



## SUBSCRIBER AGREEMENT

### COVER FLORIDA Complete 25 PLAN

This Individual Subscriber Agreement contains the terms and conditions of your Coverage (the Medical Services that you are entitled) provided by MEDICA HEALTH PLANS OF FLORIDA, INC. (also referred to as "MHP-FL") a Florida corporation organized and operating as a health maintenance organization ("HMO") under the laws of the State of Florida.

MEDICA HEALTH PLANS OF FLORIDA, INC. 4000 Ponce De Leon Blvd., Suite 750 Coral Gables, Fl.  
33146 TEL: (305) 460 - 0600 Fax: (305) 460-0613

## TABLE OF CONTENTS

SECTION I.	
Definitions.....	4
SECTION II.	
How the Plan Works.....	13
A. Your Primary Care Physician.....	13
B. Appointments, how to make one? .....	13
C. Using Other Participating Providers.....	14
D. Reimbursement for Non-Participating providers.....	14
E. Self-Referrals.....	15
F. When You Need Care After Regular Office Hours.....	16
G. How Do You Change Your Primary Care Physician?.....	16
H. Medical Necessity.....	16
I. Prior Authorization .....	17
J. Copayments.....	18
K. Calendar Year Maximum Benefit.....	18
L. Membership Identification Card.....	18
M. Termination of a Participating Provider's Contract.....	18
SECTION III.	
Eligibility and Coverage Effective Dates .....	20
SECTION IV.	
Renewal and Termination of Coverage.....	22
SECTION V.	
Emergency Services and Care.....	25
SECTION VI.	
Grievance Procedures.....	28
SECTION VII.	
Covered Services.....	32
SECTION VIII.	
Co-payments & Health Plan Premiums.....	40
SECTION IX.	
General Exclusions and Limitations.....	41
SECTION X.	
Double Coverage/Third Party Liability.....	47
SECTION XI. General Provisions.....	53
SECTION XII.	
Contact Addresses and Telephone Numbers.....	58
ATTACHMENTS:	
Attachment A: Plan Information Page	
Schedule of Benefits	

## INTRODUCTION

This Medical and Hospital Services Individual Subscriber Agreement (hereafter referred to as "Agreement") issued by MEDICA HEALTH PLANS OF FLORIDA, INC. (hereafter referred to as "MHP-FL" or "Health Plan") to a Subscriber (hereafter referred to as "Subscriber" or "Member"), sets forth the basis on which an eligible person is provided with Coverage for prepaid health care services and benefits to the extent described herein.

Upon acceptance for coverage, a Subscriber is entitled to Covered Services provided by MHP-FL commencing with each Subscriber's Coverage Effective Date.

MHP-FL is pleased that you are enrolling in our Health Benefit Plan and looks forward to meeting your health needs. MHP-FL is a health maintenance organization ("HMO") licensed by the Florida Department of Financial Services, Office of Insurance Regulation (OIR) to arrange for health care services on a managed care basis.

MHP-FL arranges for services through a network of contracted Physicians, Hospitals, and other health care providers that serve MHP-FL Members in an organized and cost-effective manner. MHP-FL will cover the cost of all Medically Necessary care provided or arranged by your Primary Care Physician, Medically Necessary care not provided by your Primary Care Physician but authorized by MHP-FL, and all Emergency Services and Care required by you. Specialty care under this Health Benefit Plan will be covered only if arranged by your Primary Care Physician, with the exception of self-referrals as outlined in this Subscriber Agreement, emergency medical conditions and those services specifically authorized by MHP-FL. If you follow these simple requirements, you will only be required to pay a Co-payment amount after applicable deductibles.

While MHP-FL arranges for the provision of a full range of Covered Services, you are required to take an active part in ensuring the success of your Health Benefit Plan. Read this Agreement carefully as it will explain your responsibilities and benefits as a Member. If after reading this Agreement you have any questions regarding this Health Benefit Plan, please contact MHP-FL's Member Services Department.

MHP-FL provides an interpreter if you do not speak English and a sign language interpreter if you have a hearing impairment. For assistance, call MHP-FL's Member Services Department at 305-460-0675 within Miami Dade County, outside of Miami Dade County 800-719-9531, or for the hearing impaired at 305-421-1251 within Miami Dade County, outside of Miami Dade County 800-517-6923 Monday through Friday 8:00 a.m. through 6:00 p.m. , EST.

The words and terms that are capitalized in this Agreement have a specific meaning as defined in the Section I, Definitions following this Introduction. Because this meaning may differ from the usual meaning of these words or phrases, please refer to this Section to be certain you understand the meaning of these words and phrases.

This Agreement is a legal contract between the Member and MHP-FL. It sets forth in detail the rights and responsibilities of the Member. By executing the Enrollment Application, the Member accepts the terms, conditions, and provisions of this Agreement. It is therefore very important that you read your Agreement carefully and familiarize yourself with its terms and conditions. For reference purposes, a Table of Contents has been included.

Welcome to MEDICA HEALTH PLANS OF FLORIDA, INC.

By: 

Chief Executive Officer  
Medica Health Plans of Florida, Inc.

## I. DEFINITIONS

“Accidental Dental Injury” means an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional and unexpected event or force. It does not include injuries to sound natural teeth caused by biting or chewing.

“Adverse Determination” means a Coverage determination by MHP-FL that an admission, availability or care, continued stay, or other Medical Service has been reviewed and, based upon the information provided, does not meet MHP-FL’s requirements for Medical Necessity, appropriateness, health care setting, or level of care for effectiveness. Coverage for the requested service is therefore denied, excluded, reduced, or terminated.

“Agency” means the Agency for Health Care Administration.

“Agreement” means this Medical and Hospital Services Individual Subscriber Agreement, including but not limited to the Enrollment Application, Evidence of Insurability and other appropriate attachments, and any amendments hereto.

“Ambulatory Surgery Center” means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other state’s applicable law, the primary purpose of which is to provide elective surgical care to a patient admitted to and discharged from such facility within the same working day, and which is not part of a Hospital.

“Applicant” means the person or persons who are petitioning MHP-FL for Coverage under this Agreement.

“Brand Name Prescription Drug” refers to a drug manufactured and marketed under a trademark or name by a specific drug manufacturer and identified on the drug Formulary Medication List as a formulary brand drug.

“Calendar Year” means the period of time starting January 1 of a year and ending on December 31 of the same year.

“Catastrophic Case” means any medical condition where the total Prevailing Rates for services (regardless of payment source) is expected to exceed seventy-five thousand dollars (\$75,000).

“Complaint” means any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, a provision of services, or quality of care provided by a provider pursuant to MHP-FL’s Agreement and which is submitted to MHP-FL or to a state agency. A complaint is part of the informal steps of a grievance procedure.

“Complications of Pregnancy” means (1) a condition, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) non-elective cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

“Condition” means any sickness, disease, disorder, infection, injury, Complications of Pregnancy, or bodily dysfunction of a Member. Condition includes Pregnancy only if conception occurred after the Member’s Effective Date, if a maternity rider is effective.

“Co-payment” means the amount required to be paid by you in connection with the services set forth in this Agreement.

“Coverage or Covered” means coverage under this Agreement for those Medical Services set forth in this Agreement.

“Covered Services” means the Medical Services and Hospital services, including Emergency Services and Care, that are covered benefits under this Agreement, as described in this Agreement and provided or arranged pursuant to the terms and conditions of this Agreement. Such Covered Services are provided in the Service Area, determined to be Medically Necessary, and are performed, prescribed, directed, or ordered by a Primary Care Physician and authorized pursuant to MHP-FL’s UM/QM Protocols.

“Custodial Care” means non-Medically Necessary care that MHP-FL determines to be provided primarily for the maintenance of a Member or is designed essentially to assist a Member in meeting his or her activities of daily living and which is not primarily for its therapeutic value in the treatment of a sickness or bodily injury. Activities of daily living include, but are not limited to, bathing, feeding, dressing, walking, and taking oral medicine.

“Department” means the Florida Department of Financial Services, Office of Insurance Regulation.

“Effective Date” means the first of the month following the date that MHP-FL accepts the Member for Coverage under this Agreement.

“Emergency Medical Condition” means (a) a medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) serious jeopardy to the health of a patient; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

“Enrollment Application” means the form executed by the Applicant that signifies the Applicant’s acceptance and adherence to the terms and conditions of this Agreement. The completed and signed Enrollment Application is an integral part of this Agreement.

“Evidence of Insurability” means the medical information questionnaire that is completed by the Applicant(s) when applying for coverage as stipulated in this Agreement. Evidence of Insurability also means any health evaluations, laboratory tests and medical history review required in order to evaluate the applicant’s status in accordance with MHP-FL’s Underwriting Criteria. The completed and signed Evidence of Insurability is an integral part of this Agreement.

“Experimental, Investigational or Unproven Services” means medical, surgical, diagnostic, psychiatric, substance abuse, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by MHP-FL (at the time it makes a determination regarding Coverage in a particular case) to be: (1) 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, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subjected to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually

subject to FDA oversight; demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

“Facility” means an institution that provides health care services and could include, but is not limited to, a Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Urgent Care Center, Ambulatory Surgical Center or free-standing outpatient center.

“Formulary” means a list of drug products, including its strengths and appropriate dosages that are available for use by Members.

“Fraudulent Insurance Act” means a person knowingly and with intent to defraud presenting, causing to be presented, or preparing with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing organization, any written statement as part of, or in support of, an application for the insurance of, or the rating of, any insurance policy or a claim for payment or other benefit pursuant to any insurance policy that the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material hereto.

“Gene Testing” means examining a sample of blood or other body fluid or tissue for biochemical, chromosomal, or genetic markers that indicate the presence or absence of a genetic abnormality.

“Gene Therapy” means treatment of disease, condition or genetic abnormality by replacing, altering, or supplementing a gene that is absent or abnormal and is responsible for the disease, condition or predisposition to disease.

“Gene Counseling” means meeting with trained Health Professionals before testing begins, when Members receive the test results, and for appropriate post-testing follow-up.

“Generic Prescription Drug” refers to a drug which is chemically the same (has the same active ingredients) as the brand-name drug. These drugs are usually referred to by their common chemical names. Generic drugs can be produced and sold after the patent has expired on a brand-name drug. Generic drugs must meet the same FDA standards as their brand-name counterparts.

“Grace Period” means a thirty one (31) calendar day period immediately following a Health Benefit Plan Premium due date during which Health Benefit Plan Premiums may be paid without penalty and membership under this Agreement continues in effect.

“Grievance” means a written complaint submitted by or on behalf of the Member to MHP-FL or a state agency regarding the: a) availability, coverage for the delivery, or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to utilization review; b) claims payment, handling, or reimbursement for Medical Services; or c) matters pertaining to the contractual relationship between a Member and MHP-FL. A Grievance does not include a written Complaint submitted by or on behalf of a Member eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVII of the Social Security Act.

“Grievance and Appeals Committee” means the formal structure that reviews a Grievance that has not been resolved by informal means or direct intervention of the Grievance and Appeals Coordinator.

“Grievance and Appeals Coordinator” means a person with problem-solving authority acting on formal and informal Complaints or Grievances and brings them to a resolution.

“Grievance Procedure” means an organized process by which a Member may express dissatisfaction with care, services or benefits received under this Agreement and the resolution of the dissatisfaction.

“Health Benefit Plan” means the Health Plan of Covered Services described in this Agreement.

“Health Professional” means physicians, dentists, nurses, midwives, nurse midwives, certified registered nurse anesthetists, advanced registered nurse practitioners, audiologists, podiatrists, osteopaths, chiropractors, ophthalmologists, physician assistants, clinical psychologists, social workers, mental health counselors, pharmacists, nutritionists, physical therapists, speech therapists and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, are certified, or practice under the authority of a Physician or legally constituted professional association, or other authority consistent with the laws of the State of Florida.

“Hospice Care” means those services that provide supportive care and counseling during the terminal phase of an illness. These services are provided when the individual is judged to have twelve (12) months of life expectancy or less and no longer elects to pursue medical treatment for the terminal illness.

“Hospital” means an institution that is licensed pursuant to law, including osteopathic institutions, and is primarily engaged in providing on an inpatient basis for the medical care and treatment of sick and injured persons through medical, surgical, and diagnostic facilities, all of which must be provided on its premises, under the supervision of a staff of Physicians and with twenty-four (24) hours a day nursing and Physician service. The term “Hospital” does not include a convalescent nursing home or any institution or part thereof which is used principally as a custodial facility or facility for the aged.

“Hospitalists” are physicians who may oversee your care while you are hospitalized. Hospitalists may be Participating Providers other than your PCP who primarily takes care of patients in an inpatient setting and work with the Member’s PCP to coordinate the Member’s care.

“Hospital Services” (as expressly limited or excluded by this Agreement) means those Medically Necessary services for registered bed patients that are (i) generally and customarily provided by acute general Hospitals in the Service Area and (ii) prescribed or directed by your Primary Care Physician and authorized by MHP-FL. The requirement that your Primary Care Physician prescribe or direct and that MHP-FL authorize your Hospital services may not apply to certain Emergency Services and Care described in this Agreement.

“Inpatient” means those Medically Necessary services that are provided in a facility that has licensed beds and is referred to as an acute care facility. The person who is treated as an Inpatient remains in the facility both days and nights for the period of service.

“Inpatient Rehabilitation Facility” means a freestanding Inpatient Rehabilitation Facility or rehabilitation unit of a licensed hospital certified under Titles XVIII and XIX of the Social Security Act that is under contract with MHP-FL.

“Medical Group” means any individual practice association or group of licensed doctors of medicine or osteopathy.

“Medically Necessary” means the use of Medical Services or supplies (as expressly limited or excluded by this Agreement) provided by a Hospital, Skilled Nursing Facility, Physician, or other provider required to identify or treat your Condition and which, as determined by MHP-FL’s Medical Director or his designee, are: (i) consistent with the symptoms or diagnosis and treatment of your Condition; (ii) appropriate with regard to standards of good Medical practice; (iii) not solely for the convenience of you or a Physician, Hospital, or other health care provider; and (iv) the most appropriate supply or level of service that can be safely provided to you. When specifically applied to inpatient care, it further means that your medical symptoms or Condition requires that the diagnosis or treatment cannot be safely provided to you as an outpatient.

“Medical Services” means, unless otherwise stated in this Agreement, the Medically Necessary professional services of Physicians, surgeons, and paramedical personnel, including medical, surgical, diagnostic, and therapeutic services and preventive services that are performed or arranged by a Member’s Primary Care Physician and authorized by MHP-FL.

“Medicare Act” means Title XVIII of the Social Security Act and all amendments thereto.

"Member" means any Subscriber as defined in this Agreement.

"MHP-FL" means Medica Health Plans of Florida, Inc., a Florida corporation licensed by the State of Florida Department of Financial Services, Office of Insurance Regulation.

"Monetary Recovery" means payment from a third party including any insurer as a result of payment of benefits, settlement, verdict, judgment, or arbitration award or recovery by any other means in money or in kind from or on behalf of a party held responsible for an injury or illness to a Member.

"Network" means the same definition as Participating Provider.

"Non-Participating Provider" means any Physician, Hospital, Skilled Nursing Facility, pharmacy, or any other duly licensed institution or health professional that is not contracted with MHP-FL to provide Medical Services to Members.

"Participating Hospital" means a Hospital that has an agreement with MHP-FL to provide Hospital services to MHP-FL Members.

"Participating Pharmacy" means a licensed pharmacy that has a contract with MHP-FL to provide services (dispensing of drugs and medications) to Members.

"Participating Provider" means a Physician, Hospital, Skilled Nursing Facility, Pharmacy, or any other duly licensed institution or health professionals that are contracted with MHP-FL to provide Medical Services to Members.

"Pre-existing Condition" is a condition or symptoms thereof, that during the 6-month period immediately preceding the Member's effective date of coverage, have manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received; or a pregnancy existing on the Member's effective date of coverage. A Pre-existing Condition or Conditions directly or indirectly caused by a Pre-existing Condition are not covered until the Member has been continuously covered for a 12-month period. This exclusionary period also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition. A Pre-Existing Condition does not include; (a) genetic information in the absence of a diagnosis of the Condition; (b) routine follow-up care of breast cancer after the individual was determined to be free of breast cancer, unless evidence of breast cancer is found during or as a result of the follow-up care; or (c) conditions arising from domestic violence.

"Physician" means an individual who is (a) licensed to practice medicine and/or surgery, or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose services are required to be covered under this Agreement by the laws of the jurisdiction where treatment is given; or is a partnership or professional association or corporation of such individuals in subsection (a) or (b).

"Premium" means the amounts established by MHP-FL to be paid to MHP-FL by Members or on behalf of the Member in consideration of the benefits provided under this Health Benefit Plan.

"Prescription Drugs" means:

All prescription drugs, biologicals, and compound medications, including birth control pills, that are listed in MHP-FL's Formulary, as it may be amended from time to time, and  
Injectable insulin and hypodermic needles and syringes used for the administration of insulin.

"Prevailing Rates" means the usual and reasonable rates for a particular health care service in the Service Area.

"Primary Care Physician ('PCP')" is a duly licensed Participating Physician licensed under Chapter 458, 459, 460 or 461 of the Florida Statutes. The Primary Care Physician is responsible for providing, prescribing and directing all care and treatment of the Member, to MHP-FL's network of Participating Health Professionals.

“Reasonable Charges” means for a Participating Provider, the contracted rates agreed upon with MHP-FL. For authorized Covered Services received from Non-Participating Providers, the Reasonable Charges will be determined using Ingenix. MHP-FL will pay Non-Participating Providers the lesser of billed charges or Ingenix, whichever is less.

“Referral Provider” means a Participating Provider to whom a Member is referred by his or her Primary Care Physician.

“Rehabilitation Therapy” means the short-term physical, speech, hearing, or respiratory therapy that a Participating Physician and the Medical Director have determined will result in a significant improvement in the condition within a period of two (2) months from the start of treatment for the said condition.

“Reconstructive Surgery” means surgery that is incidental to an injury. Sickness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. For the purpose of Coverage under this Agreement, the initial breast reconstruction following mastectomy is considered to be Reconstructive Surgery. A congenital anomaly is a defective development or formation of a part of the body, which defect is determined by a Physician to have been present at the time of birth.

“Service Area” means the geographic area in which MHP-FL is authorized to provide Medical Services. The Service Area also includes other areas as may be approved by the Agency for Health Care Administration from time to time and communicated in writing to you by MHP-FL. MHP-FL’s Service Area is comprised of Miami-Dade and Broward counties in the State of Florida.

“Skilled Nursing Care” means skilled nursing service, above the level of Custodial Care, which is Medically Necessary, ordered by a Participating Provider, and provided by a licensed Skilled Nursing Facility.

“Skilled Nursing Facility” means a duly licensed institution whose main purpose is providing skilled nursing care, in addition to room and board accommodations and is a Participating Provider. A Skilled Nursing Facility must: (1) have 24-hour nursing service by, or supervised by, a registered nurse (RN); (2) be supervised by a Physician; (3) keep medical records on each patient; (4) and is approved to receive reimbursement as a Skilled Nursing Facility by the Secretary of the United States Department of Health and Human Services pursuant to the Medicare Act or would be qualified to receive such approval if requested.

“Subscriber” means the individual specified in this Individual HMO Agreement who has elected coverage, who meets the eligibility requirements described in this Agreement, is enrolled under this Agreement as a Member, and for whom the Premium payment required under this Agreement has been received by MHP-FL.

“Totally Disabled” means having a condition resulting from an illness or injury that prevents the individual from engaging in any employment or occupation for which the individual is or may become qualified by reason of education, training, or experience and the individual is under the regular care of a Primary Care Physician. Determination of total disability shall be made by the Primary Care Physician on the basis of a medical examination of the Member and upon concurrence by MHP-FL’s Medical Director. The period of total disability must be expected to extend for at least six (6) months.

“Underwriting Criteria” means the internal criteria established by MHP-FL that each individual must satisfy before acceptance in a MHP-FL Health Benefit Plan.

“Urgent Grievance” means a Grievance that would seriously jeopardize the Member’s ability to continue or regain maximum functions if the standard time frame of the Grievance Procedure was followed.

“Utilization Management/Quality Management (UM/QM) Protocols” means those procedures adopted by MHP-FL to ensure that the Covered Services provided to Members are Medically Necessary and that preventive and acute and tertiary care are provided to Members consistent with the provision of quality care in the most cost-effective manner available.

“Urgent Care” means medical screening, examination and evaluation received in an Urgent Care Facility or rendered in your Primary Care Physician’s office after hours and the covered services for those conditions which although not life-threatening, could result in serious injury or disability if left untreated.

“Urgent Care Facility” is a licensed, non-hospital facility that has a written contract with Us as an independent contractor to provide urgent care.

“Utilization Review Committee” means the committee utilized by MHP-FL or a participating Medical Group or Primary Care Physician to promote the efficient use of resources and maintain quality of health care, which shall conduct prospective, current, and retrospective review of Covered Services.

“We, Us, Our, Company” means Medica Health Plans of Florida, Inc.

“You, Yours” refers to You the Subscriber.

## II. HOW THE PLAN WORKS

### A. Your Primary Care Physician

Each Member must choose, or have chosen on their behalf, a Primary Care Physician. The Primary Care Physician will coordinate all your health care services. All of your Medical Services must be provided or arranged by your Primary Care Physician except in certain situations as discussed in Sections II.B. and II.C. or with self-referrals as outlined in Section II.E.

A listing of all participating PCPs is available to you in the MHP-FL Provider Directory as well as hospitals and other healthcare providers who have agreed contractually to render covered services to MHP-FL members. MHP-FL contracted healthcare providers are referred to as participating providers. For certain types of described medical procedures, Physician Assistants, Nurse Practitioners, and/or Nurse Midwives or other individuals who are not licensed physicians may provide services.

You must remember that your PCP will coordinate all your care. If your Primary Care Physician believes that you need a specialist, he/she will coordinate a referral to the proper specialist except in the allowable self-referral situations in the areas of chiropractic, dermatology, gynecology (annual well-woman exam), or podiatric care.

Your PCP will also coordinate any inpatient hospital care, with the exception of emergency care, that you may need. If you or your family needs emergency care, you should go immediately to the nearest emergency room.

If you need assistance selecting your PCP, Medica Health Plans of Florida, Inc. Member Services Department is available to assist you. Please call during our office hours, 8:00 a.m. to 6:00 p.m., Eastern Standard Time.

### B.PCP Appointments: How to Make One?

Medica Health Plans of Florida, Inc. encourages that you schedule an appointment with your PCP as soon as possible, preferably within the first 90 days of becoming a member. You should call at least 1 week in advance for routine, non-emergency appointments and 2 - 4 weeks in advance for physical examinations. The telephone number of your physician is listed on the front of your Medica Health Plans of Florida; Inc. Member ID Card. Services arranged by your PCP include but may not be limited to:

- Routine Check ups & Preventive Care
- Routine Diagnostic tests & Studies, such as lab work
- Hospitalization or outpatient treatment when medically necessary
- Medical treatment of injuries or illness
- Referrals to Specialists
- Referrals for other medically necessary care

If you have to change or cancel an appointment, please call your Primary Care Physician as far in advance as possible, or at least 24 hours before the scheduled appointment.

### C. Using Other Participating Providers

If your Primary Care Physician determines you require care from a Participating Provider other than your Primary Care Physician, you will be provided with a referral. Your Primary Care Physician will utilize the specialty providers who are Participating Providers within their common Participating Medical Group. Your Primary Care Physician will continue to coordinate your diagnosis, treatment, and progress. If a member on his or her own receives services from a Provider other than the Provider referred to by his/her Primary Care Physician, then MHP-FL will not provide coverage for the cost of these services.

A Member will be entitled to coverage for Covered Services delivered by Non-Participating Providers only if the Covered Services cannot be provided by or through Participating Providers and Covered Services are authorized in advance by MHP-

FL.

Specialized and referral care is covered as a benefit under this Agreement only when it is authorized by your Primary Care Physician, as evidenced by a referral, and/or authorized by MHP-FL, as required. The only exception is Emergency Services and Care for an Emergency Medical Condition.

Do not go to a Referral Provider without a referral from your Primary Care Physician. The Referral Provider will not be paid for your care without a referral. (Exception: Emergency Services and Care). If you are a new Member and were previously receiving care from a specialist, please notify your Primary Care Physician immediately so that arrangements can be made for you to receive any necessary care.

#### D. Reimbursement for Non-Participating Providers

There may be circumstances when you may receive services from a Non-Participating Provider. The services could be for, but are not limited to, Emergency Services when you are out of the service area or care authorized by your Primary Care Physician or MHP-FL when a Participating Provider is not available in the specialty that you require. Reimbursement for these types of services is only made if there is proper authorization from either your Primary Care Physician or MHP-FL with the exception of Emergency Services. You are responsible for all applicable Co-payments.

If a Non-Participating Provider requires that you pay for the services at the time of service, then you may submit the bill and any supporting documentation of payment directly to MHP-FL for evaluation. Upon receipt of the bill and documentation, MHP-FL will determine if the services were a covered benefit and were appropriately authorized, and that all necessary documentation is present. (Exception: Emergency Services and Care for an Emergency Medical Condition.) If the services are a covered benefit and all the necessary documentation is present, MHP-FL will reimburse you the Reasonable Charges on an in-network basis in accordance with payment policies less the applicable Co-payment, not to exceed the benefit limitation. All bills and documentation must be submitted to MHP-FL within 1 year of the date of service to be eligible for payment.

MHP-FL has the right to request additional documentation regarding the services for which you are requesting reimbursement. Failure to provide such documentation may result in MHP-FL not reimbursing you for any covered services.

#### E. Self-Referrals

There are certain situations when you may self-refer to a specialist physician for care. However, if you seek services, other than Emergency Services and Care and self-referrals, from a provider other than your Primary Care Physician without a referral, you will be responsible for the cost of such services. The following outlines the situations when you may self-refer.

##### 1) Access to Dermatologists

Members shall have access to contracted Dermatologists for office visits, minor procedures, and testing with a Dermatologist under contract with MHP-FL, without a referral or other authorization before receiving services. A maximum of five (5) office visits to a Dermatologist without prior authorization for a dermatological problem within a twelve-month period is permitted. Visits exceeding the maximum of five (5) visits in a twelve (12) month period will not be covered. Covered Services are subject to the limitations, exclusions, and provisions of this Agreement. Benefits are limited as set forth in the Schedule of Benefits.

##### 2) Access to Chiropractors and Podiatrists

Members shall have access to a contracted practitioner licensed under Chapters 460 and 461 (Chiropractors or Podiatrists) for the purpose of providing Covered Services under Chapters 460 and 461 without the need for a referral from the Primary Care Physician. Covered Services are subject to the limitations, exclusions, and provisions of this Agreement. Benefits are limited as set forth in the Schedule of Benefits.

##### 3) Well-Woman Examination

A female member shall have access to a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow up care detected at that visit. Covered services are subject to the limitations, exclusions and provisions of this Agreement and in accordance with Chapter 641.51(11) of the Florida Statutes.

#### F. When You Need Care After Regular Office Hours

Participating Physicians are required to have coverage arrangements for their patients twenty-four (24) hours a day, seven (7) days a week. If you are sick or injured after regular office hours, please take the following steps:

- Call your Primary Care Physician
- Identify yourself as a Member of MHP-FL

Your Primary Care Physician or another Participating Physician may give you treatment advice by telephone, prescribe medication, ask you to come to their office, refer you to an emergency facility or to another Physician for treatment, or instruct you to make an appointment during office hours.

#### G. How Do You Change Your Primary Care Physician?

You may change your Primary Care Physician by calling MHP-FL's Member Services Department. However, MHP-FL encourages continuity of care and building a relationship with your Primary Care Physician. If you believe that you need to change your Primary Care Physician, you will be permitted to voluntarily change your Primary Care Physician. Primary Care Physician changes will be effective on the first (1st) day of the month following the month the change is requested if requested before the 25th of the month. If the request is received after the 25th of the month, the change will be effective the first (1st) day of the second full calendar month after the request is received.

However, if a Member is hospitalized, confined in a Skilled Nursing Facility (if Skilled Nursing Care is covered under the Health Plan), or otherwise receiving acute institutionalized care at the time of the request, MHP-FL will not change the Primary Care Physician during the period of institutional or acute care nor for one full calendar month following completion of care. Additionally, if you are under active treatment or are pregnant, you may want to continue with your current Primary Care Physician.

You must contact the Member Services Department at 305-460-0675 within Miami Dade County, outside of Miami-Dade County 800-719-9531 to initiate this change.

#### H. Medical Necessity

Only Medically Necessary items and services are covered Medical Services under this Agreement. MHP-FL will not provide coverage for services that your Primary Care Physician or MHP-FL deems either not Medically Necessary or for services that are not covered under this Agreement. You will be responsible for the payment of such services if they are rendered. All preventive services covered under this Agreement, as listed in Section VII, Covered Services will be provided in accordance with MHP-FL medical protocols that are established regarding the provision of such preventive services. If you obtain a Second Medical Opinion from an out-of-network (Non-Participating) provider not authorized by either your Primary Care Physician or MHP-FL, you will be responsible for the cost of this service, pursuant to Chapter 641.51(3) of the Florida Statutes, the professional judgment of a physician licensed under chapter 458, chapter 459, chapter 460 or chapter 461 concerning the proper course of treatment of a subscriber shall not be subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. This shall not be considered to restrict the utilization program established by Medica Health Plans of Florida, Inc.

#### I. Prior Authorization

In order to be eligible to receive maximum benefits available under this health benefit plan, MHP-FL requires Prior Authorization for certain services. If You fail to obtain Prior Authorization for these services, benefits otherwise payable will be denied. It is the Member's responsibility to verify with your Health

Professional that Prior Authorization has been received before the service is rendered. Prior Authorization is not a guarantee of payment and will not result in payment of benefits that would not otherwise be payable.

The following services require prior authorization:

- Inpatient: Hospital (including observation).
- Surgery and invasive procedures; performed in an outpatient hospital or ambulatory surgical facility.
- Implantable cardiac defibrillators, ventricular assist devices, and lung volume reduction surgery procedures, even if the inpatient admission has been authorized.
- MRI, MRA, CT scans, PET scans.
- Nuclear stress tests, including without limitation, thallium, technetium, cardiolite, myoview, sestambi; and myocardial perfusion and ejection fraction, and wall motion studies. Nuclear stress tests encompass non-pharmacological (exercise) and pharmacological stress tests, including without limitation adenoisine and persantine.
- Invasive vascular studies and procedures/EP studies.
- Durable medical equipment.
- Prosthetic and orthotic devices.
- Outpatient therapy: physical, occupational, speech, cardiac and respiratory.
- Wound care.
- Dialysis (inpatient)
- Chemotherapy (chemotherapeutic agents regardless of indication), radiation therapy, transfusions, infusions (inpatient).
- Chronic specialist care.
- Pain management.
- Dermatology: Visits - services or testing not considered minor or routine in nature.
- Colonoscopy/Endoscopy.
- Hospital outpatient services (all) including outpatient diagnostics, except for emergency medical conditions.
- Consultations by Specialists.

In response to the request for Prior Authorization, MHP-FL will:

1. Advise that the treatment or service is authorized; or
2. Deny Prior Authorization and advise as to the alternative treatment or service that will be authorized; or
3. Deny Prior Authorization entirely. If We deny an authorization, We will send the denial in writing to the Member, the attending Health Professional, and if applicable, the Hospital.

The Member or his/her attending Health Professional may at any time ask Us to reevaluate Our decision on Prior Authorization or extend the number of days of Hospital confinement deemed to be appropriate for the treatment of the Member's Condition.

#### J. Co-payments

Some services may be subject to a nominal Co-payment that must be paid to the Health Professional at the time a service is rendered. Co-payment amounts are set forth in the Schedule of Benefits.

#### K. Calendar Maximum Benefit

While this Plan remains in force, the total amount of all Covered benefit expenses payable under this Individual Plan for each Member shall not exceed the Calendar year Maximum Benefit set forth in the Schedule of Benefits. The Calendar Year Maximum Benefit applies regardless of the fact that some expenses for Covered Services may have separate annual or lifetime benefit maximums.

#### L. Membership Identification Card

The Membership ID Card MHP-FL issues to you are for identification purposes only. You should carry the card with you at all times and should present the card every time you receive health services. Possession

of a Membership ID Card confers no right to services or other benefits under this Agreement. To be entitled to services or benefits, you must be a Member on whose behalf all applicable Premium payments under this Agreement have been paid. Any person receiving services or benefits, for which they are not entitled, will be responsible for all costs of such services or benefits.

You must not give your membership ID card to any other person. MHP-FL may terminate your coverage if you allow another person to use your membership ID card.

If your membership identification card is ever damaged, lost or stolen, call Member Services right away and we will send you a new card. Please also check the information contained on your ID card and notify MHP-FL of any changes that need to be made.

#### M. Termination of a Participating Provider's Contract

If a Participating Provider terminates his/her contract with MHP-FL or is terminated by MHP-FL for any reason other than for cause, a Member receiving active treatment may continue coverage and care with that provider when authorized by MHP-FL. Coverage will continue through completion of treatment of a condition for which the Member was receiving care at the time of the termination until the Member selects another treating provider but not longer than two (2) months after termination of the provider's contract. A provider may refuse to continue to provide care to a Member who is abusive, non-compliant, or in arrears in payment for services provided.

### III. ELIGIBILITY AND COVERAGE EFFECTIVE DATES

#### A. General

If a Participating Provider terminates his/her contract with MHP-FL or is terminated by MHP-FL for any reason other than for cause, a Member receiving active treatment may continue coverage and care with that provider when authorized by MHP-FL. Coverage will continue through completion of treatment of a condition for which the Member was receiving care at the time of the termination until the Member selects another treating provider but not longer than two (2) months after termination of the provider's contract. A provider may refuse to continue to provide care to a Member who is abusive, non-compliant, or in arrears in payment for services provided.

1. Be between the ages of 19 and 64 at the time of application.
2. Continually and permanently work or reside within MHP-FL's Service Area.
3. Must not be covered by a private insurance policy nor eligible for coverage through a public health insurance program such as Medicare, Medicaid or Kidcare unless eligibility for coverage lapses due to no longer meeting income or categorical requirements.
4. Must not have been covered by any health insurance program at any time during the past six (6) months, unless coverage under a health insurance program was terminated within the previous six (6) months due to:
  - a. Loss of a job that provided an employer-sponsored health benefit plan;
  - b. Exhaustion of coverage that was continued under COBRA or Florida Continuation of Coverage
  - c. Reaching the limiting age under this Health Plan; or
  - d. Death of, or divorce from a spouse who was provided an employer-sponsored health benefit plan,
5. The Applicant must designate a Primary Care Physician as the primary provider of care for each enrolled Member.
6. The Applicant must provide Evidence of Insurability acceptable to MHP-FL prior to the Effective Date of Coverage.
7. The Applicant must submit a completed and signed Enrollment Application, including all requested information to MHP-FL.
8. The Applicant must be approved by MHP-FL for membership, and MHP-FL must have received the applicable monthly Premium payment by the first business day for which Covered Services are to be provided, Member must continue to pay premiums as agreed to including periodic payments to providers which are due at the time health care services are provided. Upon request by MHP-FL, the Applicant is responsible for obtaining and paying for any and all medical records, and/or information from any Physician. Hospital. Affiliated Pharmacy, or other Provider necessary for MHP-FL to approve the Applicant's enrollment in this Plan.

*The Subscriber must notify MHP-FL of any changes to the information requested or provided on the Enrollment Application within thirty(30) days of the change, including change of address in or out of the MHP-FL Service Area.*

#### B, When Does The Subscriber Become Covered?

Your Coverage will become effective on the first (1st) day of the month following receipt and acceptance (which is subject to underwriting review) of your fully completed application, subject to your satisfaction of all eligibility requirements and the payment of the applicable monthly Premium.

A Subscriber who is temporarily out of the Service Area (e.g. attending school) is entitled to Coverage only within the Service Area as coordinated by the Primary Care Physician, except for Emergency Services and Care.

#### C. Rescission/Voiding of Agreement

MHP-FL may rescind a Member's coverage back to the original effective date on a finding by MHP-FL that a Member made a material misrepresentation, omission, or gave false information on the Enrollment Application, the Enrollment Change Form, or other forms completed for MHP-FL by or on behalf of the Member, which MHP-FL relied upon in accepting the Member into the Plan. MHP-FL may also rescind a Member's coverage back to the original effective date if the Member fails to notify MHP-FL of any material information in addition to or different from the information the Member provided in the Enrollment Application regarding the Subscriber's health from the date the Enrollment Application is signed until the effective date of coverage.

MHP-FL's rescission of coverage shall void this Contract back to the effective date, and MHP-FL shall refund all premiums back to the Member from the effective date, less any claims paid by MHP-FL on the Member's behalf.

With respect to material misstatements on the application, only fraudulent misstatements in the application may be used to void this Agreement or deny any claims for loss incurred or disability two (2) years from the issue date.

Any rescission made under this provision is subject to review in accordance with the Grievance procedure described in this Plan.

#### D. Misstatements

If information about a Member is material and is either misstated or omitted in the application, MHP-FL may either as applicable:

- Rescind coverage back to the original effective date if the misstatement is discovered within 2 years of the effective date;
- Adjust the premium to correctly reflect the true information, if the Subscriber meets the requirements for coverage. The correct premium will be charged retroactive to the original effective date of coverage; or
- Apply a pre-existing condition exclusion for the specific condition not disclosed in the initial application.

In any event, MHP-FL will recover any benefits paid out that would otherwise be excluded as a pre-existing condition if the information was not disclosed in the application.

## IV. RENEWAL AND TERMINATION OF COVERAGE

### A. Terms of Renewal

Coverage under this Agreement is for an initial term of twelve (12) months commencing as of the Effective Date of the Subscriber's Coverage (the "Anniversary Date") and will automatically renew for successive terms of twelve (12) months unless terminated as provided for in this Agreement. The Plan is guaranteed renewable. However, The may refuse to renew this Agreement, and all Coverage provided for under this Agreement for any of the following reasons:

1. Failure to timely pay Premium in accordance with the terms of the Agreement;
2. Failure to pay required copayments in accordance with the terms of this Agreement;
3. The Member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Agreement;
4. The Member no longer lives or works in the MHP-FL geographic Service Area; or
5. MHP-FL elects to discontinue all Cover Florida coverage in the State of Florida.

With the exception of nonpayment of premium or loss of eligibility, if The decides to terminate or nonrenewal this Agreement, We will give at least forty-five days advance written notice. If MHP-FL discontinues offering Cover Florida Coverage in Florida, MHP-FL will give the Subscriber and the Department 180 days written notice prior to the Agreement renewal date. The coverage under this Plan for any Member will terminate at 12:01 a.m., local standard time.

### B. How Do You Terminate Coverage Voluntarily?

A Member may voluntarily terminate Coverage by signing and submitting a membership status change form. This termination will be effective on the first (1st) day of the first (1) full month following receipt of such membership status change form provided such form is received by MHP-FL at least five (5) business days before the end of the month preceding the month in which termination of Coverage is to be effective. The Subscriber shall be responsible for any Health Plan Premium after The receives notification of disenrollment. Any Member who elects to terminate Coverage will be subject to a six (6) month waiting period prior to becoming eligible to seek re-enrollment in a MHP-FL Cover Florida Plan and will upon application, be subject to an underwriting review.

### C. Grace Period

Coverage under this Health Plan has a thirty one (31) day Grace Period. This provision means that if any required Premium is not paid on or before the date it is due, it may be paid during the following grace period. During the Grace Period, Coverage under this Health Plan will stay in force. If the Premium payment is not received by MHP-FL within the Grace Period, Coverage under this Health Plan will terminate for the Subscriber enrolled under this Health Plan.

### D. Reapplication

Any payment received after the Grace Period will be returned to the Subscriber. You will receive a termination notice. To reapply for coverage you must return the reapplication form with any outstanding Premiums within thirty (30) days of receipt of the termination notice. The completion of the reapplication form does not guarantee reenrollment even though payment has been submitted and received. If MHP-FL approves your reapplication, You will be re-enrolled and Coverage will continue from this Agreement's Coverage Effective Date. Any Premium paid in connection with this application will be returned if this Agreement is not reissued by MHP-FL.

#### E. Subscriber's Termination Rights and Responsibilities

The Subscriber shall immediately inform MHP-FL of any event that would give rise to MHP-FL's right to terminate this Agreement.

#### F. Payment of Medical Services After Termination or Non-Renewal

Upon termination of coverage, MHP-FL shall have no further liability for the payment of any Medical Services provided after the date of termination.

#### G. Certificates of Creditable Coverage

Within thirty (30) days of receiving notice of the termination of an employee, a Certificate of Creditable Coverage will be mailed to the home of the terminated Member.

This Certificate provides evidence of a Member's prior coverage that may be needed if an individual becomes eligible under another group or individual health plan that has a Pre-existing Condition waiting period provision.

## V. EMERGENCY SERVICES AND CARE AND CATASTROPHIC CASE MANAGEMENT

### A. What To Do In An Emergency Within the Service Area

In the case of an Emergency Medical Condition, the Member should:

1. Go immediately to the nearest Hospital emergency room or call 9-1-1.
2. Identify yourself as a Member of MHP-FL and present your membership ID card.
3. Contact your Primary Care Physician.

If the Member is unable to contact his/her Primary Care Physician, the Member must call MHP-FL at the telephone number listed on the back of his/her membership ID card within forty-eight (48) hours after receiving treatment so that all care can be coordinated. If a Member is unable to call the emergency telephone number, as a result of his/her Medical Condition, the treating Provider, a family member, or legal guardian may make notification.

For after care and follow-up, the Member is expected to follow his or her Primary Care Physician's instructions. For those Members covered under a plan providing inpatient hospitalization, if the Member is Hospitalized in a NON-Participating Hospital for an Emergency Medical Condition, MHP-FL reserves the right to require a transfer to a Plan Hospital if, in the opinion of the Primary Care Physician, the Member is able to transfer without medically harmful results. If the Member refuses to do so, no further benefits will be provided for this confinement.

If the use of a Plan or NON Participating Hospital Emergency Room is not due to an Emergency Medical Condition, the only payment made will be for the determination of whether an Emergency Medical Condition existed. If an Emergency Medical Condition did not exist, no further benefits will be paid.

### B. If You Need Medical Care Outside the Service Area

#### I. Outside the Service Area But Within the United States:

If you obtain Emergency Services and Care while temporarily outside the Service Area (but are within the United States), you should notify MHP-FL within twenty-four (24) hours, unless your Condition makes it impossible to do so; in which case you should notify MHP-FL as soon as possible so that MHP-FL may initiate the necessary follow-up care. The telephone number to call is printed on the Member's membership ID card.

If the Member is admitted to the Hospital for Emergency Services and Care by a Physician other than the Member's Primary Care Physician, the Member, a member of the Member's family, or the attending Physician is requested to notify The or the Primary Care Physician at the earliest time reasonably possible to allow the Primary Care Physician to coordinate any necessary follow-up care. NON-Participating Providers used for Emergency Services and Care will be reimbursed reasonable and customary charges in accordance with the allowable level as defined in Section II.C., Reimbursement for Non-Participating Providers.

If you have to pay for all or part of your care, refer to Section IX, General Exclusions and Limitations for instructions regarding the submission for reimbursement of your claims. MHP-FL will not cover care sought outside the Service Area except for Emergency Medical Conditions or care authorized by The (as long it is within the United States).

#### 2. Outside the United States:

Any and all health care costs, including Emergency Services and Care, which are incurred outside of the United States are not covered.

### C. Catastrophic Case Management

MHP-FL, through its Catastrophic Case management system and at the directions of a Member's Primary Care Physician may transfer or arrange care through other Providers based on the Member's need for

Medically Necessary services. A Member's failure to agree to such a transfer shall result in a denial of further coverage for these services. In addition, MHP-FL may take other reasonable actions necessary to manage the costs of Catastrophic Cases, provided such actions are consistent with the requirements of this Health Plan, the medical needs of the Member, and the applicable Florida laws.

#### D. Centers of Expertise

For Members covered under a plan providing inpatient hospitalization, MHP-FL may transfer Members to certain Hospitals or other Providers referred to as Centers of Expertise. These facilities have developed an expertise in certain Medical or

Hospital Services such as kidney transplants, heart transplants, heart bypass surgery, or other procedures and treatments that occur infrequently, are high in cost, and/or use new and/or generally unavailable technology. The use of Centers of Expertise by MHP-FL does not mean that MHP-FL shall provide coverage for services or procedures that are excluded from coverage under this Health Plan. .

#### E. Urgent Care Services

Urgent care services are covered when provided and obtained at a Plan urgent care provider. See Section VII, Covered Services

## VI. GRIEVANCE PROCEDURES

Medica Health Plans of Florida, Inc. has a grievance and appeal procedure which complies with applicable state and federal law. We will try to resolve any problems you may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, we have a Grievance Procedure available that provides channels for you, or a provider acting on your behalf, to voice your concerns and have them reviewed and addressed at several levels within the Plan. To submit or pursue a grievance on your behalf, a provider must previously have been directly involved in the treatment or diagnosis of your case.

The Grievance Procedure includes informal as well as formal grievance steps. A grievance is not considered formal until a written request for grievance review or a completed "Formal Grievance/Appeal Form" requesting formal action is received by our Grievance & Appeal Administrator. You have one year from the date of the event/occurrence upon which the complaint is based to file a verbal or written request for grievance review.

### Level 1 – Informal Grievance or Complaint

If you have a complaint, please discuss your concern with our Customer Service Department by calling 305-460-0675 or 800-719-9531. Our customers with hearing or speech impairment can contact us at 305-421-1251 or 800-517-6923. You can also visit our offices between 8:00 AM and 6:00 PM, Monday through Friday. We are located at:

MEDICA HEALTH PLANS OF FLORIDA, INC. 4000 Ponce de Leon Blvd, Suite # 650 Coral Gables, Florida 33146

In accordance with Section 641.47 (5) F.S., a complaint is any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to contract with Medica Health Plans of Florida, Inc. and which is submitted to Medica Health Plans of Florida, Inc. or to a state agency. Every attempt will be made to resolve your concern during your initial phone call or visit.

If you are not satisfied with our response, you have the right to file a formal written grievance. In accordance with Section

641.47 (10) F.S., a grievance is a written complaint submitted by or on the behalf of a Member or provider to the plan or the agency regarding the: availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling, or reimbursement for health care services; or matters pertaining to the contractual relationship between a Member or provider and the plan or agency.

You may write us a letter specifically requesting a grievance review, or ask our Customer Service Department to provide you with "Formal Grievance/Appeal Form". If necessary, a Customer Service Representative will assist you with preparing your grievance. You may file a Grievance or Complaint one of three ways:

### Level 2 – Formal Grievance

If you disagree with the outcome of the Level - 1 review of an informal grievance, Medica Health Plans of Florida, Inc. provides members with an optional Level - 2

Formal Grievance process. Level - 2 grievances may be submitted in writing, as long as it is received by Medica Health Plans of Florida, Inc. within 30 days of your receipt of the Level - 1 determination. You may also file your formal grievance with the Florida Agency for Health Care Administration or the Florida Department of Financial Services. Please be sure to include all additional information and copies of pertinent documentation such as your Medica Health Plans of Florida, Inc. records.

If your grievance is due to an adverse determination and denied, you also have the right to request a Level - 2 formal grievance within 30 days of the determination. An adverse determination is a determination by us that an admission, availability of care, continued stay, or other health care service

was reviewed and, based upon the information provided, is not a covered benefit under your plan. Coverage for the requested service is therefore denied, reduced or terminated.

All formal grievances will be acknowledged by Medica Health Plans of Florida, Inc. within five (5) business days of receipt. You will receive written notification from Medica Health Plans of Florida, Inc. of the grievance outcome once a determination has been made, or within thirty (30) business days from the date of receipt. If your grievance involves activities which occurred outside the service area, or requires the collection of information from outside the service area, Medica Health Plans of Florida, Inc. shall have an additional fifteen (15) days in addition to each of the response/notice periods set forth above, to process your grievance.

If you disagree with our Level - 2 determination, you may request either verbally or in writing a review by our Grievance Review Panel ("the Panel"). For adverse determinations, the majority of the Panel will be persons who have the appropriate expertise, and who were not involved in the initial adverse determination. A person who was previously involved in the adverse determination may appear before the Panel to present information or answer questions. Each party related to the grievance has the right to appear in person to present arguments. The Panel will issue a final decision, in writing, to the Member, and provider if any, who files on behalf of the Member, within thirty (30) business days of a request for a Panel review. All grievances will be finalized within sixty (60) days of receipt of the formal grievance, unless additional time is needed to collect information outside the area serviced by Medica Health Plans of Florida, Inc.

#### Expedited (Urgent) Grievance Review

In all cases where the standard 30-day grievance review time frame would jeopardize your life, health, or ability to regain maximum function, you, your legal representative, or physician authorized to act on your behalf (who is directly involved in your treatment or diagnosis) may file a request for an expedited (urgent) grievance review. You may request this review either verbally or in writing by contacting Medica Health Plans of Florida, Inc. as specified above. This process only applies to a pre-service or concurrent, and not retrospective, denial. For example, this does not apply to a request for payment of services already rendered but denied, other claims review, or reimbursement. If the expedited review process does not resolve a difference of opinion between Medica Health Plans of Florida, Inc. and the Member or the provider acting on behalf of the Member, the Member or provider may submit a written grievance to the Subscriber Assistance Program.

Medica Health Plans of Florida, Inc. will, after review and validation of your request, expedite the grievance procedure, and render a determination within seventy-two (72) hours of receipt of your request. This review will be conducted by appropriate clinical peers who were not involved in the initial determination within twenty-four (24) hours after receiving a request for an expedited appeal. We will make a decision as expeditiously as required by your medical condition, but in no event in more than seventy-two (72) hours and notify you or your representative of our decision. If you are receiving the services at the time you request an expedited review of those services, you will not be liable for covered services until you are notified of our determination. Any verbal notice will be followed with written notice within two (2) working days.

#### Level 3 – State Appeals

If you do not accept the decision of our Panel, you or any authorized person acting on your behalf have the right to appeal to the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) within one (1) year from the date of receipt of our decision. If you appeal, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact AHCA or the Florida Department of Financial Services, Division of Consumer Services at any time to inform them of an unresolved grievance.

The Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire Grievance process established by Medica Health Plans of Florida, Inc., nor if the Member has instituted an action pending in the state or federal court.

## Other Agencies

Pursuant to Florida law, Medica Health Plans of Florida, Inc. may not provide information to you concerning the outcome of quality of care complaints.

If you need further assistance, you may contact:

Agency of Health Care Administration and Subscriber Assistance Program  
2727 Mahan Drive, Mail Stop 26  
Tallahassee, FL 32308  
Tel: 888-419-3436 and 850-921-5458

Florida Department of Financial Services  
Division of Consumer Services  
200 East Gaines Street  
Tallahassee, FL 32399  
Tel: 877-693-5236

## Other Rights

If you are not satisfied with the resolution of a grievance, you have the right to pursue binding arbitration after completing the grievance process established by Medica Health Plans of Florida, Inc. and as an alternative to the Subscriber Assistance Program. If you pursue binding arbitration you may incur some cost for which you will be responsible. Medica Health Plans of Florida, Inc. will not reimburse you for the cost of binding arbitration.

## VII COVERED SERVICES

### A. Medical Services

1. Medical Care and Preventive Services: Services provided in accordance with accepted medical practices by or at the direction of the Member's Primary Care Physician includes:

- a. Annual adult check-up and physical examination. Services include hearing and vision screening, immunizations (except for allergy), and lab and diagnostic procedures performed or ordered by the Physician.
- b. Annual Well Woman Examination including pap smear; PCP referral is not required
- c. Mammography Screening
- d. Well Care Visits including immunizations (except for allergy), vision and hearing
- e. Screenings

### 2. Surgical Physician Services

Surgical services and supplies on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistance, and anesthetist or anesthesiologist together with preoperative and postoperative care when ordered by the Member's Primary Care Physician and authorized pursuant to the UM/QM Protocols.

### B. Hospital and Related Services

#### 1. Inpatient Services

a. When authorized by the Health Plan, Medically Necessary Inpatient Hospital Services will be arranged by a Participating Primary Care Physician or his/her designee and rendered by a Participating Hospital. Services shall include:

- Semi-private room and board
- Care and services in an intensive care unit when Medically Necessary
- Administered drugs, medications, biologicals, fluids, and chemotherapy
- Special diets
- Dressings and casts
- General nursing care
- Use of operating room and related facilities
- Blood, blood plasma and the administration of blood transfusions
- X-rays
- Laboratory and other diagnostic services
- Anesthesia and oxygen services (including nurse anesthetists)
- Short term therapy for rehabilitation services and physical therapy
- Inhalation therapy
- Radiation therapy; and
- Other such Medically Necessary services customarily provided in acute care Hospitals.

b. Private room and special duty nursing are included only when Medically Necessary and pre-authorized by MHP-FL's Medical Director or his/her designee.

#### 2. Outpatient Services and Supplies

##### a. Emergency Services and Care

Emergency Services and Care provided at a Plan Hospital, or  
Emergency Services and Care provided at a Non-Participating Hospital

b. Non-Emergency Services and Care Outpatient or Ambulatory Facility Surgery: Services and supplies for pre-scheduled outpatient surgery provided under the direction of a Plan Hospital or other approved Health Care Facility or Program.

c. Outpatient or Ambulatory Facility Diagnostic Tests and Services: Tests and services, including X-rays and laboratory procedures, services and materials, chemotherapy, fluoroscopy, electrocardiograms, and therapeutic radiology provided under the direction of a Primary Care Provider at a Plan Hospital or other approved Plan Health Care Facility or Program.

d. Coverage for Mammograms performed for breast cancer screening:  
A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.

A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age or more frequently based on the Member's Primary Care Physician's recommendations. A mammogram every year for any woman who is 50 years of age or older. One or more mammograms a year, based upon Primary Care Physician's recommendations for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

Mammograms performed pursuant to the above are covered in full and not subject to a 'Co-payment.

Note: Any drug prescribed for the treatment of cancer on an inpatient or outpatient basis will not be excluded from coverage if the drug is not approved by the FDA for a particular indication but the drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature. Coverage includes medically appropriate services associated with the administration of the chemotherapy agent.

#### C. Dermatological Services

Coverage is provided for dermatological services for minor procedures, and testing by a dermatologist, without a referral or other authorization before receiving services. A maximum of five (5) office visits to a dermatologist without prior authorization for a dermatological problem within a twelve (12) month period is permitted. Visits exceeding the maximum of five (5) visits in a twelve (12) month period will not be covered.

#### D. Diabetic Health Services and Training

Coverage includes Medically Necessary equipment, supplies (including syringes), insulin, outpatient self-management training and educational services under the direction of your Primary Care Physician. Your Primary Care Physician will refer you, as required, to certified specialists for nutrition counseling and outpatient self-management training and educational services.

#### E. Reconstructive Surgery, Services, and Supplies

Reconstructive surgery will be covered only when the reconstructive surgery is necessary for:

1. Congenital Anomaly: Correct congenital anomalies present or apparent at birth when required to restore normal physiological functioning.
2. Cleft Lip and Cleft Palate: Coverage is provided for the treatment of cleft lip and cleft palate for a Child under the age of eighteen (18). Coverage includes medical, dental, speech therapy,

audiology, and nutrition services, if such services are Medically Necessary and are prescribed by the Primary Care Physician or treating Physician.

3. Accident, Injury, Disease, or Surgery: Restore normal physiological functioning following an accident, injury, disease, or surgery.
4. Breast Cancer: Coverage for breast cancer treatment includes inpatient hospital care and outpatient post-surgical follow-up care for mastectomies when medically necessary in accordance with prevailing medical standards. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include the hospital, treating physician's office, outpatient center, or the Member's home. Inpatient hospital treatment for mastectomies will not be limited to any period that is less than that determined by the participating physician.

Coverage for mastectomies includes:

- o all stages of reconstruction of the breast on which the mastectomy has been performed;
- o surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- o prostheses and treatment of physical complications at all stages of mastectomy, including lymph edemas.

Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining a pre-existing condition unless evidence of breast cancer is found during or as a result of the follow-up care.

#### F. Language Services

MHP-FL provides an interpreter if you do not speak the English language and sign language interpreters if you have a hearing impairment. For assistance, call MHP-FL's Member Services Department at (305) 460-0675 or 800 -719-9531 outside Dade County, or the TDD/TTY line at 305-421-1251 or 1-800-517-6923.

#### G. Outpatient Rehabilitative Services

Limited to the therapy categories listed below. MHP-FL must specifically approve a written plan of treatment submitted by the Member's Primary Care Physician and agree that the member's condition will improve significantly within 60 days of the date therapy begins.

1. Services of a licensed speech-language pathologist to aid in the restoration of speech loss or an impairment resulting from injury, stroke, or a surgical procedure while this coverage was in force.
2. Services of a licensed audiologist to determine and measure the hearing function loss and aid in the restoration of hearing function loss, if such loss occurred while this coverage was in force.
3. Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to injury, stroke, or a surgical procedure while this coverage was in force.
4. Services provided under the supervision of a Health Professional or a Health Professional trained in cardiac rehabilitation for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Rehabilitative services provided while the Member is Hospital confined will be covered for the duration of the Hospital confinement for that condition, subject to the conditions listed above.

Rehabilitative services do not include:

- o Long term physical therapy, occupational therapy, speech therapy, respiratory therapy, cardiac therapy, or other treatment of chronic conditions including any service or supply.

- Any rehabilitative services or supplies provided to a Member as an inpatient in a Hospital or other facility, where the admission is primarily to provide rehabilitative services.
- Rehabilitative services or supplies that maintain rather than improve a level of physical function, or where it has been determined that the services or supplies will not result in significant improvement in the Member's condition within a 60-day period.

Rehabilitative services are limited to outpatient services only except where specifically provided for herein and as set forth in the Schedule of Benefits.

#### H. Spine and Back Disorder Treatment

This includes manipulative services and physiological therapeutics to include X-rays when required and also includes the services of chiropractic physicians. Benefits are limited per Calendar Year as set forth in the Schedule of Benefits.

#### I. Well-Woman Examination

A Member is allowed to visit a Participating obstetrician/gynecologist Physician for one annual well-woman visit per calendar year and any necessary follow-up care as specified in this Agreement, without authorization or referral from the Member's Primary Care Physician in accordance with Florida Statutes.

#### J. Pharmacy Services

##### 1. Authorized Benefits and Services:

- a. Prescription drugs purchased from a Participating licensed pharmacy are subject to the following conditions:
  - Pharmacy copayments or discounted charges and benefit maximums as set forth in the schedule of benefits;
  - MHP-FL covers only generic drugs.
  - MHP-FL members may obtain formulary brand drugs at the discounted MHP-FL negotiated rate with the MHP-FL member card.
  - The prescription drug must be prescribed by a Participating Physician or a Referral Provider (see exception in Item b. below);
  - The prescription must be filled or refilled at a Participating Pharmacy (see exception in Item b. below); and
  - The Prescription Drug must be contained in MHP-FL's Formulary.

##### 2. Limitations:

- a. A pharmacy need not dispense an order for a prescription drug that, in the pharmacist's professional judgment, should not be filled.
- b. Prescription drugs covered under this benefit are limited to quantities not exceeding a 30-day supply.
- c. Refills will not be provided beyond one (1) year from the original date of the prescription order.
- d. If a prescription drug is dispensed at a non-participating pharmacy, the Member will have to pay the full cost of the prescription drug.
- e. MHP-FL will cover your prescription drug filled at an out-of-network pharmacy if at least one of the following applies:
  - If related to care for a medical emergency or urgently needed care.
  - If unable to receive prescription drug in a timely manner within MHP-FL's service area because there are no participating pharmacies within a reasonable driving distance that provide 24-hour service. In this situation, MHP-FL shall reimburse the Member, the usual and customary cost of the prescription drug and the customary dispensing fee minus any member cost sharing. The member must request and complete a paper pharmacy claim form and send it to MHP-FL within 30 days of the dispensing date.

- f. MHP-FL supports the use of FDA-approved prescription drug products that are both chemically and therapeutically equivalent to their brand-name counterparts. If available, the generic equivalent products will always be dispensed
- g. Certain covered prescription drugs may have additional requirements or limits on coverage. These requirements and limits may include:
  - Prior Authorization: MHP-FL requires prior authorization for certain drugs. Approval from MHP-FL must be obtained prior to filling certain prescription drugs. Prescription drugs requiring prior authorization are indicated in the prescription drug formulary.
  - Quantity Limits: For certain prescription drugs, MHP-FL limits the amount of the prescription drug that MHP-FL will cover. Certain prescription drugs are subject to quantity level limits based on FDA-approved dosing recommendations, clinical guidelines and package size. The purpose of these quantity level limits is to encourage the use of therapeutically indicated drug regimens, and ensure appropriate utilization. Prescription drugs that are subject to a quantity level limit restriction are indicated in the prescription drug formulary.
  - Step Therapy: For certain prescription drugs, MHP-FL may require an initial trial of a certain prescription drug to treat the condition before MHP-FL covers another prescription drug for that same condition.
- h. Prescription drug coverage has applicable co-payments, discounted charges and an annual calendar year maximum benefit as set forth in the Schedule of Benefits. Diabetic supplies are subject to the calendar year maximum benefit but do not contribute towards the Maximum Lifetime Benefit.

### 3. Exclusions:

- a. Drugs that are prescribed, dispensed or intended for use while you are confined in a Hospital, Skilled Nursing Facility or Alternate Facility.
- b. Prescription drug products if the amount dispensed exceeds the applicable supply limits (i.e. 30-day supply).
- c. Appetite suppressants and weight loss products.
- d. Experimental, investigational or unproven drugs.
- e. Prescription drug products for cosmetic purposes and hair loss prevention.
- f. Prescription drug products for smoking cessation.
- g. Drugs available over-the-counter (OTC) that do not require a prescription order or refill by federal or state law unless otherwise indicated in the Formulary List.
- h. Drugs that are not FDA approved. Drugs that are FDA approved when prescribed for a non-FDA approved indication (off-label use).
- i. Injectable drugs with the exception of all insulins, bee sting kits, glucagons kits and Imitrex (sumatriptan).
- j. Compounded drugs that do not contain at least one ingredient that requires a prescription order or refill.
- k. Unit dose packaging of prescription drug products.
- l. Herbal products.
- m. Prescription drug products as a replacement for a previously dispensed prescription drug product that was lost, stolen, spilled, spoiled, damaged, broken or destroyed.
- n. Prescription drug products used fraudulently by someone else other than the person for whom the drug is prescribed.
- o. Abortifacients (drugs used to induce abortion) and emergency contraceptives.
- p. Hypodermic needles and syringes except for needles and syringes for use with insulin or any other covered drug.
- q. Drugs when used for weight loss or weight gain.
- r. Drugs when used to promote fertility or to treat infertility.
- s. Prescription vitamins and mineral products, except prenatal vitamins, fluoride preparations and folic acid.
- t. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

#### K. Durable Medical Equipment

Durable medical equipment is covered when determined by MHP-FL and the Member's Plan Physician to be Medically Necessary for the care and treatment of a Condition covered under this Health Plan. Durable medical equipment will not, in whole or in part, serve as a comfort or convenience item for the member. Supplies and service to repair medical equipment may be a covered benefit only if the Member owns the equipment or purchased the equipment. The Reasonable Charges for durable medical equipment is based on the most cost effective equipment that meets the Member's needs, as determined by

MHP-FL. At MHP-FL's option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. Durable medical equipment is subject to a benefit maximum per Calendar Year as set forth in the Schedule of Benefits.

#### L. Prosthetic and Orthotic Devices

Prosthetic and orthotic devices including the initial placement of the most cost-effective prosthetic or orthotic device, fitting, adjustments, and repair are Covered if Medically Necessary. MHP-FL will also cover the replacement of such prosthetic or orthotic devices if it is determined by MHP-FL to be necessary because of growth or change. Coverage is subject to a benefit maximum per Calendar Year as set forth in the Schedule of Benefits.

#### K. Behavioral Health

Outpatient mental health or substance abuse counseling is covered when provided by a Participating Provider and is subject to the annual benefit maximum set forth in the Schedule of Benefits. Counseling provided in an Inpatient setting and detoxification provided on an inpatient or outpatient basis is not covered.

#### L. Urgent Care Services

All medically necessary covered services received in a Participating Urgent Care Facility for urgent care as defined in Section I will be covered by MHP-FL. Such services are available when your PCP's office is not available and it is not possible to wait until the office opens on the next office day but when the condition is not serious enough to require Emergency Services and Care. You can contact MHP-FL or consult the Provider Directory for specific locations and hours of operations.

## VIII. CO-PAYMENTS AND HEALTH PLAN PREMIUMS

### A. Co-payments

Members must pay or arrange for payment of Co-payments as set forth in this Agreement and Attachments. Specific service limits or specific benefit maximums noted in Section VII or in the Schedule of Benefits are applicable.

### B. Premiums

Premiums are required to be paid in order for this Agreement to be effective. Premiums are billed on a monthly basis and must be paid in accordance with established timeframes to maintain eligibility. The timeframes are included with the billing statement. Premiums are established for the type of Health Benefit Plan and any applicable riders of Coverage that you may have.

If the required Premium(s) is not paid on or before the date that it is due, the Member has a thirty (30) day Grace Period. During this Grace Period, Coverage under the Agreement will stay in force. If the Premium is not received by MHP-FL within the Grace Period, Coverage under this Agreement will terminate in accordance with the procedures outlined in Section IV, Renewal and Termination of Coverage.

## IX. GENERAL EXCLUSIONS AND LIMITATIONS

### A. GENERAL EXCLUSIONS

Unless specified as a Covered Service in your benefit package, the following services and benefits are excluded from coverage:

1. Abortion: Including any service or supply related to an elective abortion. However, spontaneous abortions and abortions performed for reasons of danger to the physical health of the pregnant Member, rape or incest are not excluded. All partial birth abortions are excluded in accordance with Florida Statute.
2. Accidental Dental: Accidental dental injuries that occurred more than twelve (12) months prior to the effective date of coverage.
3. Alcoholism or substance abuse and mental health treatment, services or supplies received on an inpatient basis is not covered. Detoxification is not covered on an inpatient or outpatient basis. Outpatient services are limited as set forth in the Schedule of Benefits.
4. Allergy Testing and Treatment.
5. Ambulance Services: Ambulance services via ground and air.
6. Ancillary Services: Home Health care, Hospice Services, Skilled Nursing Facility Services.
7. Autopsy: Autopsy and post-mortem examination services, unless specifically requested by MHP-FL.
8. Biofeedback: Biofeedback services and other forms of self-care training and any related diagnostic testing, hypnosis, meditation, acupuncture, acupressure, mind expansion, elective psychotherapy, transaction analysis, transcendental meditation, 7-therapy, EST, and pain control.
9. Christian Science Practitioners Services and Naturopath's Services.
10. Complications of Non-Covered Services: Including the diagnosis or treatment of any condition that arises as a complication of a non-Covered Service (e.g., services or supplies to treat a complication of cosmetic surgery is not covered under this Agreement).
11. Cosmetic Surgery (plastic, and non-medical reconstructive surgery): Health services and associated expense for cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery, and non-Medically Necessary reconstructive surgery not outlined in Section VII, Covered Services. Cosmetic procedures are those procedures that improve physical appearance, but that do not correct or materially improve a physiological function and are not Medically Necessary.
12. Custodial Care: Including any service or supply of a custodial nature primarily intended to assist the Member in the activities of daily living. This includes rest homes, home health aides (sitters), home mothers and domestic maid services.
13. Dental Care and Oral Surgery: Except trauma to natural teeth that occurred not more than twelve (12) months prior to the Effective Date of Coverage or any treatment relating to the teeth, jaws, or adjacent structures (e.g., periodontium), including, but not limited to: extraction or cleaning of the teeth, implant, braces, crowns, bridges, fillings, dentures, X-rays, periodontal, orthodontic, or orthognathic treatment, rapid palatal expanders, and bruxism appliance, as well as all services related to the maolocclusion or malposition of the teeth or jaws, including temporomandibular joint syndrome (TMJ) or craniomandibular joint syndrome except as outlined

in Section VII.E., Covered Services and except for Hospital, dental and Physician services and supplies and anesthesiology services recommended by a Primary Care Physician and approved in writing in advance by MHP-FL, as are necessary to safeguard the health of a Member because of a specific, non-dental physiological impairment.

14. Dietary Regimens: Or treatments for reducing or controlling weight.

15. Durable Medical Equipment and Appliances: Including Deluxe Durable Medical Equipment such as total electric hospital bed, Powered Operated Vehicle; three or four wheeled motorized wheelchair, electric lift chair, specialty beds, exercise equipment, or any other equipment that does not meet the criteria set forth in Section VII, Covered Services.

16. Experimental or Investigational Treatment: This Agreement does not provide any Coverage for Experimental or Investigational treatments. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore, not a covered benefit under this Agreement, are within the sole discretion of the MHP-FL Medical Director.

17. Eye Care: including:

The purchase, examination, or fitting of eyeglasses or contact lenses, except for the placement of post-cataract extraction contact lenses.

Radial keratotomy, myopic keratomileusism and any surgery that involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

Training or orthoptics, including eye exercises.

18. Family Planning Services: Other methods of contraception other than those services specifically described in Section VII and contraceptive devices are specifically excluded.

19. Failure to Follow Treatment: Further care for a condition under treatment will not be covered if the Member refuses to accept any treatment, procedure, or facility transfer recommended by MHP-FL.

20. Foot Care/Routine: Including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, the treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, unless determined to be Medically Necessary.

21. Gene testing, therapy and counseling.

22. Hearing Aids (external or implantable): Services related to the fitting or provision of hearing aids, including tinnitus maskers.

23. Hypnotism: Or hypnotism anesthesia.

24. Immunizations and Physical Examinations: When required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

25. Infertility Treatment: Services and supplies, this includes artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, gamete or zygote intra-fallopian tube transfer (GIFT or ZIFT), or cryogenic or other preservation techniques used in such or similar procedures.

26. Maternity care including complications of pregnancy is not covered.

27. Military Service-Connected Medical Care: For which the Member is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the Member.

28. Miscellaneous Health Care Costs: Related to the following:  
Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy.  
Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.
29. Newborn Care is not covered in any medical setting.
30. Non-Prescription Drugs: Including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.
31. Obesity Treatment: Including surgery for obesity, including gastric stapling, gastric bypass, gastric bubbles, intestinal bypass, lipectomy, suction lipectomy, and any other surgical, Experimental or Investigational Treatment, the purpose and result of which is simple to remove adipose tissue.
32. Orthomolecular Therapy: Including nutrients, vitamins, and food supplements.
33. Personal Comfort, Hygiene, or Convenience Items: Including services and supplies deemed to be not Medically Necessary by MHP-FL and not directly related to the care of the Member, including, but not limited to, air conditioners, air filter, home monitoring devices, humidifiers, dehumidifiers, repair or duplication thereof, even through prescribed by a physician or any other equipment or devices for use outside of the hospital and services and supplies connected therewith or rendered in conjunction therewith and outpatient medical disposable/consumable supplies, beauty and barber services, radio and television, guest meals, travel expenses, motel/hotel accommodation, telephone charges, take-home supplies, massages, physical fitness equipments, Dyathermy Machines Diapers/Brief/underpads, except as specifically set forth in the Covered Services Section.
34. Private Duty Nursing Care.
35. Private Rooms: During a hospital or other facility admission, unless in the sole judgment of the Medical Director of MHP-FL and the Participating Physician that a private room is Medically Necessary for the Member's condition.
36. Prosthetic and Orthotic Devices (external), which do not meet the criteria set forth in the Covered Services section.
37. Rehabilitative Therapy Services: Including speech, occupational and physical therapy, except when part of a short-term rehabilitation program. Therapy for long-term chronic conditions is excluded.
38. Second Medical Opinion with a non- participating physician.
39. Services or Supplies that are: Determined to be not Medically Necessary; Not specifically listed in Section VII, Covered Services unless such services are specifically required to be covered by state or federal law. This Agreement will provide coverage on a primary and secondary basis as required by state or federal law; Court ordered care or treatment, unless otherwise covered in this Agreement ; and For the treatment of a condition resulting from: 1) War or act of war, whether or not declared 2) Participation in any act that would constitute a riot or rebellion, or a crime punishable as a felony 3) Engaging in an illegal occupation 4) Services in the armed forces 5) Suicide or suicide-related activity, intentionally self-inflicted injuries 6) Being under the influence of alcohol or any other narcotic unless taken on the specific advice of a Physician. 7) Received prior to a Member's Effective Date or received on or after the date a Member's coverage terminates 8) Provided by a Physician or other Health Care Provider related

to the Member by blood or marriage 9) Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group 10) Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change. 11) Supplied at no charge when insurance coverage is not present.

40. Sexual Re-assignment or Modification Services: Including any service or supply related to such treatment, including psychiatric services.

42. Sleep-related disorders.

43. Smoking Cessation Programs: Including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including, but not limited to, nicotine withdrawal program and nicorette gum.

44. Training and Educational Programs: Such as vocational rehabilitation.

45. Transplantation or Implantation Services and Supplies: Excluded services and supplies include the transplant or implant. Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ; any organ that is sold rather than donated to the Member and any service or supply in connection with the identification of a donor from a local, state, or national listing.

46. Transportation Services that is non-emergency transportation between institutional care facilities, or to and from the Member's residence and air ambulance of any kind.

47. Volunteer Services: Or services that would normally be provided free of charge to the Member.

48. Voluntary, Surgical-Induced Sterility: Including tubal ligation and vasectomies and the reversal of such procedures.

49. Weight Control/Loss Programs: Including, but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

50. Work Related Condition Services to the extent that the Member is paid under a workers' compensation law. If the Member enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, MHP-FL will not pay for past or future Medical Services that are the subject of or related to that settlement. In addition, if the Member is paid by a workers' compensation program that limits benefits and other than specified health care providers are used and the Member receives care or services from a health care Provider not specified by the program, MHP-FL will not pay for the balance of any costs remaining after the program has paid.

51. Nutritional Foods

## B. LIMITATIONS

1. Member is not eligible for coverage under this Agreement until the first of the month following the month that MHP-FL approves the Member's application for enrollment.
2. A Member is not eligible to receive services or supplies that are considered Covered Services under the terms of this Agreement for Pre-Existing Conditions for twelve (12) months following the Member's Effective Date of Coverage. However, credit will be given for the time you were covered under previous Creditable Coverage if the previous Creditable Coverage was continuous to a date not more than sixty-two (62) days prior to your effective date of coverage.

If there was a break in coverage of sixty-two (62) days or more, no credit will be given for prior Creditable Coverage. Creditable Coverage means health care coverage which is continuous to a date within sixty-two (62) days of your Effective Date of Coverage. Such health care coverage includes any of the following: a group health insurance plan; individual health insurance; Medicare part A and part B; Medicaid; benefits to members and certain former members of the uniformed services and their dependents; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan; or a health benefit plan of the Peace Corps.

## X. DOUBLE COVERAGE/THIRD PARTY LIABILITY

### A. Your Cooperation

Member agrees to fully cooperate in protecting the interests of MHP-FL under this Section. It will be your responsibility to complete and submit to MHP-FL such consents, releases, assignments, and other documents as may be requested by MHP-FL in order to obtain or ensure reimbursement to MHP-FL under Medicare, workers' compensation, or other plans. It is your responsibility to file claims in a timely manner with your other insurance coverage. If you fail to do so, you must pay the customary charge for the services rendered.

Member shall not settle any claim or release any person from liability, without prior written consent of MHP-FL, if such release or settlement will extinguish or act as a bar to MHP-FL's rights to reimbursement.

### B. Attorney's Fees

In the event that MHP-FL employs an attorney for the purposes of enforcing any of its rights under this Section, including claims based on Member's failure to cooperate with MHP-FL, the prevailing party in any legal action or proceeding shall be entitled to recover its reasonable attorneys' fees. The attorneys' fees provision applies only to legal action including an arbitration that must be taken to enforce MHP-FL's rights to reimbursement for money paid or payable to Member by third parties of other insurers. Except as provided in this Section, there is no prevailing party attorneys' fee provision in this Agreement.

### C. Medicare

Except as otherwise provided by law, the benefits that you receive under this Agreement do not duplicate any benefit to which you receive under the Medicare Act. All sums payable by Medicare for services provided to you by MHP-FL are deemed to be assigned to MHP-FL, except as otherwise prohibited by law.

### D. Worker's Compensation

MHP-FL shall not furnish benefits under this Agreement to any Member that duplicates the benefits to which such Member receives or is paid under any applicable workers' compensation law. The Member is responsible for taking whatever action is necessary to obtain payment under workers' compensation insurance laws where payment under the workers' compensation system can be reasonably expected. Failure of the Member to take proper and timely action to secure payment or benefits under applicable workers' compensation laws will relieve MHP-FL from responsibility to furnish the Member with any benefits that could have been reasonably expected under workers' compensation laws, if a dispute arises between the Member and the workers' compensation carrier, as to the Member's ability to recover under workers' compensation laws, MHP-FL will provide the benefits described in this Agreement until resolution of the dispute.

If MHP-FL, for any reason, provides benefits that duplicate the benefits to which Member is entitled under workers compensation laws, the Member agrees to reimburse MHP-FL, or its nominee, for the cost of all such services and benefits provided by MHP-FL, at Prevailing Rates, immediately upon obtaining a Monetary Recovery. Member shall hold any sum collected as a result of a workers' compensation action in trust for MHP-FL. Such a sum shall not exceed the lesser of the amount of the recovery obtained by the Member or the value at Prevailing Rates of all services and benefits furnished to the Member or on the Member's behalf by MHP-FL as a result of each incident.

### E. Automobile, Accident and Liability Coverage

If you are in an accident and have no control over where you are taken following the accident you or someone on your behalf should notify your physician or Medica Health Plans of Florida, Inc. within 48 hours, or as soon as reasonably possible.

MHP-FL shall not furnish benefits under this Agreement that duplicates the benefits of any other automobile, accident, or liability coverage. A Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage and shall notify MHP-FL of such coverage when it is available. If MHP-FL provides benefits that duplicate the benefits which the Member receives under such other coverage, the Member will reimburse MHP-FL for services and benefits provided by MHP-FL at the Prevailing Rates immediately upon obtaining a Monetary Recovery from the insurance carrier.

#### F. Services in Excess of Other Reimbursement

Should the cost of Covered Services furnished to a Member under this Health Benefit Plan in any of the circumstances described in this Section exceed the coverage or reimbursement available from the applicable third party pursuant to the provisions of this Section, MHP-FL shall provide benefits over and above such coverage or reimbursement to the extent that benefits are available under this Health Benefit Plan.

#### G. Coordination of Benefits

When a Member has other coverage, the coordination of benefits provisions and requirements of Florida Statutes apply as follows. In the event that the application of coordination of benefits rules require that coverage be primarily provided by a plan other than MHP-FL, a Member will be entitled to benefits under this Agreement, only to the extent such benefits are not provided under any other plan. The rules establishing the order of benefits determination between this Agreement and any other plan or Plan, are as follows:

1. If the other plan does not contain a coordination of benefits provision, the benefits of the other plan shall be primary with respect to the benefits of this Agreement.
2. If the other plan or Plan has applicable coordination of benefits provisions, the following rules shall apply:
  - a. The benefits of a Plan or plan that covers the Member other than as a Dependent are determined before the benefits of the Plan or plan that covers the Member as a Dependent;
  - b. Except as provided in paragraph (c) below, when two (2) or more policies or plans cover the same dependent child of different parents:  
The benefits of the Plan or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the Plan or plan of the parent whose birthday, excluding year of birth, falls later in the year; but,  
If both parents have the same birthday, the benefits of the Plan or plan that covered the parent for a longer period of time are determined before those of the Plan or plan that covered the parent for a shorter period of time.

Notwithstanding the foregoing, if a Plan or plan subject to the rules based on the birthdays of the parents as stated above coordinates with an out-of-state Plan or plan that contains provisions under which the benefits of a Plan or plan that covers a person as a Dependent of a male are determined before those of a Plan or plan that 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 Plan or plan shall determine the order of benefits.

- c. If two (2) or more policies or plans cover a Dependent Child of divorced or separated parents, benefits for the Dependent Child shall be determined as follows: First, the Plan or plan of the parent with the custody of the Dependent Child; Second, the Plan or plan of the Spouse of the parent with custody of the Child, and Third, the Plan or plan of the parent not having custody of the Child. Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of the Plan or plan of that parent has actual knowledge of those terms, the benefits of that Plan or plan are determined first, provided, however, benefits under such Plan or

plan shall not be determined first with respect to any claim determination period or plan or Plan year during which any benefit are actually paid or provided before that entity has the aforementioned actual knowledge.

d. The benefit of a Plan or plan that 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 Plan or plan that covers that person as a laid-off or retired employee or as that employee's dependent. In the event the other Plan or plan is not subject to this paragraph (d), and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph (d) shall not apply.

e. In the event the rules set forth in paragraphs (a), (b), (c), or (d) are inapplicable in determining the order of benefits, the benefits of the Plan or plan that covered the Member for a longer period of time are determined before those of the Plan or plan that covered the Member for the shorter period of time.

f. Whenever a Member of MHP-FL is also a Medicaid recipient, the HMO Coverage shall be primary to the recipients' Medicaid benefits and the organization shall be a third party.

#### H. Subrogation

As used herein, the term "Third Party" means any party that is, or may be, or is claimed to be responsible for injuries or illness to a Member. Such injuries or illness are referred to as "Third Party injuries." "Responsible Party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of Third Party injuries.

If this Plan provides benefits under this Contract to a Member for expenses incurred due to Third Party injuries, then HMO retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the Member that are associated with the Third Party injuries. HMO's rights of recovery apply to any recoveries made by or on behalf of the Member from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a Member for Third Party injuries.

By accepting benefits under this Plan, the Member specifically acknowledges HMO's right of subrogation. When this Plan provides health care benefits for expenses incurred due to Third Party injuries, HMO shall be subrogated to the Member's rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. HMO may proceed against any party with or without the Member's consent.

By accepting benefits under this Plan, the Member also specifically acknowledges HMO's right of reimbursement. This right of reimbursement attaches when this Plan has provided health care benefits for expenses incurred due to Third Party injuries and the Member or the Member's representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a Member for

Third Party injuries. By providing any benefit under Contract, HMO is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the full cost of all benefits provided by this Plan. HMO's right of reimbursement is cumulative with and not exclusive of HMO's subrogation right and HMO may choose to exercise either or both rights of recovery. By accepting benefits under this Plan, the Member and the Member's representatives further agree to:

A. Notify HMO promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party injuries sustained by the Member;

- B. Cooperate with HMO, provide HMO with requested information, and do whatever is necessary to secure HMO's rights of subrogation and reimbursement under this Contract;
- C. Give HMO a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- D. Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due HMO as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement, and regardless of whether such payment will result in a recovery to the Member which is insufficient to make the Member whole or to compensate the Member in part or in whole for the damages sustained), unless otherwise agreed to by HMO in writing; and
- E. Do nothing to prejudice HMO's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this Plan.
- F. Serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party injuries.

HMO may recover the full cost of all benefits provided by this Plan under this Contract without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from HMO's recovery, and HMO is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the Member to pursue the Member's claim or lawsuit against any Responsible Party without the prior express written consent of HMO. In the event the Member or the Member's representative fails to cooperate with HMO, the Member shall be responsible for all benefits provided by this Plan in addition to costs and attorney's fees incurred by HMO in obtaining repayment.

#### I. Recovery Rights Related to Workers' Compensation

If benefits are provided by HMO for illness or injuries to a Member and HMO determines the Member received

Workers' Compensation benefits for the same incident that resulted in the illness or injuries, HMO has the right to recover as described under the Subrogation and Right of Recovery provision. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, a workers' compensation insurance carrier, or any fund designed to provide compensation for workers' compensation claims. HMO will exercise its Recovery Rights against the Member.

The Recovery Rights will be applied even though:

- a) The Workers' Compensation benefits are in dispute or are paid by means of settlement or compromise;
- b) No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the Member's employment;
- c) The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the Member or the Workers' Compensation carrier; or
- d) The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

By accepting benefits under this Plan, the Member or the Member's representatives agree to notify HMO of any Workers' Compensation claim made, and to reimburse HMO as described above.

## XI. GENERAL PROVISIONS

### A. Premium Payments

Premiums are due as of the Premium due date of any month that Coverage is provided. Only Subscribers for whom the agreed payment is actually received within the time specified will be entitled to Coverage under this Agreement and then only for the period for which payment was received. Subject to the approval of the Office of Insurance Regulation, MHP-FL reserves the right to adjust the Premium charged to a Subscriber, prior to the Subscriber's renewal date, upon no less than thirty (30) days notice to the Subscriber. All Premium adjustments will be deemed accepted by the Subscriber unless notice of non-acceptance is received by MHP-FL any time prior to the Effective Date of the adjustment. If notice of nonacceptance is received from the Subscriber, this Agreement will terminate on the date the adjustment would have been effective.

### B. Negligence of Participating Providers

The relationship between MHP-FL and certain Participating Providers is an independent contractor relationship. In no case will MHP-FL be liable for the negligence, wrongful acts, or omissions of any independent contractor Participating Provider.

### C. Gender

The use of any gender shall be deemed to include the other gender and, whenever appropriate, the use of the singular shall be deemed to include the plural (and vice versa). The term "you" refers to the Subscriber when the context so requires.

### D. Time of Commencement or Termination

Wherever an Effective Date of commencement or termination of any part or all of the Coverage is provided, such commencement or termination shall be effective as of 12:01 AM of that date.

### E. Applications and Statements

As a Member, you agree to complete and submit to MHP-FL such applications or other forms or statements as may be requested. You further agree that (1) all such information provided to MHP-FL regarding your past and present health is true, correct, and complete to the best of your knowledge and belief, and (2) that all rights to benefits and Coverage under this Agreement are subject to the condition that all such written information is true, correct and complete to the best of your knowledge and belief.

### F. Medical Information and Confidentiality

MHP-FL is entitled to receive from any Provider of services to a Member information reasonably necessary in connection with the administration of this Agreement but subject to all applicable confidentiality requirements. By accepting Coverage under this Agreement, you authorize every Provider rendering services to disclose all facts pertaining to such care and treatment and your physical condition to MHP-FL upon request, rendering reports pertaining to the same to MHP-FL, and permitting copying of records by MHP-FL. Information from your medical records and information received from Physicians or Hospitals incident to the Physician/patient or Hospital/patient relationship will be kept confidential, except for use reasonably necessary in connection with the administration of this Agreement and to comply with governmental requirements established by law.

### G. Policies and Procedures

MHP-FL may adopt policies and procedures to promote orderly and efficient administration of this Agreement.

### H. Waiver and Notice

No agent or other person, except an officer of MHP-FL, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making a payment, or to bind MHP-FL by making any promise or representation, or by giving or receiving any information. No change in this Agreement will be valid unless signed by one of the previously mentioned officers. Any written notice under this Agreement will be sufficient when addressed to you at your address as it appears on MHP-FL records.

#### I. Amendments

This Agreement, including any and all appendices, riders and attachments, constitutes the entire agreement between the Subscriber and MHP-FL. No person is entitled to any benefits other than those specified in this Agreement. All prior representations or agreements, whether oral or written, not expressly incorporated into this Agreement are superseded. This Agreement is subject to amendment or modification by MHP-FL upon forty-five (45) days notice (or a lesser period if required to permit MHP-FL to comply with any provision of applicable law) to Subscriber.

#### J. Claims Reimbursement

In some cases Non-Participating Providers may not be willing to bill MHP-FL directly (for example, Emergency Services and Care received from other than a Participating Provider), and you may have to send an itemized bill to MHP-FL before payment can be made to the provider or reimbursement made to you. A covered expense will be considered to have been incurred on the date on which the service is rendered.

Send itemized bills, within sixty (60) days of receiving services, to:

MEDICA HEALTH PLANS OF FLORIDA, INC.  
P.O. Box 14 - 5330 Coral Gables, FL 33114 -5330

You must include your name, membership number, date of birth, and brief explanation of the reason for the claim along with the bill.

In no event will MHP-FL be responsible for claims that are submitted for payment more than one (1) year after the performance of the services, except in circumstances in which the absence of legal capacity prevents the submission of claims.

#### K. Time Limit on Certain Defenses

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

#### L. Rates to be Charged

Rates to be charged will be provided to Applicant at time of enrollment. MHP-FL will give the Subscriber written notice of any change in premium at least thirty (30) days prior to the Subscriber's renewal date.

#### M. Civil Remedy

In any civil action brought to enforce the terms and conditions of a health maintenance organization contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. This Section shall not be construed to authorize a civil action against the Department, its employees, or the Insurance Commissioner or against the Department.

#### N. Member Non-Liability

In no event shall any Member be responsible to pay for Covered Services received in accordance with the terms and conditions of this Agreement, except for Co-payments or as otherwise expressly provided in this Agreement.

#### O. Member Services Department

The Member Services Department of MHP-FL is staffed by representatives who are sensitive to the health care needs of Members. This Department is available to help Members understand this Health Benefit Plan, to help them select a Primary Care Physician, and to assist them with any concerns about using this Health Benefit Plan. To reach a Member Services Representative, call (305) 460-0675 or 1-800-719-9531 outside of Dade County.

#### P. Membership ID Card

Each Member will receive an identification card. Possession of the ID card does not entitle a Member to services or other benefits under this Health Benefit Plan. The holder of an ID card must be a Member on whose behalf all applicable Health Benefit Plan Premiums, Co-payments, and other charges have been received by MHP-FL or a Participating Provider, as the case may be. The Member should show his/her ID card each time the Member visits a Primary Care Physician or other Participating Provider. If any Member permits the use of his/her ID card by any other person, MHP-FL may immediately terminate that Member's Coverage as provided in Section IV of this Agreement.

#### Q. Governing Law

This Agreement is subject to the laws of the State of Florida, including the Health Maintenance Organization Act, codified in Chapter 641 of the Florida Insurance Code, and the regulations promulgated there under by the Office of Insurance Regulation. Any provisions required to be in this Agreement by the above laws and regulations or other laws that govern MHP-FL, the arrangement of Covered Services or the relationship between MHP-FL and the Member or Member shall bind MHP-FL and Member whether or not expressly provided in this Agreement.

#### R. Physical Examination and Autopsy

MHP-FL shall have the right and opportunity to cause an examination of the person of a Member when and as often as may reasonably be required by MHP-FL in connection with any claim for payment or demand for services made under or in connection with this Agreement and to cause the performance of an autopsy, in the case of death, unless forbidden by law.

#### S. Non-Assignability of Benefits and Agreement

This Agreement and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by the Member or any Member and shall not be subject to execution, attachment, or similar process against the Member or any Member. Notwithstanding the above, MHP-FL may, without the consent of any Member or Member, assign this Agreement to the fullest extent permitted by the laws of the State of Florida.

#### T. Validity

If any term, provision, covenant, or condition of this Agreement is held by a court or government agency of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and in no way shall be affected, impaired, or invalidated.

#### U. Attachments

This Agreement, the Evidence of Insurability, the Enrollment Application, and any appropriate Attachments attached hereto are incorporated by reference and made an integral part of this Agreement.

#### V. Misstatement on Enrollment Application

Relative to misstatements on the Enrollment Application, after two (2) years from the effective date of coverage, only fraudulent misstatements on the Enrollment Application may be used to void this Agreement or deny a claim for loss incurred or disability starting after the two (2) year period.

#### W. Waiver of Default

The waiver by MHP-FL of any one or more defaults by a Subscriber shall not be construed as a waiver of any other or future defaults, under the same or different terms, conditions, or covenants contained in this Agreement.

#### X. Entire Agreement

This Agreement contains, together with the attachments hereto referred to in Section XII.U, above, the entire understanding of the Subscriber and MHP-FL with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between the Member and MHP-FL with respect to the subject matter of this Agreement.

#### Y. Certificate of Creditable Coverage

Within thirty (30) days of a Member's last date of coverage with MHP-FL, a Certificate of Creditable Coverage will be mailed to the Member's home. This Certificate will indicate the period of time the Member was enrolled with MHP-FL and provides evidence of a Member's coverage with MHP-FL that may be needed when applying for health coverage in the future.

#### Z. Performance Outcomes and Financial Data

You may obtain information regarding performance outcomes and financial data for MHP-FL published by the State of Florida Agency for Health Care Administration by accessing the MHP-FL website [www.medicaplans4u.com](http://www.medicaplans4u.com). This website includes the link to FloridaHealthStat where this information is published, or You can go directly to [www.floridahealthstat.com](http://www.floridahealthstat.com).

## XII. CONTACT ADDRESSES AND TELEPHONE NUMBERS

Corporate Office Address: Medica Health Plans of Florida, Inc.  
4600 Ponce De Leon Blvd. Ste.750  
Coral Gables, FI 33146

Corporate Website Address: [www.mhpfl.com](http://www.mhpfl.com)

Main Telephone Number: 305-460-0600

Member Services Department: 305-460-0675 or 800-719-9531

Hearing Impaired Line: 305-421-1251 or 800-517-6923

Member Eligibility Line: 305-460-0675 or 800-719-9531

Grievance Coordinator: 305-460-0675 or 800-719-9531