefits" in the Certificate of Coverage. It includes those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury or their symptoms. |
| Eligible Expenses | The amount of each Covered Health Service the plan will pay is known as the "Eligible Expense". Eligible expenses are determined by the claims administrator.<br>When you use in-Network providers, you are not responsible for any difference between the eligible expense and the amount the provider charges. For Out-of-Network Benefits, you are responsible for paying the provider the difference between the amount the provider bills and the amount the claims administrator will pay. |
| Exclusions | Medical Services that are not covered are called "exclusions". |
| Network | The claims administrator has arranged for certain Physicians, Hospitals and other providers to participate in a Network. These are said to be Network providers. In general, you pay much less out of your pocket for covered services when you use Network providers. |
| Non-Network | If a provider has not agreed to be part of the Network, they are said to be Non-Network providers. |
| Inpatient | When you are admitted to a Hospital, you are known as an "inpatient". |
| Physician | Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law. Also, any podiatrist, dentist, or psychologist. |

This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and terms under which they are provided are contained in the Certificate of Coverage that you receive upon enrolling in the plan. If this benefit summary conflicts in any way with the Certificate of Coverage, the Certificate of Coverage shall prevail.

**YOUR BENEFITS**

# Cover Florida

## *UnitedHealthcare* - Cover Florida Standard Plus Plan

This plan pays a portion of your costs when you receive covered medical services. The purpose of this document is to summarize:

- Services the Cover Florida Standard Plus Plan pays for,
- Services the Cover Florida Standard Plus Plan does not pay for,
- The percentage or dollar amount you must pay.

As you read through this Benefit Summary, please note:

- Only certain Physicians, Hospitals and other providers have agreed to be part of the Network.
- The plan only provides Non-Network benefits for Emergency Services and Inpatient Hospital Services.
- The plan only pays a portion of Emergency Services and Hospital Inpatient Services charges from Non-Network providers and it is your responsibility to pay the remainder.
- You may obtain treatment from any provider without a referral.

**The Cover Florida Standard Plus Plan is a limited health benefit program which does not encompass all required benefit mandates as provided for under Florida law. Please consider your other coverage options carefully and compare them to the benefits available in this program.**

# **Cover Florida Standard Plus Plan** Benefit Summary

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|
| This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.<br><br>**All Benefit limits apply to any combination of Network and Non-Network Benefits.**<br><br>*Prior Notification is required for certain services. | **Annual Deductible:** $500 per Covered Person<br><br>**Out-of-Pocket Maximum:** No Out of Pocket Maximum.<br><br>**Maximum Policy Benefit:** $500,000 per lifetime. | **Annual Deductible:** $500 per Covered Person<br><br>**Out-of-Pocket Maximum:** No Out of Pocket Maximum.<br><br>**Maximum Policy Benefit:** $500,000 per lifetime.<br><br>**Non-Network Benefits are only provided for Emergency Services and Inpatient Hospital Services.** |
| **(1) Hospital – Inpatient Stay**<br>Benefits for services, supplies and room and board in a Semi-private Room during an Inpatient Stay.<br>**Annual Benefit Maximum:**<br>Benefits are limited to a maximum of 10 days per Covered Person per Policy year regardless of whether you use Network or Non-Network Providers or any Combination. | *We pay $2,000 in Eligible Expenses per day. | *We pay $1,000 in Eligible Expenses per day. |
| **(2) Outpatient Diagnostic Services**<br>Benefits for services received on an outpatient basis at a Hospital or Alternate Facility include lab and radiology/X-ray (such as CT scans, PET scans, and MRI), mammography testing, electrocardiograms (ECG) and electroencephalograms (EEG).<br>**Annual Benefit Maximum:**<br>Limited to $500 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | Not covered. |
| **(3) Outpatient Surgery**<br>Benefits for outpatient surgery received at a Hospital or Alternate Facility include the facility charge, the charge for required services, supplies and equipment and the Facility-Based Physician fees.<br>**Annual Benefit Maximum:**<br>Limited to $1,500 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | Not covered. |

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|
| **(4) Outpatient Services**<br>Benefits for services received on an outpatient basis at a Hospital or Alternate Facility include Physician and Facility charges.<br>**Annual Benefit Maximum:**<br>Limited to $400 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | Not covered. |
| **(5) Preventive Care Services**<br>Benefits are provided for charges from a Physician, Outpatient Hospital Department or Alternate Facility for preventive care services. Services include exams, lab and radiology/X-ray, and surgery (including anesthesia).<br>**Annual Benefit Maximum:**<br>**Office Services**<br>Included in the Annual Benefit Maximum for Physician's Office Services.<br>**Outpatient Services**<br>Limited to $600 in Eligible Expenses per Covered Person per Policy year for services provided at an Outpatient Hospital or Alternate Facility. | We pay 100% of Eligible Expenses. | Not covered. |
| **(6) Physician's Office Services**<br>Benefits are provided for the diagnosis and treatment of Sickness or Injury. Services include lab and radiology/X-ray, surgery (including anesthesia) performed in a Physician's office.<br>**Annual Benefit Maximum:**<br>Limited to $1,000 in Eligible Expenses per Covered Person per Policy year. | You pay $20 per visit. | Not covered. |
| **(7) Professional Fees for Surgical and Medical Services - Inpatient**<br>Benefits are provided for Professional Fees for Surgical and Medical Services provided during an Inpatient Stay in a Hospital.<br>**Annual Benefit Maximum:**<br>Limited to $1,000 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | Not covered. |
| **(8) Emergency Services**<br>Benefits are only provided for services provided in a hospital's emergency department for the treatment of an accidental Injury, Trauma-related Injury, heart attack or stroke. Services for an accident or Trauma-related Injury must be provided within three days of the Injury.<br>**Annual Benefit Maximum:**<br>Benefits are limited to $1,500 in Eligible Expenses per Covered Person per Policy year regardless of whether you use Network or Non-Network Providers or any Combination. | We pay 80% of Eligible Expenses. | We pay 80% of Eligible Expenses. |

| Types of Coverage | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|
| **(9) Ambulance Service**<br>Emergency transportation to the nearest facility equipped to treat the condition.<br>**Annual Benefit Maximum:**<br>Limited to $500 in Eligible Expenses per Covered Person per Policy year regardless of whether you use Network or Non-Network Providers or any Combination. | You pay $100 copayment per trip. | You pay $100 copayment per trip. |
| **(10) Urgent Care Center**<br>Services provided at an Urgent Care Center for the diagnosis and treatment of Sickness or Injury.<br>**Annual Benefit Maximum:**<br>Limited to $250 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | Not covered. |
| **(11) DME and Prosthetics**<br>Durable Medical Equipment and medical supplies include insulin pumps, and prosthetic devices.<br>**Annual Benefit Maximum:**<br>Limited to $500 in Eligible Expenses per Covered Person per Policy year. | We pay 80% of Eligible Expenses. | Not covered. |
| **(12) Diabetic Supplies**<br>Benefits for medical supplies used in the treatment of diabetes include needles, syringes, lancets, test strips and blood glucose monitoring devices.<br>**Annual Benefit Maximum:**<br>Limited to $100 in Eligible Expenses per Covered Person per Policy year. | You pay $25 per item for up to a 31 day supply. | Not covered. |
| **(13) Mental Health Services**<br>Services provided for the diagnosis and treatment of mental health conditions include inpatient and outpatient treatment. Excludes substance abuse conditions.<br>**Annual Benefit Maximum:**<br>Inpatient limited to five days per Covered Person per Policy year. Outpatient limited to five visits per Covered Person per Policy year. | You pay $500 per day for inpatient services.<br><br>You pay $40 per visit for outpatient services. | Not covered. |

| **Prescription Drug Coverage**<br>**Annual Benefit Maximum:**<br>Benefits for Prescription Drug Products are limited to $500 per Covered Person per Policy year. | **Retail Network Pharmacy**<br>For up to a 31 day supply | **Home Delivery Network Pharmacy**<br>For up to a 90 day supply | **Retail Non-Network Pharmacy**<br>For up to a 31 day supply |
|---|---|---|---|
| **Generic** | $10 | $25 | $10 |
| **Brand, other than Diabetic** | No benefit. | No benefit. | No benefit. |
| **Diabetic Brand Name Drugs (including oral and self injectables)** | $45 | $112.50 | $45 |

## Medical Exclusions

The information below describes medical services that are *not* covered by Cover Florida Standard Plus Plan.

**Preexisting Conditions** are not covered by your plan. A preexisting condition is a sickness or Injury that was: (a) diagnosed or treated within 6 months prior to the start of this coverage, or (b) a condition or Injury for which medications were prescribed or taken within 6 months prior to the start of this coverage. Benefits for the treatment of a Preexisting Condition are excluded until you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

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| **Alternative treatments** such as acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, or other forms of alternative treatment. |
| **Comfort or convenience items** such as TV, phone, beauty/barber service, guest service, air conditioners, air purifiers or filters, batteries or battery chargers, dehumidifiers or humidifiers, or devices and computers to assist in communication or speech. |
| **Dental** care of any kind. |
| **Drugs: Prescription drug products** for outpatient use that are filled by a prescription order or refill. Self-injectable medications, non-injectable medications given in a Physician's office except as required in an emergency, **over-the-counter drugs** and treatments, and **allergy injections**. |
| **Experimental, investigational or unproven services** are excluded, except for medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in the medical literature. |
| **Foot care** if it is not related to an Injury or illness, such as removal of corns/calluses, soaking/cleaning of feet, nail trimming, application of skin creams in order to maintain skin tone, treatment of flat feet, treatment of subluxation of the foot, or shoe orthotics. |
| **Home health care** or other care provided by a home health agency. |
| **Hospice care** including bereavement counseling. |
| **Inpatient** services including, but not limited to, care at a **nursing home, a skilled nursing facility, or inpatient rehabilitation facility.** This exclusion does not apply to Hospital – Inpatient Stay. |
| **Medical equipment, supplies and appliances** used as safety items, sports-performance enhancing items, orthotic appliances that straighten or reshape a part of the body (including cranial banding and braces), and oral appliances for snoring. |
| **Mental Health/Substance Abuse services** for the treatment of substance abuse and chemical dependency. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. |
| **Nutrition:** Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups; enteral feedings and other nutritional and electrolyte supplements, including formula and donor breast milk. |
| **Physical Appearance: Cosmetic procedures** including, but not limited to, pharmacological regimens, nutritional procedures or treatments, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Breast implant replacement if the earlier breast implant was for cosmetic rather than medical reasons. **Physical conditioning programs and medications** for athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. **Weight loss programs. Wigs**, regardless of the reason for hair loss. |
| **Providers:** Services from a provider who is a family member by birth or marriage or services performed by a provider with the same legal address as you. This includes services that a provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a physician. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services that are ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility when that Physician or other provider has not been actively involved in your medical care prior to ordering the service or who is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing. |
| **Reproduction** including **infertility treatments, surrogate parenting,** and the **reversal of voluntary sterilization**, health services and associated expenses for elective abortion, contraceptive supplies and services, fetal reduction surgery and health services associated with the use of non-surgical or drug-induced Pregnancy termination. |

**Services provided under another plan:** Health services paid under arrangements by federal, state or local law to be purchased or provided through other arrangements including, but not limited to, coverage paid by worker's compensation or no-fault automobile insurance. Health services for treatment of **military** service-related disabilities if you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

**Transplants:** This plan does not cover health services for solid organ, bone marrow and stem cell transplants and transplant evaluations. This plan does not cover health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. The only exceptions to this exclusion are corneal transplants, bone/cartilage grafts and skin grafts.

**Travel/Transportation:** This plan does not cover health services provided in a foreign country. This plan does not cover travel or transportation expenses (except emergency ambulance) even when prescribed by a physician.

**Vision and Hearing:** Routine refractive eye examinations, eye exercise therapy and surgery to help you see better without glasses, including radial keratotomy, laser, and other refractive eye surgery is not covered. Purchase cost and fitting of eyeglasses, contact lenses, or hearing aids are not covered.

**Other exclusions under this plan:**

- Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered by the plan when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services received after the policy ends.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- In the event that a non-Network provider waives Copayments for a particular health service, no Benefits are provided for the health service for which the Copayments are waived.
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Services for the evaluation and treatment of temporomandibular joint syndrome **(TMJ)**, whether the services are considered to be medical or dental in nature.
- **Jawbone surgery** (upper and lower), except as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea.
- Surgical and non-surgical treatment of **obesity** (including morbid obesity).
- **Growth hormone therapy**.
- Sex transformation operations.
- Treatment of benign breast enlargement in males.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment of snoring, except when provided as part of treatment for documented obstructive sleep apnea.
- Custodial care, domiciliary care, respite care, rest cures or private duty nursing.
- Psychosurgery.
- Charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
- Charges for services, supplies or equipment advertised by the provider as free.
- Charges prohibited by federal anti-kickback or self-referral statutes.

## Prescription Drug Exclusions

The information below describes prescription drug services that are not covered by your Cover Florida Standard Plus Plan.

*Exclusions from coverage listed in the Certificate also apply to this Outpatient Prescription Drug Coverage. In addition, the following exclusions apply:*

Brand prescription drugs, except where specified in section "Prescription Drug Coverage".

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to e experimental, investigational or unproven.

Prescription Drug Products furnished by the local, state, or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to generic Depo Provera and other generic injectable drugs used for contraception.

Durable Medical Equipment.

General vitamins, except the following which require a Prescription Order or Refill: generic prenatal vitamins, generic vitamins with fluoride, and single entity generic vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Prescription Drug Products when prescribed to treat infertility.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in the over-the-counter form or equivalent.

Prescription Drug Products for smoking cessation.

Compounded drugs that contain one or more brand drugs.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

## Glossary

| | |
|---|---|
| Alternate Facility | A health care facility that is not a Hospital, but provides surgical services and laboratory or diagnostic services on an outpatient basis. |
| Notification | We require notification before you receive certain Covered Health Services. If you do not notify us in advance, your Benefits may be reduced or may not be covered at all. Services for which you must provide prior notification are listed in the Certificate of Coverage under the "Must you notify us?" column. To notify us, call the telephone number on your medical ID card for customer service. |
| Continuous Creditable Coverage | Health care coverage during which there was a break in coverage of no more than 63 days. A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage. |
| Covered Health Services | Services that the plan pays either completely or partially for are called "Covered Health Services". A Covered Health Service is a health care service or supply described in "Section 1: What's Covered – Benefits" in the Certificate of Coverage. It includes those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury or their symptoms. |
| Eligible Expenses | The amount of each Covered Health Service the plan will pay is known as the "Eligible Expense". Eligible expenses are determined by the claims administrator.<br>When you use in-Network providers, you are not responsible for any difference between the eligible expense and the amount the provider charges. For Out-of-Network Benefits, you are responsible for paying the provider the difference between the amount the provider bills and the amount the claims administrator will pay. |
| Exclusions | Medical Services that are not covered are called "exclusions". |
| Network | The claims administrator has arranged for certain Physicians, Hospitals and other providers to participate in a Network. These are said to be Network providers. In general, you pay much less out of your pocket for covered services when you use Network providers. |
| Non-Network | If a provider has not agreed to be part of the Network, they are said to be Non-Network providers. |
| Inpatient | When you are admitted to a Hospital, you are known as an "inpatient". |
| Physician | Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law. Also, any podiatrist, dentist, or psychologist. |

This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and terms under which they are provided are contained in the Certificate of Coverage that you receive upon enrolling in the plan. If this benefit summary conflicts in any way with the Certificate of Coverage, the Certificate of Coverage shall prevail.