American Care Health Flex Plan

11255 SW 211 Street
Miami, Florida 33189-2240
Member Services: 1.888.240.6745

INDIVIDUAL SERVICE AGREEMENT

THIS AGREEMENT sets forth the health services provided by American Care Health Flex Plan (hereinafter referred to as the “Plan”) to the extent herein defined and limited. In consideration of the Application made by

_____
(Hereinafter referred to as the “Individual”)

A copy of which is attached hereto and made a part of this Agreement, and in consideration of payment by the Individual of the appropriate premiums, the Plan hereby agrees to provide the services and benefits described herein commencing on the effective date shown hereon.

"The benefits provided by this health plan are limited. You should carefully review the benefits offered under this health plan."

IN WITNESS WHEREOF, the Plan has caused this Agreement to be executed this _____ day of _____, 20_____

AMERICAN CARE HEALTH FLEX PLAN

Jose E. Garcia, MD
President and Chief Executive Officer

Effective Date: _____

SECTION I

DEFINITIONS

AGREEMENT means the health services Agreement between the Individual Subscriber and the Plan.

BONE MARROW TRANSPLANT means human blood precursor cells administered to a patient to restore hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood.

CALENDAR YEAR is a period of one year, which starts on January 1 and ends on December 31

COPAYMENT means a specified dollar amount the Covered Person must pay directly to the plan Provider for specified services at the time services are to be rendered.

COVERED SERVICE means those services and supplies described in Section IV and V, which are not otherwise excluded or limited by this Agreement. In order to be a Covered Service, the service must be rendered by a Plan Provider in accordance with the referral and approval procedures described herein.

CUSTODIAL CARE means services rendered in the home or in any type of facility that primarily involve assistance with feeding, bathing, dressing or other normal activities of daily living regardless of the illness or injury necessitating such services.

ELIGIBLE DEPENDENT means the Subscriber's:
a. spouse by legal marriage;
b. unmarried child under age 27; and

Eligible Dependents do **not** include any spouse or child:
a. whose legal residence is outside of the Service Area;
b. who spends more than 90 consecutive days in any year outside the United States, whether for work or pleasure;
c. who is in the armed forces of any country; or

EMERGENCY MEDICAL CONDITION means:
a. a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of medical attention could reasonably be expected to result in any of the following:
   1. a serious jeopardy to the health of a patient, including a pregnant woman or fetus;
   2. serious impairment of bodily functions, bodily organ or part.
b. With respect to a pregnant woman, an Emergency Medical Condition also means:
   1. that there is insufficient time to effect safe transfer to a Plan Hospital prior to delivery; that such a transfer may pose a threat to the health and safety of the patient or fetus; or
   2. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES means medical screening, examination, and evaluation by a Physician, or other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists. If an emergency exists, the treatment for a covered service by a Physician necessary to treat the Emergency Medical Condition, within the service capability of the Hospital.

ENROLLED DEPENDENT means a Dependent who has met the health flex requirements and is properly enrolled for coverage under this Agreement.

ENROLLMENT APPLICATION means the completed forms signed by the Subscriber providing required information to the Plan, listing all dependents that are to become Covered Persons.

HOME HEALTH CARE means health care services by a Home Health Care Agency for the care and treatment of the patient who is under the direct care and supervision of a Physician. Requires that a treatment plan be established in writing and approved by a Physician.

HOME HEALTH CARE AGENCY means a home health care agency duly licensed as a Home Health Care Agency under the laws of the State in which it is located or an agency operated by state or local government which provides Home Health Services in the home through its employees in accordance with applicable laws.

HOME HEALTH SERVICES means:
a. intermittent skilled nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
b. intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse

(R.N.) or a physical, speech, or occupational therapist;
c. physical, occupational, or speech therapy; and
d. medical supplies, drugs, medicines and related pharmaceutical and laboratory services that are prescribed by a Physician.

HOSPICE mans an agency or organization that is licensed pursuant to the laws of the State in which services are rendered to provide counseling and medical services and may provide room and board to a terminally ill person.

HOSPITAL means an institution that:
a. is licensed and operated as a hospital under the laws of the State where it is located; and
b. is accredited as an allopathic hospital by the Joint Commission on accreditation of Health Care Organizations or accredited as an osteopathic hospital by the American Osteopathic Association.

ILLNESS means a bodily or mental disorder, and any condition Centers for Disease Control (CDC) has determined to be diseases and conditions.

INDIVIDUAL EFFECTIVE DATE means the date from which a Covered Person is entitled to receive services from the Plan.

INJURY means an accidental bodily injury that is caused directly and independently of all other causes. Injury does not include intentional self-inflicted injury or attempted self-destruction, whether sane or insane.

INPATIENT HOSPITAL SERVICE means the Medically Necessary services and supplies furnished to a person when such person is registered as an inpatient in the Hospital.

MEDICAL DIRECTOR is a Physician employed by the Plan to direct the Plan on issues requiring medical opinion, or his or her appointed designee.

MEDICALLY NECESSARY means those Covered Services determined by the Plan's Medical Director to constitute a medical necessity. The Plan's determination of medical necessity shall be based upon consideration of whether services: (i) are appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; (ii) provide for the diagnosis or direct treatment of a medical condition; (iii) are not primarily for the convenience of the Covered Person, the Covered Person's family, attending or consulting Physician, or other health care provider; (iv) are in accordance with standards of good medical practice within the community in which such services are provided; (v) are the most appropriate, efficient and economical medical supply, service, or level of care which can be safely provided.

OUTPATIENT SERVICES means those institutional services rendered to a Covered Person who is not a Hospital Inpatient or resident of a Skilled Nursing Care Facility at the time services are rendered.

PHYSICIAN is an individual who is duly licensed to provide medical services by the State(s) in which he or she practicing.

PHYSICIAN'S SERVICES are professional services rendered by a Physician that are reasonable and necessary for the diagnosis or treatment of an illness of injury.

PLAN means American Care Health Plan.

PLAN HOSPITAL is a Hospital that has agreed in writing with the Plan to render services to Covered Persons.

PLAN PROVIDER means Hospitals, Physicians, Podiatrists, Chiropractors and other providers of health care goods and services who have agreed in writing with the Plan to render services to Covered Persons.

PLAN PHYSICIAN means a Physician who has agreed in writing with the Plan to render services to Covered Persons.

PLAN PHYSICIAN OFFICES means the offices and clinical facilities operated by or for Plan Physicians to provide services to Covered Persons under this Agreement.

PRE-EXISTING CONDITION means: (i) any illness or Injury for which a Covered Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, during the two year period just before his or her Individual Effective Date of coverage; or (ii) a Covered Person's pregnancy existing on the Individual Effective Date of Coverage for that person.

PREMIUM means the amount charged by the Plan for all benefits and services covered under the Agreement.

PRIMARY CARE PHYSICIAN means designated Plan Physicians, from which the Covered Person chooses to be responsible for providing, prescribing, authorizing, and coordinating all medical care of the Covered Person.

SERVICE AREA means counties in Florida in which American Care has been authorized by the Department of Insurance to operate.

SKILLED NURSING FACILITY means an institution that is licensed by the state where it is located and operated as a Skilled Nursing Facility as defined by State laws;

SPECIALIST means any health professional who has a written agreement with the Plan to render services to Covered Persons and to whom a Covered Person is referred for consulting or treatment by the Covered Person's Primary Care Physician.

SUBSCRIBER means the Eligible Employee who has enrolled in the Plan.

SUBSCRIBER IDENTIFICATION CARD means the document of identification issued by the Plan.

USUAL, CUSTOMARY AND REASONABLE means charges for Covered Services, which, as determined by the Plan, are representative for the geographic area in which the Covered Service was rendered by consulting data such as the Medicare fee schedule.

SECTION II

EFFECTIVE DATE AND TERMINATION OF AGREEMENT

1) Effective Date. This Agreement shall become binding upon the parties hereto on the date of its execution and shall become effective as an Individual Subscriber Service Agreement on the effective date indicated on page one of this Agreement; subject, however to the conditions precedent listed thereon. The Plan may change the monthly Premiums hereunder whenever the terms of the Agreement are changed by endorsement or as of the Agreement renewal date upon giving 45 days prior notice to the Individual Subscriber.

2) Termination of Agreement. This Agreement may be terminated by the Individual Subscriber with no less than 30 days written notification to the Plan. The termination will become effective at the end of the month for which the last premium was paid. The Plan may terminate or non renew the Agreement with no less than 45 days written notification to the Individual Subscriber, except that 10 days written notice will be provided for non-payment of premium. Such notification shall include the reasons for termination or non-renewal. However, in the case of non-payment of Premiums, the Plan may terminate the Agreement immediately with written notification.

3) Payment of Premiums, Grace Period. Payments of Premiums are due on the first of each calendar month. A grace period of 10 days will be allowed for payment of Premiums. Grace Period means that if any required Premium is not paid before the date it is due, it may be paid during the following Grace Period. This Agreement will stay in force during the Grace Period. If payment is not received upon the completion of the Grace Period, the Plan shall terminate the Agreement effective the last month the Premium was paid. The Individual Subscriber must pay all unpaid Premiums, including those of the Grace Period.

4) Reinstatement. The Individual Subscriber may make a written request to the Plan for reinstatement after the end of the Grace Period. Reinstatement shall occur no sooner than 4 months after termination date. The effective date of such reinstatement will be the date of acceptance in writing by the Plan. Reinstatement is made upon the sole discretion of the Plan.

5) Effect of Termination. In the event of termination of this Agreement by the Individual Subscriber, all Covered Persons' benefits shall be terminated as of the effective date of termination. This Agreement shall have no force or effect as of the date of termination.

SECTION III

INDIVIDUAL ENROLLMENT, EFFECTIVE DATE, TERMINATION OF COVERAGE

1) Subscriber and Dependents Enrollment,
Eligible Subscribers and Dependents must complete and sign an Enrollment Form.

2) Eligibility Criteria

Per Florida Statute 408.909. Eligibility to enroll in an approved health flex plan is limited to residents of this state who: (1) Open to all ages (As of May 2011 there are no age restrictions for HealthFlex); (2) Have a family income equal to or less than 300 percent of the federal poverty level; (3) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that:

a. A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 which was also an approved health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or

b. A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met.

3) Effective Date of Coverage.
a. Individual Subscribers who submit their completed Enrollment Form and pay their Premium shall be covered upon their Individual Effective Date and are subject to this Agreement. The Plan shall not expel or refuse to renew the coverage of nor refuse to Eligible Dependents on the basis of the race, color, creed, marital status, sex, or national origin. Also, the Plan shall not expel or refuse to renew the coverage of a Covered Person on the basis of such Covered Person's age, health status, health care needs or prospective cost of health care, services of the Covered Person.
b. Adopted Children. Benefits will be provided to a Subscriber's adopted child, if such child is placed prior to his or her 18th birthday in compliance with Chapter 63, Florida Statutes.
c. Newborn children. Newborn children born to Subscribers or the Subscriber's Enrolled Dependent after the Individual Effective Date and prior to termination shall be covered under the terms of this Agreement. The Subscriber must notify the Plan in writing of change of coverage within 30 days of the birth of the newborn child (the "Birth Notice Period") in order for no additional premium to be charged for the Birth Notice Period.

4) Re-Enrollment After Termination. A Subscriber and/or Dependent(s) who is terminated by such Subscriber may request re-enrollment.

5) Termination of Coverage. Coverage cannot be terminated due to the amount, variety, or cost of services required by a Covered Person. Coverage can be terminated due to the following: a) The enrollee no longer qualifies under the Health Flex eligibility standards as specified in Section 408.909 of the Florida Statutes. b) Nonpayment of premium. c) Complete termination of Health Flex plan business by filing entity. d) or that the pilot program was not extended.

6) Exceptions to Termination of Coverage.
a. If an Eligible Dependent child's coverage is due to be terminated because of the child's attainment of the applicable limiting age as set forth in Section I, 8, of this Agreement (the "Limiting Age"), but the child cannot support himself or herself due to physical disability or mental retardation and is dependent on the Subscriber, coverage will continue during such incapacity as long as:
1. the child's Premiums are paid;
2. the Subscriber's coverage remains in effect;
3. the Plan is provided with proof of the child's incapacity when coverage is denied due to the child's attainment of the Limiting Age.

7) Extension of Benefits
Not a Covered Benefit. No extension of benefits beyond the termination of this Agreement.

SECTION IV

CREDITABLE COVERAGE

The plan does not constitute Creditable Coverage, as defined in Section 627.6561, Florida Statutes. This plans covers limited services only, and does not constitute comprehensive health care coverage.

SECTION V

HOSPITAL AND RELATED BENEFITS

1) HOSPITAL BENEFITS Not a covered benefit

2) ALCOHOLISM AND DRUG DEPENDENCY Not a Covered Benefit

3) SKILLED NURSING FACILITY Not a Covered Benefit

4) HOME HEALTH CARE BENEFITS Not a Covered Benefit

5) HOSPICE CARE Not a Covered Benefit

6) TRANSPLANT SERVICES Not a Covered Benefit

7) MENTAL HEALTH AND NERVOUS DISORDERS Not a covered benefit. Only services provided by the primary care physician for these disorders are covered.

8) MATERNITY SERVICES Not a Covered Benefit

SECTION VI

MEDICAL AND SURGICAL SERVICES

Covered Persons shall select a Primary Care Physician from those Physicians listed in the Provider Directory. Specialist physician care is NOT a covered benefit.

On or after the Individual Effective Date a Covered Person is entitled, subject to the Exclusions and Limitations in Section VII and the provisions below, to services and care when reasonable and necessary for the diagnosis or treatment of an Illness or Injury.

1) PHYSICIAN'S SERVICES
a. Consultation, examination and treatment by a Plan Physician at a Plan Physician's Office. See attached provider network for participating providers.
b. Periodic health assessment, to include adult health examinations, medical history, physical examination, necessary laboratory, x-ray and other screening or diagnostic tests as indicated by the age, sex, medical history, or physical examination of the Covered Person when deemed beneficial and provided or ordered by a Plan Physician in accordance with the Plan's standard protocols.
c. Child Health Supervision Services.

2) SURGICAL SERVICES
Outpatient surgical services performed at the Primary Care Physicians Office are covered. Only office based surgical procedures listed in the summary of benefits are covered.

3) NEWBORN **CHILDREN.** Services for newborn children consist of well baby care and diagnosis and treatment of Injury or Illness as outpatient patients only.

4) OUTPATIENT DIAGNOSTIC SERVICES. Outpatient diagnostic services as listed in the Service Agreement.

5) MAMMOGRAPHY SCREENING. Mammography screening as follows:
a. a baseline mammography for women ages 35 to 39;
b. a mammography for women ages 40 to 49 every 2 years or more frequently based on the recommendation of the Plan Physician;
c. a mammogram every year for women age 50 to 64; and
d. if a woman is more at risk for breast cancer due to family history, a history of biopsy-proven benign breast disease, a mother, sister, or daughter who has had breast cancer, or a woman who has not given birth before age 30.

6) OUTPATIENT THERAPIES. Physical and respiratory therapies provided at Primary Care Physician office only. It shall not exceed 60 days in one Calendar Year.

7) RADIATION THERAPY. Not a Covered Benefit.

8) HEARING EXAMS. One hearing exam per Calendar Year, with the purpose of determining the need for hearing correction.

9) VISION SCREENING. Vision screening performed by the Primary Care Physician, limited to one per Calendar Year.

10) INFERTILITY SERVICES. Not a Covered Benefit

11) FAMILY PLANNING. Family planning limited to physician services for prescription.

12) EYE EXAMINATIONS. Eye examination for disease of the eye deemed Medically Necessary by the Primary Care Physician. Eyeglasses and contact lenses are not covered benefits.

13) PROSTHETIC DEVICES. Not a Covered Benefit

14) BRACES. Not a Covered Benefit

15) DURABLE MEDICAL EQUIPMENT (DME) AND DISPOSABLE MEDICAL SUPPLIES. Not a Covered Benefit

16) BLOOD. Not a Covered Benefit

17) CHIROPRACTIC SERVICES. Not a covered benefit.

18) DIABETES. Limited to Physician Services for diagnosis, prescriptions and covered medications, including laboratory testing. Refer to formulary for covered medications. Supplies and equipment are not a Covered Benefit under the basic plan.

19) ORAL SURGICAL SERVICES. Not a Covered Benefit

20) RECONSTRUCTIVE SURGERY. Not a Covered Benefit

21) AMBULANCE. Not a Covered Benefit

22) HOSPITAL BASED PHYSICIAN. Not a Covered Benefit

23) SECOND MEDICAL OPINION. Each covered person is entitled to request a second medical opinion from a Plan Physician with the stipulation that the Covered Person pays all applicable Co-Payments.

24) PODIATRIC SERVICES. Not a covered service.

25) OSTEOPOROSIS. Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals, including (i) estrogen deficient individuals who are at clinical risk for osteoporosis; (ii) individuals who have vertebral abnormalities; (iii) individuals who are receiving long-term glucocorticoid (steroid) therapy; (iv) individuals who have primary hyperparathyroidism; and (v) individuals who have a family history of osteoporosis. Limited to physician services, laboratory and radiology testing and prescription.

SECTION VII

EMERGENCY MEDICAL CONDITIONS IN OR OUT OF THE SERVICE AREA

1) EMERGENCY CARE AND SERVICE. Not a Covered Benefit when rendered at a Hospital or a non-participating facility. Covered only when rendered at an American Care medical center.

2) HOSPITAL, MEDICAL AND SURGICAL SERVICES. Not a covered benefit.

3) AMBULANCE SERVICES. Not a Covered Benefit

4) EMERGENCY ROOM. Not a Covered Benefit

5) OUT-OF-SERVICE AREA BENEFITS. Not a Covered Benefit

6) HOSPITAL TRANSFER. Not a Covered Benefit

SECTION VIII

EXCLUSIONS AND LIMITATIONS

NO BENEFITS OR COVERAGE ARE PROVIDED FOR THE FOLLOWING SERVICES:

1) EXCLUSIONS
a. Services not provided, arranged, or authorized by a Plan Physician;
b. Hospital or Skilled Nursing Facility expenses;
c. Covered Services received outside the Service Area;
d. For any service or supply received in connection with a facility or program operated, or for which payment is made, by federal or state government or any agency or subdivision thereof and/or when a Covered Person has no legal obligation for payment;
e. Services solely for the personal comfort of the Covered Person;
f. Any inpatient surgery or outpatient surgical center;
g. Any hospitalization or emergency room services;
h. Dental services;

i. Treatment of learning disabilities, mental retardation, and other developmental disorders including, but not limited to, learning disorders, motor skills disorders, communication disorders, and autistic disorders;
j. Items or services determined to be investigational or experimental by the Plan Medical Director in accordance with standards of the American Medical Association, the Food and Drug Administration, the National Institutes of Health or other organization recognized by the Plan;
k. Examinations for insurance, employment, flight physical, travel, or school, unless the service is within the scope of, and coincides with, a periodic health assessment as provided; or services provided to evaluate scholastic and/or occupational ability, performance or potential;
l. Services that are payable in part or in whole under any Workers' Compensation Act or similar law;
m. Pregnancy or termination of pregnancy;
n. Physical, respiratory, occupational, or speech therapy;
o. Any services related or ordered by a court of law, unless medically necessary;
p. Treatment for intentional self-inflicted Injury or attempted self-destruction, whether sane or insane;
q. Items or services incurred as a result of voluntary participation in an assault, felony, insurrection, or riot;
r. Acupuncture, acupressure, hypnosis, or biofeedback;
t. Services for the treatment of any kind of addiction;
u. Services whose primary purpose is the treatment of sexual dysfunction, gender change, or treatment for gender identity, disorders; or medical or surgical treatment to improve or restore sexual function;
v. Home Health Care;
w. Services or treatment provided by a person or facility, which is not properly approved or licensed as required;
x. Services rendered out of the Service Area;
y. Any DME products;
z. Any services not stated as a Covered Service in Section IV or V;
aa. Treatment and/or evaluation of complications arising from any non-covered services;
ab. Travel or lodging of any kind;
ac. Services or supplies not medically necessary;
ad. Pre-existing conditions prior to 92 days from the effective date;
ae. Treatment of any Illness or Injury due to war or any act of war, declared or undeclared, and any illness or Injury due to the services in the armed services;
af. Pre-conception testing or genetic testing.

2. LIMITATIONS

THE FOLLOWING LIMITATIONS ARE IN ADDITION TO ANY BENEFIT LIMITATIONS DESCRIBED IN ARTICLES IV AND V.

A. Major Disasters
In the event of any major disaster, epidemic, war, riot, or civil insurrections, the Plan Physician shall render medical services. Neither the Plan nor its Physicians shall have any liability or obligation for delay or failure to provide medical services.
B. Pre-existing Conditions Limitations
Pre-existing Conditions Limitation applies to an Eligible Subscriber and an Eligible Dependent.
Primary care physician services have no pre-existing conditions.
If the Eligible Subscriber and/or Eligible Dependent have a Pre-existing Condition, specialty physician services for that condition will not be covered until 92 days after the Effective Date. If the Eligible Subscriber and/or Eligible Dependent have a Pre-existing Condition, hospitalization services coverage for that condition will not be covered until 2 years after the Effective Date.
C. Cap Limit
The cap limit per enrollee, per year is $500. American Care pays healthcare providers through a capitation compensation model. This amount reflects the aggregate of all the capitations paid to providers per member annually. The capitation model allows health plan members to visit providers as needed during their period of coverage, provided enrollee pays the applicable co-payment. Members have unlimited number of visits to participating PCP's, and participating specialists, provided there is medical necessity.

SECTION IX

COST SHARING PROVISIONS

The following co-payments will apply at the time services are to be rendered.

OUTPATIENT SERVICES	**COPAYMENTS**
Primary Care Office Visits	$0 per visit
Prescription generic medications (When dispensed at contracted medical centers only, refer to	$4.00 per prescriptions

covered formulary)

Surgical Procedures and Application of Plaster Casts (services at physician's offices or clinics)	$0 ($200.00 per procedure for services in the first 92 days of enrollment)
Laboratory examinations and services	$0
Periodic physical examinations	$0
Well child care and pediatric services	$0
Health Education	$0
Routine Vision and Hearing Examinations	$0
Physical Therapy	$0
Therapeutic and Diagnostic Services:	
24 Holter Monitor	$0 ($100.00 per procedure for services in the first 92 days of enrollment)
Audiometry	$0 ($25.00 per procedure for services in the first 92 days of enrollment)
Cardiac Stress Test	$1200.00 per procedure
CT Scan with or without contrast	$500.00 per procedure
Diagnostic Ultrasound	$0 ($100.00 per procedure for services in the first 92 days of enrollment)
Echocardiogram with Doppler	$0 ($200.00 per procedure for services in the first 92 days of enrollment)
Mammogram	$100.00 per procedure
MRI with or without contrast	$800.00 per procedure
Nuclear medicine	$800.00 per procedure
Vascular ultrasonography	$0 ($200.00 per procedure for services in the first 92 days of enrollment)
X-Ray Contrast	$100.00 per procedure
X-Ray Plain	$0 ($30.00 per procedure for services in the first 92 days of enrollment)
Urgently Needed Care (at contracted medical centers)	$0 per visit

SECTION X

GENERAL PROVISIONS

1. No statement by the Subscriber in the Enrollment/Change Form shall void his coverage hereunder or be used in any legal proceedings hereunder unless such Enrollment/Change Form or an exact copy thereof is included in or attached to his Member Handbook. All statements made by the Subscriber shall be deemed representations and not warranties.

2. All Covered Services provided by the Plan shall be paid directly to the Plan Provider, unless a reimbursement is being paid to the Covered Person. The Covered Person must pay directly to the plan Provider any co-payments due for specified services at the time services are to be rendered. Refer to co-payment schedule for applicable co-payments.

3. No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days following a final appeal in accordance with requirements of this Agreement. No such action may be brought after the expiration of the applicable statute of limitations. The statute of limitations applicable to any action relative to this appeal shall commence from the date of treatment.

4. No interest in this Agreement issued pursuant hereto is assignable without written consent of the Plan being first obtained.

5. Only the Covered Person is entitled to benefits.

6. The Covered Person shall present his or her Subscriber Identification Card provided by the Plan when applying for benefits.

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

a. If to the Plan, mailed to the address printed on the Application for Individual Service Agreement.
b. If to a Covered Person, mailed to the last address provided by the Covered Person.

8. This Agreement shall be governed by and construed in accordance with the laws of the state of Florida, and the exclusive and sole venue for any action arising hereunder shall be in Dade County, Florida.

9. This Agreement in writing and the Application for Enrollment constitute the entire contract between the Plan and the Individual. No agent of the Plan other than a corporate officer can change or waive any of the provision of the Agreement. No change or amendment

shall be valid unless evidenced by an endorsement, rider, or amendment to the Agreement and signed by an authorized representative of the Plan.

10. The Health Care Services required by such Subscribers will be rendered under reasonable standards of quality of care as certified by the Agency for Healthcare Administration.

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

SECTION XI

COMPLAINTS AND GRIEVANCES

The member can file a grievance with the Health Plan in the event of a complaint or disagreement. If the decision made by the Plan is not satisfactory to the member, he or she can appeal the decision.

SECTION XII

PRESCRIPTION DRUGS

The health plan shall cover a limited number of generic formulations. Not all drug classes are covered. Only drugs listed in the formulary are covered. If a medication or drug formulation is required because of a specific illness and is not listed in the drug formulary such medications or drug formulations are not covered and are the full financial responsibility of the health plan member. Covered drugs have an applicable co-payment as determined by the health plan. The health plan at its discretion may assist the member in obtaining medications not in the drug formulary from wholesalers. Medications and drug formulations obtained for the member but not covered in the formulary are the full financial responsibility of the health plan member.