FLORIDACARE HEALTH PLANS, INC
5730 SW 74th ST
Suite 200
South Miami, Florida 33143

INDIVIDUAL
PREPAID HEALTH CLINIC
MEMBER CONTRACT

FloridaCare Health Plans. Inc is a Florida corporation organized and operating as a prepaid health clinic under the laws of the State of Florida. This Contract is delivered in and governed by the laws of the State of Florida.

FloridaCare Health Plans, Inc, (hereinafter referred to as "FCHP") agrees to provide Coverage for prepaid health care clinic services and benefits to the extent described herein, to the Subscriber and the Subscriber's family members if any, subject to the terms, conditions, exclusions and limitations of this Contract. This Contract is issued on the basis of the Subscriber's application and payment of the required premium and fees.

This Contract includes the Schedules of Benefits, the Subscriber's application, and rate letters, riders, and amendments which are or may be incorporated in this Contract from time to time. Any changes in this Contract must be approved by an officer of the company and endorsed on the Contract or attached to it. Any verbal promise made by an officer or employee of FCHP or any other person, including an agent, will not be binding on the company unless it is contained in writing in this Contract or an endorsement to it.

This Contract shall take effect on the date specified on the Plan Information Page and will be continued in force by the timely payment of the required Premium when due, subject to termination of this Contract as provided herein. All Coverage under this Contract shall begin at 12:01 a.m. and end at 12:00 midnight Eastern Standard Time.

NOTE: THIS CONTRACT ONLY PROVIDES COVERAGE FOR SPECIFIC OUTPATIENT SERVICES. INPATIENT HOSPITAL SERVICES ARE NOT COVERED.

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Officer's Signature and Title

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This Prepaid Health Clinic Contract (includes this document and attachments to it, Your Membership Identification Card, Application for Coverage, and any Membership Status Change Forms) contains the terms and conditions of Member Coverage (the Covered Services that You are entitled) provided by FloridaCare Health Plans, Inc (also referred to as “FCHP”) a Florida corporation organized and operating as a prepaid health clinic under the laws of the State of Florida.

I. DEFINITIONS

"Agency" means the Agency for Health Care Administration.

"Condition" means any sickness, disease, disorder, infection, injury, or bodily dysfunction of a Member, except self- inflicted Conditions.

"Contract" means this Prepaid Health Clinic Contract.

"Contract Year" means a period of twelve (12) consecutive months as determined from the Effective Date of this Contract.

"Copayment" means the amount required to be paid by the Member prior to Covered Services being rendered as set forth in this Contract.

"Controlled Specialist" means a Plan Physician to whom the Member is referred by his or her Plan Primary Care Physician, General Practitioner or Specialist Physician for consultation, diagnostics, treatment or care.

"Coverage or Covered" means inclusion of an individual for payment of expenses related to Covered Services under this Contract.

"Covered Services" (as expressly set forth as covered, excluded or limited by this Contract) means those professional services of Plan Physicians and other Plan Providers.

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

"Dependent" means any member of the Subscriber's family who meets the eligibility requirements for coverage as set forth in Part III of this Contract.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health.

"Experimental and/or Investigational Treatment" means, for the purposes of this Contract, a drug, treatment, device, surgery or procedure that may be determined to be experimental and/or investigational if any of the following applies:

a. the Food and Drug Administration (FDA) has not granted the approval for general use; or

b. there are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

c. there is no consensus among practicing physicians that the drug, treatment, therapy, procedure or device is safe or effective for the treatment in question or such drug, treatment, therapy,

procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physician in treating other patients with the same or similar condition; or

d. such drug treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.

"Grievance" means a written complaint submitted by or on behalf of the Member to FCHP 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 Covered Services; or c) matters pertaining to the contractual relationship between a Member and FCHP.

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 Committee" means the formal structure which reviews a Grievance that has not been resolved by informal means or direct intervention of the Grievance Coordinator.

"Grievance Coordinator" means a person with problem solving authority acting on formal and informal complaints 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 Contract and the resolution of the dissatisfaction.

"Hospital" means an institution which 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, and diagnostic facilities, all of which facilities 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.

"Medically Necessary" means the use of Covered Services or supplies (as expressly limited or excluded by this Contract) provided by a Plan Provider required to identify or treat the Member's Condition and which, as determined by Our Medical Director, is: (i) consistent with the symptoms or diagnosis and treatment of the Member's Condition; (ii) appropriate with regard to standards of good Medical practice; (iii) not solely for the convenience of You or a Physician or other Health Care Professional.

"Member" means the Subscriber or an Eligible Dependent or Relative who is covered under this Contract and for whom premium has been received.

"Non-Plan Provider" means a Physician or any other duly licensed Health Care Professional that is not contracted with FCHP to provide Covered Services to FCHP Members.

“Plan Health Care Professional” means: Physicians, Specialists and other professionals engaged in the delivery of health services, who are licensed by the State of Florida and practice within the scope of that license, and who have entered into a written contract to provide Covered Services to FCHP Members.

“Plan Physician” means a Physician or osteopath who is licensed by the State of Florida and practices within the scope of that license and who has contracted with FCHP to provide or arrange Covered Services to FCHP Members.

“Plan Provider” means a Physician or Health Care Professional, organization, supplier of healthcare items, or a health care facility having a written contract with FCHP to provide medical services to a FCHP member.

“Plan Primary Care Physician (‘PCP’)” is a General Practitioner Physician who is licensed by the State of Florida and practices within the scope of that license and who has contracted with FCHP to provide or arrange Covered Services to FCHP Members and who is primarily responsible for the overall medical care of the Member.

“Plan Specialist” means a Plan Physician duly licensed to practice specialized medicine or osteopathy in the State of Florida.

“Premium” means the monthly payment made to FCHP by You, or on the Member’s behalf, that entitles the Member to the benefits outlined in this Contract.

“Relative” means a brother, sister, mother, father, uncle, aunt or first cousin of the Subscriber or the Subscriber’s spouse.

“Service Area” means the geographic area in which FCHP is authorized to provide Covered Services. FCHP’s Service Area is [Dade, Broward, Palm Beach, Orange, Osceola and Seminole] counties in the State of Florida. The Service Area may be amended from time to time to include other areas as may be approved by the Agency for Health Care Administration.

“Subscriber” means a person who has entered into a contract with Floridacare Health Plans Inc., and for whom the required premium has been received by FCHP. A Subscriber’s coverage is not effective unless approved by FCHP.

“Urgent Care” means acute medical situations which may require prompt medical attention, although not considered an emergency.

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

“Usual and Customary” is the payment methodology FCHP uses when paying Non-Plan Providers for second medical opinions. The usual and customary charge will be based on the current Medicare fee schedule.

"Waiting Period" means the period, if any, commencing from the individual's effective date of coverage, that must pass before the individual is eligible to receive Covered Services.

"We, Our" means Floridacare Health Plans, Inc.

"You, Your" means the Member.

II. HOW THE PLAN WORKS

FCHP arranges for Covered Services to be provided to members through a network of contracted Physicians and other Plan Providers. FCHP will only cover the cost of Covered Services rendered by Plan Providers. FCHP uses a PHC license to offer you covered servives, and through our Discount Medical Plan network we offer you an extensive network of Specialist at low cost to you, buy using Florida's Medicaid reimbustment as your 100% fee.

A. The Member's Primary Care Physician (PCP)

If a member requires health care services, the member should make an appointment with any General Practitioner (GP) listed in the FCHP Plan Provider Directory. Although you can elect to receive Covered Services from any general practitioner, FCHP encourages you to select and develop a relationship with one general practitioner as your Primary Care Physician (PCP) who will coordinate any diagnosis, treatment, care and progress. Your Primary Care Physician or Specialist Physician is also responsible for arranging any referrals to Controlled Specialists and other Covered Services requiring a referral.

B. Referral Requirements for Using Other Plan Providers

Except for Specialist Office Visits (not including Controlled Specialists), Urgent Care or Vision Care,, a Member may not seek care from any Plan Health Care Professional without a referral from the Member's PCP, GP or Specialist Physician. Most referrals will be made only for a single visit or service. If the Plan Physician believes that additional visits or services are required, the Plan Physician will obtain authorization from FCHP for the appropriate number of additional visits or services.

C. Additional Provider Information

1. If a Plan Physician terminates his or her contract with FCHP or is terminated by FCHP for any reason other than for cause, a member receiving active treatment may continue coverage and care with that Provider when medically necessary and 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 six (6) 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.

2. Certain types of Covered Services may be provided by Plan Physicians' physician assistants, nurse practitioners, or other individuals who are not licensed physicians.

D. When You Need Care After Regular Office Hours

Except for urgent care, if you are sick or injured after regular office hours, please call your primary care physician or general practitioner. The Plan Physician may give the Member treatment advice by telephone, prescribe medication or instruct the Member to make an appointment during office hours. If You have an emergency or urgent situation, Your Plan Physician may advise you to go to the nearest hospital emergency room or urgent care center.

E. Urgent Care

Urgent Care is a Covered Service if Medically Necessary and the care is provided in order to treat an unexpected illness or accidental injury and prevent a serious deterioration in the Member's health if treatment were delayed. Urgent Care Covered Services are limited as set forth in Section VI.

The Member is encouraged to contact his or her PCP or GP for guidance when time and circumstances permit. If the Member cannot call his or her PCP or GP, or requires care without an appointment or after office hours, the Member should go to the nearest Plan Urgent Care Center. The Member should notify his or her PCP of any treatment received for after-care and follow-up.

Urgent Care Services set forth in the Covered Services Section which are received from Non-Plan Providers or Providers located outside the FCHP Service Area are not covered.

F. Emergency Care

Emergency Care Services are not Covered Services. If such a situation arises, a Member is urged to go immediately to the nearest hospital emergency room for medical care, or call 911 You should advise your Primary Care Physician or General Practitioner of any treatment received on an emergency basis for after-care and follow-up in Your Physician's office.

G. Medical Necessity

All Covered Services provided under this Contract, as set forth in Section VI, will be provided in accordance with FCHP utilization guidelines that FCHP establishes regarding the provision of such services.

H. Membership Identification Card

The Membership Identification Card FCHP issues to a Member, is for identification purposes only. You should carry the card at all times and should present the card every time You receive health services from FCHP Plan Providers. A Member does not have to fill out any claim forms. When the Member presents his or her Member Identification Card, the Plan Provider will handle the paperwork on the Member's behalf.

Possession of a Membership Card confers no right to services or other benefits under this Contract. To be entitled to services or benefits, You must be a Member on whose behalf all applicable Premium payments under this Contract 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. A Member must not give his or her

Membership Card to any other person. FCHP may terminate the Member's coverage if he or she allows another person to use the FCHP Membership Card.

The Member must obtain Covered Services from Plan Providers only. Failure to obtain care according to the rules of this Contract, may make the Member personally responsible for payment for the services rendered.

I. Copayments

A Member is responsible for paying a portion of the cost of some Covered Services. Usually, this portion is a flat dollar amount referred to as a Copayment. Copayments are required to be paid by the Member prior to Covered Services being rendered. The Copayment requirements for this Contract are set forth in the Schedules of Benefits.

III. ELIGIBILITY AND COVERAGE EFFECTIVE DATE

A. Member Eligibility

In order to maintain eligibility as a Subscriber under this Contract, the Subscriber subject to the following requirements:

1. The Subscriber must continually live or work within FCHP's Service Area.

2. The Subscriber must remit to FCHP the applicable monthly Premium payment. Legal representatives of Members who are incapable of legally contracting must remit the applicable monthly premium on behalf of the Member under the same terms described herein.

3. The Subscriber must notify FCHP of any changes to the information requested or provided on the FCHP Member Application within thirty (30) days of the change. This information includes the Member's address, relocation out of the FCHP Service Area and eligibility or enrollment in Medicare. By electing Membership under this Contract, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting shall agree to all the terms, conditions, and provisions herein.

B. Eligibility for Dependents or Relatives

The Subscriber's Dependents and Relatives are eligible for coverage. The Dependent or Relative must live in the FCHP Service Area and reside with the Subscriber. Dependents and Relatives eligible for coverage are:

1. Spouse: The Contract-holder's lawful Spouse, or

2. Children: A child of the Member including natural children, legally adopted children, foster children, step-children, or any child who lives with the Subscriber in a normal parent-child relationship.

3. Relative: A brother, sister, mother, father, uncle, aunt or first cousins of the Subscriber or the Subscriber's spouse.

If a Subscriber wants to apply for coverage for a Dependent or Relative, please contact FCHP at 1-877-827-0711 or a FCHP agent and request a Member application. A completed application and premium must be submitted to FCHP at least 30 days of the requested coverage date.

C. Enrolling New Family Members – Coverage Effective Date

The Subscriber may add a Dependent or Relative at any time by contacting FCHP or an FCHP agent. The Dependent or Relative must complete an Application and pay any additional charges and fees, if applicable.

IV. RENEWAL AND TERMINATION OF COVERAGE

A. How Does the Member Terminate Coverage?

A Member may terminate coverage by signing (or, if a minor, having signed on his/her behalf by a legal guardian) and submitting a Membership Status Change form. This termination will be effective on the first (1st) day of the month following our receipt of such Membership status change form provided such form is received by FCHP at least five (5) business days before the end of the month preceding the month in which termination of coverage is to be effective.

B. Terms of Renewal and Termination of Coverage

FCHP may at its discretion and at any time, discontinue this contract. We will give the Member thirty (30) days written notice prior to terminating this Contract. The written notice shall state the reason or reasons for the cancellation, termination, or renewal. Coverage for each Member, including Covered Services rendered after the date of termination for Conditions arising prior to the date of termination, shall automatically terminate as set forth below:

1. The last day of any calendar month that this Contract is terminated or FCHP ceases offering this Contract to all Members.
2. Twelve o'clock midnight on the day premium is due if the premium is not paid by the end of the grace period. Coverage automatically terminates retroactive to the last paid date of coverage.
3. The date specified by FCHP that all coverage will terminate because the Member has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of this Contract.
4. The date specified by FCHP that all coverage will terminate because the Member permitted the use of his or her Membership Identification Card by an unauthorized person or used another Member's card.
5. The date a Member no longer lives or works in FCHP's Service Area. The Member is responsible for notifying FCHP of a Member's move from the Service Area. Coverage will terminate on the date of such move, even if the required notice is not provided to FCHP.
6. The date specified by FCHP that Coverage will terminate due to fraud or material misrepresentation or omission in the Member's applying for or presenting any claim for benefits.

7. The date specified by FCHP that Coverage will terminate for cause, due to disruptive, unruly, abusive or uncooperative behavior to the extent that such Member's continued Membership with FCHP impairs FCHP's ability to administer this Contract. FCHP will ascertain to the extent possible, that the behavior is not related to the use of Covered Services or mental illness and will document the problems, efforts and medical conditions. FCHP will make a reasonable effort to resolve the problem including the use of attempted use of the Grievance Procedures.
8. The date in which the Covered Dependent or Covered Relative no longer lives with the Subscriber. The Member is responsible for notifying FCHP. Coverage will terminate on the date of such move, even if the required notice is not provided to FCHP.
9. The last day of any calendar month in which the Member ceases to be eligible as a Member.

C. Coverage Alternatives after Termination

If a Member's coverage terminates, the Member may, depending on his or her situation, have the right to apply for individual coverage. Eligibility and coverage information may be obtained by calling FCHP at 305-294-9292 or by contacting an FCHP agent.

V. GRIEVANCE PROCEDURE

FloridaCare Health Plans, Inc. (FCHP) 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 FCHP.

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 FCHP "Formal Grievance/Appeal Form" requesting formal action is received by FCHP's Grievance & Appeal Administrator. You have one (1) 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

In accordance with Section 641.47(5) F.S., a complaint is an expression of dissatisfaction, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to FCHP's contract and which is submitted to FCHP or to a state agency. If you have a complaint, please discuss your concern with our Customer Service Department by calling 305-294-9292, writing to us at 5730 SW 74th Street, Suite 200, South Miami, FL 33143, or visiting FCHP during normal working hours. Every attempt will be made to resolve your concern during your initial phone call or visit or within a reasonable time.

Level 2 – Formal Grievance

If your grievance is due to an adverse determination and denied, you also have the right to request a formal grievance within thirty (30) days after 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.

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 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 and the plan.

To file a formal grievance, submit your grievance in writing or contact the Customer Service Department by calling 305-294-9292 and ask for a "Formal Grievance / Appeal Form". If necessary, a Customer Service Representative will assist you with preparing your grievance.

FCHP will acknowledge a formal grievance within five (5) business days of receipt. You will receive written notification from FCHP of the grievance outcome once a determination has been made, or within thirty (30) business days after 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, FCHP shall have an additional thirty (30) days in addition to each of the response / notice periods set forth above, to process your grievance.

Expedited (Urgent) Grievance Review

In cases where the standard 30-day grievance review timeframe 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 FCHP as specified above. This process only applies to a pre-service or concurrent denial, not a retrospective denial regarding services already rendered, other claims review, or reimbursement.

FCHP 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 review. We will decide within seventy-two (72) hours and notify you of our decision. Any verbal notice of our decision will be followed with written notice within two (2) working days.

Level 3 – Panel Review

If your formal grievance involves an adverse determination, and you disagree with our decision regarding your grievance, you may request either verbally or in writing a review by the FCHP Grievance Review Panel ("the Panel") within 30 days after receiving notice of an adverse determination. 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 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 thirty (30) additional days are needed to collect information outside the FCHP service area. If FCHP notifies the Member in writing that additional information is required for proper review of the grievance, the time for resolution of the grievance shall be tolled (delayed) until such time that the Member provides the needed information.

External Complaint

You also have the right to contact the Florida Agency for Health Care Administration and the Florida Department of Financial Services about your complaint. Their contact information is as follows:

The Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
Telephone: 1-888-419-3456

The Florida Department of Financial Services
Division of Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone: 1-877-693-5236 (Monday to Friday, 8 a.m. to 5 p.m. Eastern Time)

VI. COVERED SERVICES

All Covered Services set forth in this section and in the Schedules of Benefits must be deemed to be Medically Necessary by Floridacare Health Plans, Inc. All Covered Services are also subject to the Limitations, Exclusions and Conditions Section. Please refer to the Schedules of Benefits for terms and conditions and the applicable Copayment for each Covered Service.

Please note that if you are unable to keep your appointment, please notify the Plan Provider by calling him/her at least 48 hours in advance and re-schedule for a more convenient date and time.

Except for Specialist Physician Office Visits, Urgent Care and Vision Care, all Covered Services require a referral from your Primary Care Physician, General Practitioner or Specialist Physician before services can be rendered by a Plan Provider.

A. Primary Care Physician (PCP or GP) Office Visit. If a Member requires health care services, the Member should make an appointment with his/her Plan Primary Care Physician (PCP) or General Practitioner (GP). An office visit includes a consultation and/or an examination for a medical condition. Any NON Covered Services performed during an office visit is subject to a separate Copayment as set forth in the Schedules of Benefits. Whenever a Medically Necessary Covered Service is needed and cannot be provided by your PCP or GP, he/she will provide you with a referral to another Plan Provider.

B. Specialist Physician Office Visit. Examinations and consultations performed by a Plan Specialist are Covered Services. Any Covered Services performed during an office visit is subject to a separate Copayment as set forth in the Schedules of Benefits. Whenever a Medically Necessary Covered Service is needed and cannot be provided by the Specialist, he/she will provide you with a referral to another Plan Provider. The following Plan Providers are considered Specialist Physicians:

*Podiatry*Internal Medicine *Pediatric*Dermatology*Gynecology*Ophthalmology*Orthopedic*Urology

*Please note that all Plan specialists may not be available in all Service Areas.

C. Controlled Specialist Office Visit. Some examinations and consultations are Covered Services when referred by the Member's PCP, GP or Specialist Physician and the services are authorized by FCHP. Please refer to Schedural of Benifits The following Plan Providers are considered Controlled Specialists:

*Gastroenterology*Psychiatry*Cardiology*Otorhinolaryngology (ENT)*Surgeons
*Endocrinology*Pulmonology*Neurology

*Please note that all Plan specialists may not be available in all Service Areas.

D. Diagnostic Procedures. Invasive and non-invasive diagnostic procedures must be Medically Necessary and performed in a Plan Physician's office or with a written referral to another Plan Provider. Please consult the Diagnostic Procedure Schedule of Benefits for Covered Services and Copayments.

E. Control Panels.

1. Panels A, B, C, D, and F: After a three (3) month waiting period commencing from the member's coverage effective date, a member is eligible to have one of Panels A-F every 3 months per contract year. Panels A-F cannot be repeated and/or accumulated during each contract year. The procedure must be performed in a Plan physician/specialist's office or Plan diagnostic center upon referral from a Plan Physician.

2. Panel H: After a one (1) month waiting period commencing from the member's coverage effective date, a member is eligible to have lab tests performed three times per contract year. The lab tests must be medically necessary and be performed in the member's primary care physician or general practitioner's office.

Procedures from Panel H cannot be used less than three months between office visits but can be combined with procedures from Panel A-F.

3. Panel I: After a one month waiting period commencing from the member's coverage effective date, a member is eligible to have procedures described in Panel I performed. This panel has a $200.00 credit every contract year. This credit does not accumulate. The procedure must be performed in a Plan Physician/Specialist's office or Plan diagnostic center upon referral from a Plan Physician and with the exception of child immunizations and flu shots, must be medically necessary.

4. Panel J: After a one month waiting period commencing from the member's coverage effective date, a member is eligible to have dental procedures described in Panel J performed, the panel is available once per contract year and must be performed in the Plan Provider's office.

G. Urgent Care Services. IS NOT A COVERED BENEFIT

H. Endoscopic Procedures. IS NOT A COVERED BENEFIT

I. Vision Care Services. Members may choose from 2 options. Each option includes a vision exam per calendar year

2018 Benefits-At-A-Glance Silver

Schedule of benefits for FloridaCare by Plan	
PCP*	MEMBER PAY
Annual Wellness Visit	$0 Copay
One Sick Visit per Calendar year	$0 Copay
Unlimited follow up visits	$25 Copay
INCLUDED IN WELLNESS VISIT	
Obesity Screening and Management (all adults via body mass index BMI)	$0 Copay
HPV DNA Testing	$0 Copay
Colorectal cancer (fecal occult blood testing)	$0 Copay
Hepatitis B and C Screening	$0 Copay
Diabetes (Type 2)	$0 Copay
Lipid disorders	$0 Copay
Screening for pregnant women	$0 Copay
Iron deficiency anemia screening	$0 Copay
Abdominal aortic aneurysm screening (men 65-75 never smoked)	$0 Copay
Reproductive health screenings (HIV, Gonorrhea, Syphilis, Chlamydia)	$0 Copay
Hypertension and Blood Pressure Screening	$0 Copay
VISION*	MEMBER PAY
Option 1 = Free Eyeglasses Annually OR Option 2 = $50 Allowance towards any eyewear including contact lenses	$0 CoPay
Eye Exam a calendar year	$0 CoPay
Contact lens per calendar year	$0 CoPay
DENTAL*	MEMBER PAY
Full mouth x-ray	$0 CoPay

One Fluoride treatment	$0 CoPay
Oral Exam	$0 CoPay
Two simple extraction	$0 CoPay
Regular cleaning	$0 CoPay
Two fillings of one surface	$0 CoPay
LABS*	MEMBER PAY
CBC	$0 CoPay
THS	$0 CoPay
Lip Panel	$0 CoPay
Urine	$0 Copay
Uric Acid	$0 CoPay
Comp Metabolic Panel	$0 CoPay
Blood Panel	$0 CoPay
Prostate-Specific Antigen (PSA)	$0 CoPay
Pap Testing (women 18 and older + with cervix) (After 3 months membership)	$0 CoPay
PSYCHIATRIST*	MEMBER PAY
One office visit per calendar year	$0 CoPay
Follow Up- Visits	Medicaid Reinburstment Amount
Behavioral Counseling	$0 CoPay
Tobacco counseling and cessation interventions	$0 CoPay
Intimate partner violence screening and counseling	$0 CoPay
Alcohol misuse screening and counseling	$0 CoPay
Breastfeeding supports(equipment rental,counseling, Consultation with trained provider)	$0 CoPay
Skin Counseling	$ 0 CoPay
DIAGNOSTICS*	MEMBER PAY
Mammography (women over 40, after 3 months of membership)	$0 CoPay

One ultrasound a calendar year after 3 months of membership.	$0 CoPay
MRI at no cost every three-calendar year, after 1 year of membership	$0 CoPay
CT scans for preventive digital (1 per calendar year) After 1 year of membership	$0 CoPay
Lung cancer screening annual tomography (adults 35-80 with history) After 3 months of membership	$0 CoPay
Osteoporosis screening (After 3 months of membership)	$0 CoPay
EKG (After 3 months of membership)	$ 0 CoPay

VII. LIMITATIONS, EXCLUSIONS AND CONDITIONS

All Covered Services must be provided by or arranged for by the Member's Primary Care Physician or Plan General Practitioner. Covered Services that are not provided by or arranged for by the Member's PCP or Plan General Practitioner are excluded. Additionally Services not covered in the schedule of benefits are specifically excluded from coverage under this Contract.

VIII. THIS CONTRACT AND OTHER PLAN PAYMENT ARRANGEMENTS

A. Subrogation

Sometimes, the situations that cause a Member to need the Covered Services provided under this Contract, also result in actions by the Member to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that FCHP has already provided to the Member. To protect FCHP from this type of duplicate payment, FCHP reserves the right to get involved in that recovery process. FCHP's right to get involved is called "subrogation".

1. If FCHP has paid for services or supplies to a Member under this Contract, the Member will, to the extent of such services or supplies rendered, have subrogated FCHP to all causes of action and rights of recovery that the Member may have or has against any persons and/or organizations that are related to the incident that necessitated the rendering of the services or supplies. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.

2. The Member must promptly execute and deliver instruments and papers related to these subrogation rights as may be requested by FCHP. Further, the Member shall promptly notify FCHP of any settlement negotiations prior to entering into a settlement agreement affecting FCHP's subrogation rights.

3. In no event should a Member fail to take any action where action is appropriate, or take any action that may prejudice FCHP's subrogation rights. No waiver, release of liability, settlement, or

other documents executed by a Member without prior notice to and approval by FCHP, shall be binding upon FCHP.

4. FCHP retains the right to recover such payments and/or the reasonable value of the benefits provided from any person or organization to the fullest extent permitted by law.

B. Right to Receive and Release Information

FCHP has the right to receive and release necessary information. By accepting coverage under this Contract, the Member gives permission for FCHP to obtain from or release to any insurance company or other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a claim and to implement
such provisions. FCHP may obtain or release this information without consent from or notice to anyone. Any person who claims benefits under this Contract agrees to furnish to FCHP information that may be necessary to implement this provision.

C. Facility of Payment

Whenever payment which should have been made by FCHP is made to any other person, plan, or organization, FHCP shall have the right to pay to that other person, plan or organization any amounts FCHP determines to be necessary under this provision. Amounts paid to another plan in this manner will be considered benefits paid under this Contract. FCHP is discharged from liability under this Contract to the extent of any amounts so paid.

D. Right of Recovery

If FCHP makes larger payments than are required under this Contract, then FCHP has the right to recover any excess benefit payment from any person to whom such payments were made.

E. Non-Duplication of Government Programs

The benefits of this Contract shall not duplicate any benefits that are received or paid to the Member under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Law, to the extent allowed by law. In any event, if this Contract has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to FCHP to the extent of such duplication.

F. Workers' Compensation

This Contract does not affect or take the place of Worker's Compensation.

G. Non-Duplication of Other Coverage

The benefits under this Contract do not duplicate any benefits to which Members are entitled by law, and/or for which they are eligible under any extension of benefits and/or coverage provisions of any other plan, policy, program, or contract.

H. Cooperation of Members

Each Member shall cooperate with FCHP, and shall execute and submit to FCHP such consents, releases, assignments, and other documents as may be requested by FCHP in order to administer and exercise its rights under the subrogation provision or to process claims. Failure to do so may result in the reduction of benefit payments under this Contract.

I. Coordination of Benefits

In the event that the application of coordination of benefit rules require that coverage be primarily provided by a Plan other than this FCHP Contract, a Member will be entitled to benefits under this Contract, only to the extent such benefits are not provided under any other Plan. The rules establishing the order of benefits determination between this Contract and any other Policy 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 Contract.

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 which covers the Member other than as a Dependent are determined before the benefits of the Plan or Plan which covers the Member as a Dependent;

b. Except as provided in paragraph (c) below, when two or more policies or Plans cover the same dependent child of different parents:

i. 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,

ii. If both parents have the same birthday, the benefits of the Plan or Plan which covered the parent for a longer period of time are determined before those of the Plan or Plan which 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 which contains provisions under which the benefits of a Plan or Plan which covers a person as a Dependent of a male are determined before those of a Plan or Plan which covers the person as a Dependent of a female, and if as a result, the policies or Plans do not agree on the order of benefits, the provisions of the other Plan or Plan shall determine the order of benefits.

c. If two or more policies or Plans cover a dependent child of divorced or separated parents, benefits for the dependent child shall be determined as follows:

i. First, the Plan or Plan of the parent with the custody of the dependent child;

ii. Second, the Plan or Plan of the spouse of the parent with custody of the child, and

iii. 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 which covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a Plan or Plan which 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 which covered the Member for a longer period of time are determined before those of the Plan or Plan which covered the Member for the shorter period of time.

f. Whenever a Member under this Contract is also a Medicaid recipient, FCHP shall be primary to the recipient's Medicaid benefits and FCHP shall be a third party to the provisions of s.409.910(4)

X. PREMIUM PROVISIONS

A. Acceptance

By electing Membership under this Contract, a Member legally capable of contracting and the legal representatives of any Member incapable of contracting shall agree to all the terms, conditions, and provisions herein.

B. Premium Payments

Premiums are due as of the premium due date of any month that coverage is provided. Only Members for whom the agreed payment is actually received by FCHP within the time specified will be entitled to coverage under this Contract and then only for the period for which payment was received. Subject to the approval

of the Florida Department of Financial Services, FCHP reserves the right to adjust the premium charged to a Member upon thirty (30) days notice to the Member. All premium adjustments will be deemed accepted by the Member unless notice of non-acceptance is received by FCHP any time prior to the effective date of the adjustment. If notice of non-acceptance is received from the Member, this Contract will terminate on the date the adjustment would have been effective.

C. Grace Period

This contract has a thirty (30) day grace period. This means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period immediately following the premium due date. During the grace period, the contract will stay in force. The grace period does not apply if the Subscriber has given FCHP notice that the contract is to be terminated prior to the premium due date.

Any payment received after the grace period will be returned to the Subscriber. A Subscriber whose coverage has been terminated due to non-payment of premium is allowed to apply for coverage with FCHP once immediately after cancellation. If a Subscriber is cancelled a second time for non-payment of premium, he/she must wait 30 days before re-applying for coverage. A Subscriber will not be eligible for coverage if coverage is cancelled three times for non-payment of premium. An individual re-applying for coverage under these guidelines must complete a new enrollment application which is subject to the regular policies and procedures of FCHP for evaluating membership, which will include medical underwriting.

X. GENERAL PROVISIONS

A. Negligence of Plan Providers

The relationship between FCHP and Plan Providers is an independent contractor relationship. In no case will FCHP be liable for the negligence, wrongful acts, or omissions of any independent contractor Plan Provider or Plan Physician.

B. Applications and Statements

As a Member, You agree to complete and submit to FCHP such applications or other forms or statements as FCHP may request. The Member further agrees that (1) all such information provided to FCHP regarding the past and present health of the Member is true, correct, and complete to the best of his or her knowledge and belief, and (2) that all rights to benefits and coverage under this Contract are subject to the condition that all such written information is true, correct and complete to the Member's knowledge and belief.

C. Medical Information

FCHP is entitled to receive from any provider of services to a Member, information reasonably necessary in connection with the administration of this Contract but subject to all applicable confidentiality requirements. By accepting coverage under this Contract, You authorize every provider rendering services to disclose all facts pertaining to such care and treatment and the Member's physical condition to FCHP upon request, render reports pertaining to the same to FCHP, and permit copying of records by FCHP. Information from the Member's 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 Contract and to comply with governmental requirements established by law.

D. Waiver and Notice

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

E. Entire Contract

This written Contract is the agreement between the Member and FCHP whereby coverage and benefits specified herein will be provided to the Member. This Contract includes all applications, rate letters, face sheets, riders, amendments, addenda, and exhibits which are or may be incorporated in this Contract from time to time. A Member is not entitled to any benefits other than those specified in this Contract. All prior representations or agreements, whether oral or written, not expressly incorporated into this Contract are superseded. This Contract is subject to amendment or modification by FCHP upon thirty (30) days written notice to the Member (or a lesser period if required to permit FCHP to comply with any provision of applicable law).

F. 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 this Contract or deny any claim for loss incurred or disability starting after the 2-year period.

G. Civil Remedy

In any civil action brought to enforce the terms and conditions of the FCHP 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 of Financial Services, its employees, or the Department's Chief Financial Officer.

H. Assignment

Neither this Contract, nor the benefits provided under this Contract, may be assigned except as otherwise specifically described in this Contract.