



# Certificate of Coverage

CARE ACCESS HEALTH PLAN, INC.  
P.O. Box 4276  
Hallandale, Florida 33008-4276  
1-877-411-2247

## Group Prepaid Health Plan Certificate of Coverage

**NOTE: THIS CERTIFICATE OF COVERAGE ONLY PROVIDES COVERAGE FOR SPECIFIC OUTPATIENT SERVICES OUTSIDE THE HOSPITAL. INPATIENT HOSPITAL AND EMERGENCY ROOM SERVICES ARE NOT COVERED.**

Group Name: Miami Dade County Public School

Group Contract Number: E0006

This Certificate of Coverage is part of the Group Contract that is a legal document between Care Access Health Plan, Inc. (Hereinafter called CAHP) and Group to provide certain benefits to covered persons, subject to the terms, conditions, exclusions and limitations of the Group Contract. Covered persons can review the Group Contract at the office of Group during regular business hours. The Benefits in this Certificate of Coverage are effective only to a person who is eligible for Coverage, becomes Covered, and remains Covered in accordance with the terms of the Group Contract. Care Access Health Plan, Inc. is a Florida corporation organized and operating as a Prepaid Health Plan under the laws of the State of Florida.

This Certificate of Coverage is issued on the basis of the submission of the Group Application and Certification and payment of the required Covered Charge. Coverage is subject to the terms, conditions, Benefits, limitations and exclusions of this Certificate of Coverage.

**NOTE:** Read Your Certificate of Coverage carefully, to become familiar with your Coverage. If you have any questions, or wish to obtain Coverage information or assistance in resolving any problems, please call 1-877-411-2247.

Any changes in this Certificate of Coverage may be made from time to time by CAHP, must be approved by an officer of CAHP, and endorsed on the Certificate of Coverage or attached to it. Any verbal promise made by an officer or employee of CAHP, or any other person, including an agent, will not be binding on CAHP unless it is contained in writing in this or any other Certificate of Coverage as an endorsement, Rider or Amendment attached to either.

This Certificate of Coverage is delivered in and governed by the laws of the State of Florida.

By: Gerald B. Sternstein  
Gerald B. Sternstein  
President  
Care Access Health Plan, Inc.

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Offered by:



## Welcome to Care Access...

As a new Member, it is our pleasure to welcome you to Care Access Health Plan! This Certificate of Coverage was prepared to assist you in the use of your Care Access Health Plan. It is intended to help you get the most out of your Plan Membership and make it easier to obtain Covered Medical Services.

Care Access is a "Limited Prepaid Health Plan." This means that we provide you with access to a wide variety of affordable health care services with emphasis on preventive care, with the following exception: **YOUR CARE ACCESS HEALTH PLAN DOES NOT COVER INPATIENT OR OUTPATIENT OR EMERGENCY ROOM HOSPITAL SERVICES.**

Care Access *DOES* cover urgent care, primary and specialty physician care (*other than hospital related physician services*), prescription medications, routine ambulatory surgery and diagnostic treatment, and preventive health care services. Please refer to your Schedule of Benefits which is incorporated into the Certificate of Coverage as well as the description of Covered Medical Services and limitations, including the Prescription Drug Benefit and limitations, Non-Pharmacy Drug Benefit and limitations, Allergy Treatment Benefit and limitations and Exclusions found in this Certificate of Coverage for a full explanation of the benefits of your Care Access Health Plan.

Care Access gives you access to a prestigious panel of participating primary care and specialty Providers, and many of the area's finest ancillary Providers throughout South Florida, all dedicated to helping you maintain your health. Your Primary Care Physician will coordinate all of the Covered Medical Services rendered to you. This helps promote the very important doctor-patient relationship. It also provides a "medical home base" for your ongoing treatment, preventive care and follow-up. You, however, play the most important part in keeping yourself healthy by practicing sound health measures and following your Primary Care Physician's treatment plan and advice.

To get the most from your Care Access Membership, please read this Certificate of Coverage carefully. Use it as a guide to receiving all the Covered Medical Services under your Care Access Health Plan. If you have any questions or suggestions, please call the Care Access Member Service Department at the following numbers:

Miami-Dade County: 305-614-5050

Broward County: 866-429-2882

Palm Beach County: 866-429-2882

We will be happy to assist you in any way possible!

A handwritten signature in black ink that reads "Gerald B. Sternstein".

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Gerald B. Sternstein  
President

<b>SCHEDULE OF BENEFITS</b> Covered Medical Services when performed by a Contracted Provider	<b>HIGH OPTION</b> \$ Co-pay	<b>LOW OPTION</b> \$ Co-Pay		Maximum Annual Benefit: \$25,000. Hospital Services Excluded (Professional and Facility) Health Screen may be required / Pre-existing Condition Limitations may apply Excludes coverage for Medicare eligibles and Age 65+
<b>PCP / Pediatrician</b>	<b>10</b>	<b>20</b>		<ul style="list-style-type: none"> <li>Includes immunizations and vaccines recommended by Advisory Committee on Immunization Practices, American Academy of Pediatrics and the American Academy of Family Physicians; <b>except those</b> related to occupation or travel.</li> </ul>
<b>Allergy Treatment</b> <i>(Injection / testing / therapy)</i>	<b>15</b>	<b>30</b>	R	<ul style="list-style-type: none"> <li>In addition to office visit co-pay if performed in a PCP or Specialist office</li> <li>\$1200. per year maximum benefit (Excludes co-pay, No carry-over)</li> <li>Maximum Plan Payment \$100. per Month (Excludes co-pay, No carry-over)</li> </ul>
<b>Specialists</b>	<b>25</b>	<b>35</b>	R	<ul style="list-style-type: none"> <li>Includes Obstetrician visits for pre/post-natal care. Obstetrical delivery and Hospital care or Birthing Center excluded.</li> </ul>
<b>Mental Health Services</b> <i>(Group or Individual)</i>	<b>10 / 25</b>	<b>20 / 35</b>	R	<ul style="list-style-type: none"> <li>20 visits per Contract Year</li> </ul>
<b>Routine Radiology Services</b>	<b>15</b>	<b>30</b>	R	<ul style="list-style-type: none"> <li>In addition to office visit co-pay if performed in a PCP or Specialist office</li> </ul>
<b>High Tech Radiology Services</b>	<b>50</b>	<b>100</b>	R	<ul style="list-style-type: none"> <li>Including but not limited to: Bone Scan, CT Scan, MRI, and Nuclear Medicine</li> </ul>
<b>Laboratory Services</b>	<b>0</b>	<b>0</b>	R	
<b>Home Health Services</b>	<b>10</b>	<b>20</b>	R	<ul style="list-style-type: none"> <li>30 visits per Contract Year limit</li> </ul>
<b>Prescription Drugs</b> <i>Generic</i>	<b>7</b>	<b>15</b>		<ul style="list-style-type: none"> <li>\$1200 per year maximum benefit (Excludes co-pay, no carry-over)</li> <li>Maximum Plan Payment: \$100. Per Month (Excludes co-pay, no carry-over)</li> <li>Coverage includes Oral Contraceptive under generic co-pay only</li> <li>Requires a prescription from a contracted provider or as a result of an out-of-area Urgent Care visit and Pharmacist will dispense generic counterpart, unless there is no generic counterpart to the brand name drug formulary.</li> </ul>
<i>Non-Generic</i>	<b>25</b>	<b>35</b>		
<b>Non-Pharmacy Drugs</b>	<b>0</b>	<b>0</b>		<ul style="list-style-type: none"> <li>Injectibles, intravenous medications and any other non-pharmacy drugs and non-pharmacy medications.</li> <li>\$1200. per year maximum benefit. (Excludes co-pay, No carry-over)</li> <li>Maximum Plan Payment \$100. Per Month (Excludes co-pay, No carry-over)</li> <li>Immunizations and vaccines addressed under <i>PCP/Pediatrician</i> above not subject to this maximum benefit.</li> </ul>
<b>Chiropractic Services</b>	<b>25</b>	<b>35</b>		
<b>Ambulatory Surgical Center (ASC)</b>	<b>100</b>	<b>200</b>	R	<ul style="list-style-type: none"> <li>Surgical procedures performed in a contracted ASC are a covered medical benefit</li> <li>Maximum Plan Payment (after co-pay): \$750. Per Episode -excluding physician charges</li> </ul>
<b>Urgent Care Center</b> <i>(Outside the Hospital)</i>	<b>25</b>	<b>50</b>		<ul style="list-style-type: none"> <li>Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit.</li> </ul>
<b>Out -of-Area Urgent Care Center</b> <i>(Outside the Hospital)</i>	<b>50</b>	<b>75</b>		<ul style="list-style-type: none"> <li>Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit.</li> <li>Rendered outside of the service area by a non-contracted provider</li> <li>Maximum Plan Payment (after co-pay): High Option- \$100. Per Episode / Low Option—\$75. Per Episode</li> </ul>
<b>Eye Examination / Refraction</b> <i>(Optometrist)</i>	<b>25</b>	<b>35</b>		<ul style="list-style-type: none"> <li>1 per Contract Year limit</li> </ul>
<b>Vision Services</b> <i>(Glasses or Contacts)</i>	<b>0</b>	<b>0</b>		<ul style="list-style-type: none"> <li>1 per Contract Year limit</li> <li>After 6 months of continuous coverage Maximum</li> <li>Plan Payment: High Option- \$100. Per Year / Low Option—\$50. Per Year</li> </ul>
<b>Hearing Services</b>	<b>25</b>	<b>35</b>		<ul style="list-style-type: none"> <li>1 per Contract Year limit</li> </ul>
<b>Hearing Aids</b>	<b>0</b>	<b>0</b>		<ul style="list-style-type: none"> <li>After 6 months of continuous coverage</li> <li>Limit 1 every 2 yrs.</li> <li>Adult: Maximum Plan Payment: High Option- \$100. Per Year / Low Option—\$50. Per Year</li> <li>Pediatric: Maximum Plan Payment: High Option- \$200. Per Year / Low Option—\$100. Per Year</li> </ul>
<b>Rehabilitative Services</b> <i>(Physical or Occupational or Speech Therapy)</i>	<b>25</b>	<b>35</b>	R	<ul style="list-style-type: none"> <li>30 visits per Contract Year limit.</li> </ul>
<b>Durable Medical Equipment</b>	<b>10</b>	<b>20</b>	R	<ul style="list-style-type: none"> <li>Co-pay is payable upon delivery and subsequently, if monthly maintenance is required.</li> </ul>
			"R"	<b>Requires referral from PCP and / or authorization from Plan's U/M Dept.</b>

# INTRODUCTION

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## Introduction to Your Certificate

We are pleased to provide you with this Certificate of Coverage. This Certificate of Coverage and the other Contract documents describe your Benefits, as well as your rights and responsibilities, under the Contract. We encourage you to read your Certificate of Coverage carefully. We especially encourage you to review the Benefit limitations of this Certificate of Coverage by reading (Covered Medical Services and Limitations, pages 24-26), (Prescription Drug Benefits and Limitations, page 28), (Non-Pharmacy Drug Benefits and Limitations, pages 28-29), (Allergy Treatment Benefits and Limitations, page 29), and (Exclusions, pages 30-33). You should also carefully read (General Legal Provisions, pages 40-42) to better understand how this Certificate of Coverage and your Benefits work. You should call us if you have questions about the limits of Coverage available to you. Many of the sections of the Certificate of Coverage are related to other sections of the document. You may not have all the information you need by just reading one section. We also encourage you to keep your Certificate of Coverage and any attachments in a safe place for your future reference.

Please be aware that your physician or Provider does not have a copy of your Certificate of Coverage, and is not responsible for knowing or communicating your Benefits.

The Contract may require the Subscriber to contribute to the required Premiums. You can contact your Enrolling Group for information about any part of the Premium cost you are responsible for paying.

## Facts about Care Access

Care Access is a limited prepaid health plan licensed by the State of Florida under Chapter 641, Part II, Florida Statutes. Care Access does not directly provide Covered Medical Services to its Members. It does make available Covered Medical Services, **excluding care in a hospital setting** to its Members through the Plan's Contracted Providers, who are not agents or employees of Care Access. These Contracted Providers provide Covered Medical Services to Care Access Members based upon their knowledge and expertise in the areas of practice for which they are licensed and/or trained. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Contracted Providers maintain the physician/patient relationship with the Member and are solely responsible for all Covered Medical Services which they provide to Members. Therefore, Care Access shall not be liable for any negligent act or omission committed by Providers, nurses, medical personnel, and/or health care facility that may from time to time provide Covered Medical Services to Members of Care Access, whether Contracted or not Contracted. Furthermore, Care Access shall not be vicariously or otherwise liable for any negligent act or omission of any Contracted Providers or other Providers who treat a Member of Care Access Health Plan.

## About Your Plan

We at Care Access want to assist you in obtaining quality health care. This Certificate of Coverage and all other Contract documents set forth the terms, conditions, limitations, exclusions, rules, policies and procedures by which Care Access agrees to make available Covered Medical Services to you, and under which you agree to be bound. When reading this Certificate of Coverage, please note that, when referring to your Care Access Health Plan, the words "Health Plan", "Plan", "We" or "Us" may be used. When referring to you, the words, "Member", or "You" may be used.

Also, this Certificate of Coverage describes the administrative details, services, provisions, limitations, and exclusions of the Plan. The Covered Medical Services described in this Certificate of Coverage are effective only if a person is accepted for Coverage, becomes Covered, and remains Covered in accordance with the terms and conditions of this Plan.

The Schedule of Benefits, which is attached here to, and defined herein, describes certain Covered Medical Services, limitations, and Maximum Contract Benefit under this Certificate of Coverage.

By enrolling or accepting Covered Medical Services under this Plan, Members agree to and are obligated to understand and abide by all items, terms, conditions and provisions of this Certificate of Coverage.

Any changes to this Certificate of Coverage must be approved in writing by an officer of Care Access, and endorsed or attached to this Certificate of Coverage.

Any verbal promise made by an officer or employee of the Plan, or any other person, including an agent, will not be binding on Care Access unless it is contained in writing in this Certificate of Coverage or an endorsement to it.

Any and all decisions that pertain to the medical need, or desirability of the provision or non-provision of Covered Medical Services, must be made solely by the Member and his/her Provider, in accordance with the normal patient/physician relationship for purposes of determining what is in the best interest of the Member.

The Plan does not have the right of control over the medical decisions made by the Members, independent Providers or Contracted Providers. The ordering of a service by a Provider, whether a Contracted Provider or not, does not in and of itself make such service a Covered Medical Service. We acknowledge that a Member and his/her Provider may determine that such services or supplies are appropriate even though such services and supplies are not Covered, will not be paid for or made available as a Covered Medical Service by the Plan.

## **ADMINISTRATIVE PROVISIONS**

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### **Coverage**

No Coverage is in effect unless the applicant receives written notice of approval after an enrollment application has been presented to the Plan. Benefits are available only if all of the following are true:

- Covered Medical Services are received while the group Contract is in effect.
- Covered Medical Services are received prior to the date that any of the individual termination conditions listed in (Pages 13-14) occurs.
- The person who receives Covered Medical Services is a Covered person and meets all eligibility requirements specified in the Contract.

The applicant should not cancel any current Coverage prior to receiving written notice of approval. It is the Member's responsibility to make sure that there will be no lapse between coverage. The Plan will not be liable for any claim incurred and no Coverage is in effect until Coverage by the Plan is approved.

### **How to Enroll**

To enroll, the Eligible Person must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the properly completed forms to us, along with any required Premiums. We will not provide Benefits for health services that you receive before your effective date of coverage.

### **Eligible Person Coverage**

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. An Eligible Person does not actually need to enroll, as in some cases only that Eligible Person's Dependents will only enroll. In either case, whether the Eligible Person enrolls or does not enroll with Plan, we refer to that person as a Subscriber. We and the Enrolling Group determine who is eligible to enroll under the Contract. Eligible Persons must reside within the Service Area, which is a specific geographic area that we serve. Except as we have described in this Certificate of Coverage and Contract, Eligible Persons may not enroll without our written permission.

### **Eligible Dependent Coverage**

Dependent usually refers to the employee's spouse or Domestic Partner and children but may also include the newborn child of any covered Dependent other than the Subscriber's spouse. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. We and the Enrolling Group determine who qualifies as a Dependent. Dependents of an Eligible Person may enroll even though the Eligible Person is not Covered under the Contract. Except as we have described in this Certificate of Coverage and Contract, Dependents may not enroll without our written permission.

### **Enrollment Period**

When the Enrolling Group purchases coverage under the group Contract from us, the initial enrollment period is the first period of time when Eligible Persons can enroll. Eligible Persons may enroll themselves and their Dependents. Coverage

begins on the date identified in this Certificate of Coverage if we receive the completed enrollment form and any required Premium prior to the date the Eligible Person becomes eligible to enroll.

During an Open Enrollment Period, Eligible Persons may enroll themselves and their Dependents. We and the Enrolling Group determine the Open Enrollment Period. Coverage begins on the date identified by the Enrolling Group and us if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons may enroll themselves and their Dependents. Coverage begins on the date identified by the Enrolling Group and us if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes first eligible to enroll.

Newborn and adopted children are automatically covered if the parent/legal representative is an enrolled Member and the child was enrolled within 60 days from birth or date of adoption. For newborns and adopted children, no premium will be charged for the first 30 days if written notice to enroll the new Dependent is given within 30 days of the event. In the case of newborn and adopted Dependents, if the Member fails to enroll the new Dependent within 30 days, but enrolls the Dependent within 60 days of the event, Premium will be required to be paid from the date of birth or placement. If written notice is not given within 60 days of the birth or adoption of the child, we will deny Coverage due to the failure of the Member to timely notify the Plan of the birth or adoption of the child. If this occurs the newborn or adopted child may apply for Coverage upon the next Open Enrollment Period.

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis. A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs: (1) birth, (2) legal adoption, (3) placement for adoption, or (4) marriage. A special enrollment period applies to an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true: (1) The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and (2) Coverage under the prior plan ended because of any of the following: (i) loss of eligibility (including, without limitation, legal separation, divorce or death), (ii) the employer stopped paying the premiums or (iii) In the case of COBRA continuation coverage, the coverage ended. Coverage begins on the date identified by the Enrolling Group and us if we receive the completed enrollment form and any required Premium within 31 days of the date of the event.

## **Changes**

### **Changes to your Coverage**

Any changes to this Certificate of Coverage must be approved in writing by an officer of the Plan, and endorsed or attached to this Certificate of Coverage. Any verbal promise made by an officer or employee of the Plan, or any other person, including an Agent, will not be binding on the Plan unless it is contained in writing in this Certificate of Coverage and/or an endorsement to it.

### **Name/Address Change**

A Member must submit a request in writing and provide their full name and Member identification number as it appears on the ID Card, or call Member Service Department at 305-614-5050, to request a change of address. If the request is for a change in name, we must be provided with the reason for the change and appropriate documentation.

## **Financial Matters**

### **Financial Responsibilities of the Member**

Care Access reserves the right to recover any benefit payments made to or on behalf of any individual whose Coverage has been terminated or rescinded. Recovery efforts will relate to benefit payments made for services, prescription drugs, or supplies rendered subsequent to the Member's termination date or subsequent to the last Coverage date in which premiums were received for. The Member shall cooperate with and support such recovery efforts.

## **Payment of Co-payments and out-of-pocket expenses**

In your Schedule of Benefits, you will notice that you are, in some instances, required to pay part of the cost of some services. Care Access will pay its part directly to the Provider. Your Co-payment and out-of-pocket expenses over scheduled benefit limitations must be paid directly to the Provider.

### **If You receive a Bill**

If you receive a bill for services, which you feel, are Covered by Care Access, DO NOT IGNORE IT! You should first verify that this is not a statement for your records. If you determine that it is a bill, please request from the Contracted Provider to submit a claim form to Care Access, or submit the bill to our office immediately for our review. IN ALMOST ALL CASES, WE WILL BE BILLED DIRECTLY BY THE PROVIDER OF SERVICES, BUT OCCASIONALLY YOU MAY MISTAKENLY RECEIVE A BILL. If the service is not a Covered benefit, we will notify you in writing so that you may make payment arrangements with the Provider.

## **General**

### **Your Member Service Representatives**

As a Member of Care Access, you are able to speak to a Care Access Member Service Representative who will assist you with the Plan's services. Consider the Representative as your Plan assistant, and if you have questions or problems concerning Care Access, please call Care Access Member Service.

We encourage you to offer comments and suggestions to help us continue to improve our service to you. If you have ideas or suggestions about technological advancements that could help us improve our service to you, we would like to hear about them. You will discover that your Member Service Representative will be most helpful when you have questions, when you are uncertain about Benefits, or when you need assistance in any way.

### **If You Have a Complaint**

Occasionally, misunderstandings or errors occur. A solution can usually be found for the problem resolved informally by contacting a Member Service Representative at the number listed below.

If your complaint cannot be resolved informally, you may file a formal grievance by writing to the Grievance and Appeals Department. The procedures regarding a formal grievance are written in the section of this Certificate of Coverage entitled Grievance.

A Member Service Representative can also assist you in filing a grievance.

## **Termination – When Does My Coverage End**

### **General Information about When Coverage Ends**

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Contract. Your entitlement to Benefits ends on the date that coverage ends. When your coverage ends, we will still pay claims for Covered Medical Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended. An Enrolled Dependent's coverage ends on the date the Subscriber ceases to be an Eligible Person (i.e. employment or relationship with Group terminates or ends) or the Subscriber's coverage ends.

### **The Entire Group Contract Ends**

Your coverage ends on the date the group Contract ends. The Enrolling Group is responsible for notifying you that your coverage has ended.

### **You No Longer Reside in the Service Area**

Your coverage ends on the last day of the calendar month in which you no longer reside in the Service Area. Coverage will end on the date of that move, even if you do not notify us. The Subscriber or the Enrolling Group must notify us if you move from the Service Area.

### **You are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or an Enrolled Dependent. If a Dependent's eligibility ends due to reaching the Dependent's limiting age, the Dependent's eligibility continues until the end of the calendar year in which the Dependent reaches the limiting age.

### **We Receive Notice to End Coverage**

Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. You agree the Enrolling Group is responsible for providing written notice to us to end your coverage.

### **Other Events Ending Your Coverage**

When any of the following happen, we will provide written notice to the Member that coverage has ended on the date we identify in the notice:

**Fraud, Intentional Misrepresentation or False Information - Care Access may rescind a Member's Coverage back to the original effective date on a finding by Care Access that a Member made a material misrepresentation or omission, or gave false information on the Enrollment Application, the Enrollment Change Form, or other forms completed for Care Access by or on behalf of the Member which Care Access relied upon in accepting the Member into the Plan. Plan may also rescind a Member's Coverage if the Member engages in fraud, or makes a material misrepresentation or omission in applying for Membership or requesting Coverage. Care Access' rescission of Coverage shall void Member's Coverage back to the effective date, and Care Access shall refund all premiums related to the Member from the effective date, less any claims paid by Care Access on the Member's behalf. With respect to a material misstatement on the Enrollment Application, only fraudulent misstatements in the Application may be used to void Coverage as to the Member, or deny any claims for loss incurred or disability after two (2) years have passed from the date of eligibility under the Certificate of Coverage. Any termination made under this provision is subject to review in accordance with the Grievance Procedure described in this Certificate of Coverage.**

**Violation of Contract – There was a violation of the terms or conditions of the Contract.**

**Improper Use of ID Card – You permitted an unauthorized person to use your ID card, you used another person’s ID card, or other misuse of the ID card.**

**Failure to Pay – You failed to pay a required Copayment.**

**Behavior - The Member is disruptive, unruly, abusive and uncooperative to the extent that the Member’s continued membership in Care Access impairs Care Access’ ability to administer the Plan or to arrange for the delivery of medical care services to such Member or other Members.**

**Limiting Age – The Member reaches age 65 or becomes eligible for or enrolls in Medicare.**

## **Continuation of Coverage under Individual Contract with Plan**

**If your coverage ends under your group Contract through no wrong doing of yours, you may be eligible to continue coverage with Plan under Plan’s Individual contract in the Service Area, if available, in accordance with the individual contract then in effect, timely payment of premiums in accordance with the Individual contract and all terms and conditions contained in such individual contract. In order to be eligible for this limited continuation of coverage option, the Member is responsible, and not the Enrolling Group nor Plan or any other person, for completing the Individual Enrollment Application and delivering such form with the applicable premiums to Plan (with confirmation of receipt by Plan) no later than the 20<sup>th</sup> day of the month of the loss of coverage through the Enrolling Group or within ten (10) days of the loss of coverage through the Enrolling Group. We are not obligated to provide any continuation of coverage as specifically set forth above or otherwise if you or the Enrolling Group fail to notice us within the time period and as specifically set forth above.**

## DEFINITIONS

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The following terms used in this Certificate of Coverage have the meanings defined below:

**“Amendment”** means any attached written description of additional provisions to the Contract. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Contract, except for those that are specifically amended.

**“Benefit (s)”** is your right to payment for the Covered Medical Services you receive under the Contract. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Contract, including this Certificate of Coverage and any attached Riders and Amendments.

**“Calendar Year”** means the period of twelve (12) consecutive months commencing on January 1 through December 31.

**“Care Access”** is an entity licensed by the State of Florida as a limited prepaid health plan under Chapter 641, Part II, Florida Statutes.

**“Contract”** means the entire agreement issued to the Enrolling Group, that includes all of the following: the group Contract, this Certificate of Coverage, the Enrolling Group’s application, Amendments and Riders.

**“Contract Charge”** means the sum of all Premiums for all Subscribers and Enrolled Dependents enrolled under the Contract.

**“Contract Year”** means the period of twelve (12) consecutive months commencing on the effective date of the Contract. Claims payment, benefit limitations and out-of-pocket expenses are calculated based on a 12 month Contract Year, except as otherwise specifically provided in the Contract.

**“Contracted Provider”** means a physician or other health care Provider, including your PCP, with whom the Plan has a Contract to provide Covered Medical Services.

**“Co-payment”** means a specific dollar amount that the Member must pay for Covered Medical Services specified in your Schedule of Benefits.

**“Covered or Coverage”** means the inclusion of a Member for Covered Medical Services under the Certificate of Coverage.

**“Covered Medical Service(s)”** means the Medically Necessary, medical and other non-hospital outpatient services Covered under the Certificate of Coverage as described in Section - Covered Medical Services and Limitations, which is not excluded under Section - Exclusions, and performed, prescribed or directed by Contracted Providers in the Service Area except for Urgent Care within the United States.

**“Covered Person”** means either the Subscriber (if enrolled) or an enrolled Dependent, but this term applies only while the person is enrolled under the Contract.

**“Dependent”** is a legally married spouse or Domestic Partner, natural and/or adopted child of the Member living in the same household and residing in the Service Area, which has applied and been approved by the Plan for Coverage.

**“Domestic Partner”** – a person of the opposite or same sex with whom the Eligible Employee has established a Domestic Partnership.

**“Domestic Partnership”** A relationship between an Eligible Employee and one other person of the opposite or same sex. All of the following requirements apply to both persons:

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

- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least six months duration.
  - They have joint ownership of residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary.

The Eligible Employee and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

**“Eligible Person”** means a certain employee of the Enrolling Group who is not otherwise eligible for that certain other coverage offered by a third party carrier to the Enrolling Group or a Dependent of such an employee of the Enrolling Group, any Dependent of any employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Contract. An Eligible Person must reside within the Service Area.

**“Emergency Medical Conditions”** is defined as 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:

- Serious jeopardy to the health of a patient, including a pregnant woman or a fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman, an Emergency Medical condition is:

1. Inadequate time to affect safe transfer to another hospital prior to delivery.
2. Transfer may pose a threat to the health and safety of the patient or fetus.
3. Evidence of the onset and persistence of uterine contractions or rupture of the membranes.

**“Enrolled Dependent”** means a Dependent who is properly enrolled under the Contract.

**“Enrolling Group”** means the employer, or other defined or otherwise legally established group, to whom the Contract is issued.

**“Enrollment Date”** means with respect to an individual covered under a group health contract, the date of enrollment of the individual in the plan or coverage.

**“Exclusion”** means any service that is not covered or is otherwise restricted. Refer to the Exclusions and Limitations sections of this Certificate of Coverage.

**“HIPAA”** is the Health Insurance Portability and Accountability Act passed by the United States Congress in 1996 that protects the privacy rights of individuals, including those with health Coverage.

**“Identification Card” or “ID Card”** is the card you will receive when you become a Member of Care Access. It will have on it your name, Care Access Member number and is to be presented to Contracted Providers when you obtain Covered Medical Services.

**“Initial Enrollment Period”** means the initial period of time, as we agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under the Contract.

**“Limitation”** means any provision other than an Exclusion which limits Coverage of Covered Medical Service under your Health Plan.

**“Live or “reside”** means a principal place of residence within the Service Area. You must live or reside in the Service Area and obtain services from the Plan in the Service Area.

**“Maximum Contract Benefit”** means the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Contract issued to the Enrolling Group as set forth in the Schedule of Benefits.

**“Medical Necessity or Medically Necessary”** means determinations on decisions that are, or that could be considered, Covered Medical Services. This includes determinations for:

Covered Medical Services as defined by the Plan, including care or service that could be considered either Covered or non-covered, depending on the circumstances.

**“Member”** means an Eligible Person or Enrolled Dependent who is properly enrolled under the Contract.

**“Open Enrollment Period”** means a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and other Dependents under the Contract. We and the Enrolling Group will agree upon the period of time that is the Open Enrollment Period.

**“Other Coverage”** means any benefits the Member may be Covered for by another insurance company or health plan, whether on an insured or uninsured basis.

**“Plan”** means the licensed entity known as Care Access Health Plan which provides Coverage and has issued this Certificate of Coverage and has entered into the Contract with Enrolling Group, and may also referred to herein as Care Access Health Plan, Health Plan or Care Access.

**“Premium”** is the periodic fee required for each Subscriber and Enrolled Dependent, in accordance with the terms of the Contract.

**“Preventive Care”, “Preventive Health Care Services”, or “Preventive Pediatric Health Care”** means a program of health evaluation, education and immunizations which is designed to prevent illness and disease and to improve the general health of Members.

**“Primary Care”** means the level of care that encompasses routine care of individuals with common health problems and chronic illnesses that can be managed on an outpatient basis.

**“Primary Care Physician or PCP”** means a Contracted Provider who provides primary care services and manages the routine health care needs of a Member and who has the majority of his/her practice in the areas of Pediatrics, Internal Medicine, Family or General Medicine.

**“Provider”** means any physician, or other institution, organization, or person that provides medical services and is licensed or otherwise authorized to practice in the State, which may include physician assistants and advanced registered nurse practitioners within their scope of licensure, and supervising physician’s oversight.

**“Rescission or Rescind”** means to void either the Contract with Enrolling Group or Coverage with respect to a Member back to the original effective date as a result of Group or a Member’s nondisclosure or misstatement of a material fact during the enrollment application process upon or as otherwise set forth in the Contract which the Plan relied in accepting the Group or the Member into the Plan.

**“Rider”** means any attached written description of additional Covered Medical Services not described in this Certificate of Coverage. Covered Medical Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us are subject to all conditions, limitations and exclusions of the Contract except those that are specifically amended in the Rider.

**“Schedule of Benefits”** further describes the Covered Medical Services which the Plan has agreed to provide you when Medically Necessary, administered by a Contracted Provider, referred by your PCP and authorized by the Plan. The Schedule of Benefits is incorporated and attached hereto as part of this Certificate of Coverage, and lists medical services or supplies, Co-payments and Maximum Contract Benefit information for such Covered Medical Services. Any medical service obtained by you which is not a Covered Medical Service, is excluded or which has exceeded the limitation for that Covered Medical Service, will be your responsibility to pay.

**“Service Area”** means the geographic area known as Broward, Miami-Dade and Palm Beach counties, in which the Plan has arranged with Contracted Providers, and other non-hospital Providers to provide Covered Medical Services to Members and is licensed to do business by the State of Florida.

**“Subscriber”** means the Eligible Person under the Contract. The Subscriber is the person on whose behalf the Contract is issued to the Enrolling Group.

**“Urgent Care”** means medical care or treatment which is a Covered Medical Service and time sensitive requiring attention, which in the opinion of the Contracted Provider with knowledge of the Member’s medical condition, would subject the Member to severe pain or damage if not treated timely.

## MEMBER RIGHTS AND RESPONSIBILITIES

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Members are obligated to inform Care Access' Member Service Department as to any change in residence and any circumstance that may affect entitlement to Coverage or eligibility under this Certificate of Coverage and the Contract, such as Medicare eligibility. Members must also immediately disclose to Care Access' Member Service Department whether they are or become covered for Other Coverage under a group health plan or otherwise, or have filed a Workers' Compensation claim, were injured by a third party, or have received a recovery as described in this Certificate of Coverage.

Florida law requires that your Provider recognize your rights while you are receiving medical care and that you respect the Provider's right to expect certain behavior on the part of the patient. You may request a copy of this law from your Provider.

A summary of your rights and responsibilities are as follows:

### **Care Access Member's Rights**

Know the names and qualifications of Contracted Providers involved in your medical treatment.

Get up-to-date information about Covered Medical Services or services not Covered, and any applicable limitations or exclusions.

Know what Covered Medical Services are.

Receive a detailed description of the processes used to process requests for referrals and/or to authorize Covered Medical Services.

Get information about Co-payments and out-of-pocket expenses that you must pay.

Get up-to-date information about Contracted Providers.

Be informed on how to file a complaint or appeal with the Plan.

Request a description of the Plan's Quality Assurance Program Description.

Receive information from Contracted Providers about your medications, including what the medications are how to take them and possible side effects.

Receive policies and procedures relating to the Plan's Prescription Drug Benefits, its use of a formulary, or whether a specific drug is covered.

Receive from Contracted Providers as much information about any proposed Covered Medical Service as you may need in order to give an informed consent or refuse a course of treatment.

Be informed by Contracted Providers about continuing health care requirements following discharge from outpatient facilities.

Receive an explanation regarding services that are not Covered Medical Services.

Receive a prompt reply when you ask the Plan questions or request information.

### **Access to Care**

Obtain primary and preventive Covered Medical Services from the Primary Care Physician you chose.

Change your Primary Care Physician to another available Primary Care Physician.

Obtain Medically Necessary, Covered Medical Services from Contracted Providers.

Be referred to Contracted Providers who are experienced in treating your illness.

Be told by your Contracted Provider or PCP how to schedule appointments and get Covered Medical Services during and after office hours.

Be told how to get a second opinion.

Receive urgently needed Medically Necessary, Covered Medical Services.

### **The Freedom to Make Decisions**

Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care.

Have any person who has legal responsibility to make medical care decisions for you exercise these rights on your behalf in accordance with applicable law.

Refuse treatment or leave a medical facility, even against the advice of Providers (providing you accept responsibility and the consequences of the decision).

Complete an Advance Directive, Living Will, or other directive and give it to your Contracted Provider.

Know that you or your Contracted Provider cannot be penalized for filing a complaint or appeal.

### **Personal Rights**

Be treated with respect for your privacy and dignity.

Have your medical records kept private, except when permitted by law or with your approval.

Help your Contracted Providers make decisions about your health care.

Have your Contracted Providers help in decisions about the need for Covered Medical Services and in the complaint process.

Suggest changes in the Plan's policies and services.

## **Care Access Member's Responsibilities**

Carry your Identification Card at all times and never let another person use it.

Choose a Primary Care Physician from the Plan's Directory and form an ongoing patient-physician relationship. Help your Contracted Provider make decisions about your health care.

### **Follow Instructions**

Read and understand your Contract and benefits. Know the Co-payments and what medical services are Covered, excluded or limited.

Follow the directions and advice of your Contracted Provider.

Make sure you have the appropriate authorization for Covered Medical Services.

Show your ID Card to Contracted Providers before getting care from them.

Pay the Co-payments and any other out-of-pocket expenses required by your Coverage.

Follow your Plan's complaint procedures if you believe you need to submit a complaint.

Treat all Providers, their staff, and the staff of the Plan with respect.

Not be involved in dishonest activity directed at the Plan or at any Provider.

### **Communicate**

Tell your Contracted Provider or PCP if you do not understand the treatment you receive and to ask if you do not understand how to care for your illness.

Tell your PCP or Contracted Provider promptly when you have unexpected problems or symptoms.

Consult with your Primary Care Physician when possible for referral to an Urgent Care Center for Covered Medical Services.

Understand that Contracted Providers and other Providers who care for you are not employees of Care Access and that Care Access does not control them.

Call the Care Access Member Service Department about your Coverage if you do not understand your plan's Covered Medical Services.

Give correct and complete information to Contracted Providers and Providers who care for you.

Advise Care Access about any Other Coverage you or your family Members may have.

Ask your PCP or Contracted Provider about all treatment options and their compensation arrangement with Care Access.

## **Other Member Guidelines**

### **Identification Card**

Carry your Identification Card at all times and never let another person use it. It is a violation of your coverage under the Contract and this Certificate of Coverage with this Plan to let another person use your Identification Card, as it will result in the termination of your Coverage; and, you may be subject to any and all remedies available to the Plan as a result of this violation. This Identification Card contains important information about you and your Coverage under the Plan. Present your ID Card every time you seek Covered Medical Services. When you present your Identification Card, the Contracted Provider will handle the paperwork on your behalf.

If there are any changes to the information in your Enrollment Application Form or your ID Card such as: your address, phone number, or Other Coverage, you must contact the Plan immediately to provide the updates.

This Identification Card can only be used to access your Coverage under the Plan.

**Failure to obtain Covered Medical Services according to the rules of this Certificate of Coverage and Contract may make you personally responsible for payment.**

### **Advance Directives**

Florida and Federal law requires the Plan to provide you with information about advance directives and your legal choices in making decisions about your medical services. You have the right to fill out a paper known as an "Advance Directive" which explains what kind of treatment you want or do not want under certain special, serious medical circumstances – under conditions that would prevent you from telling your doctor how you want to be treated at the time. This law concerning advance directives is intended to increase your control over medical service decisions.

An Advance Directive allows you to state your choices for medical services or to name someone to make those choices for you if you become unable to make decisions about your medical service treatment.

Generally, an Advance Directive is a written statement which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directive are: a "Living Will"; and a "Durable Power of Attorney for Health Care".

A Living Will generally states the kind of medical service and care you want (or do not want) if you become unable to make your own decision. It is called a "living will" because it takes effect while you are still living. A Durable Power of Attorney for Health Care is a signed, dated and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend, as your "agent" or "proxy" to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid.

The State of Florida has specific statutes concerning advance directives: Chapter 709 pertains to Durable Power of Attorney; Chapter 745 pertains to Health Care Surrogate; and Chapter 765, the Life-Prolonging Procedure Act of Florida, pertains to advance directives generally. If you are considering an advance directive for yourself, you should discuss it with your family and legal counselor before completing any documents. It is important that you fully understand any document you complete and that it is completed properly.

If you do have an advance directive, **YOU MUST GIVE A COPY TO YOUR PCP FOR YOUR MEDICAL RECORDS.** Be advised that your PCP maintains your medical records in his or her medical office. Care Access does not maintain any medical records in its administrative offices.

## ACCESS TO CARE

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### **Selecting a PCP**

Choosing a PCP is the first step in receiving good medical care. If you have not already chosen a PCP, you must choose one from the list of Contracted Providers in our Provider directory. If you do not select a PCP the Plan will select one in the area near or in close proximity to your residential zip code. If you have a PCP and he or she is Contracted with the Plan, feel free to continue in his or her care by choosing that Contracted Provider as your PCP. If you require assistance, a Member Service Representative will be glad to help you.

### **Changing Your PCP**

We want you to be comfortable and satisfied with your PCP and, for that reason, you may change your PCP during the Calendar Year. A change of PCP may occur up to three times in one Calendar Year without review from the PCP or Plan, unless you are under active medical treatment for a medical condition for which the PCP believes does not meet the medical guidelines to allow a change. To request a PCP change under the guidelines above, you may do one of the following:

- Complete a PCP Change Form and mail it to the Member Service Department; or
- Call the Member Service Department.

PCP changes become effective the first of the month following your receipt request provided it is received by the 15<sup>th</sup> of the previous month in order to be effective the first of the following month. PCP changes may not be made retroactively or effective the middle of a month. If you need assistance in selecting a new PCP, please contact the Member Service Department.

### **The Referral Process**

The PCP you choose will direct and coordinate all of your Covered Medical Services. Whenever a Medically Necessary Covered Medical Service is needed and cannot be provided by your PCP, he/she will suggest and choose the appropriate Contracted Provider, such as a specialist or ancillary Provider. Referrals to Contracted Providers must be arranged in advance by your PCP and authorized by the Plan in order for it to be a Covered Medical Service.

Your PCP will initiate a referral to the Plan requesting an authorization for you to receive a Medically Necessary, Covered Medical Service via phone/fax/e-mail. The Plan will notify your PCP or you once the referral is approved, at which time your PCP or you can schedule an appointment for you to receive Covered Medical Services from a Contracted Provider. In most cases, your PCP or you will receive a Referral Form including a prior authorization number from the Plan which must be taken by you to the Contracted Provider at the time of your scheduled appointment.

Covered Medical Services rendered by a non-Contracted Provider, without a referral from your PCP and prior authorization from the Plan will not be Covered. If you are in need of medical attention when your PCP's office is not open, you can reach your PCP through his or her answering service by calling their office number.

### **Exceptions to the Referral Process**

Gynecologist for annual well woman exam:

For an annual well woman exam, you may make an appointment to visit a Contracted Provider without first obtaining a referral from your PCP and authorization by Plan. For Medically Necessary follow-up care, as a result of your annual well woman exam, the Plan requires that the treating Contracted Provider (Gynecologist) coordinate the Covered Medical Service through the Member's PCP.

### Chiropractic Services

You do not need a referral from your PCP and authorization by Plan to receive chiropractic services which are Covered Medical Services from a Contracted Provider who is a Chiropractor. You can call directly and schedule an appointment for your care.

### Dermatology Services

You do not need a referral from your PCP and authorization by Plan to receive routine office evaluation dermatology services which are Covered Medical Services from a Contracted Provider who is a Dermatologist. This lack of a referral and authorization for these certain routine office evaluation dermatology services is only up to a maximum of five (5) visits per Contract Year. You can call directly and schedule an appointment for your care for these specific five (5) visits to a Dermatologist. For any Medically Necessary follow-up care, as a result of your routine office evaluation dermatology services, the Plan requires that the treating Contracted Provider (Dermatologist) coordinate the Covered Medical Service through the Member's PCP subject to referral and authorization requirements. Any routine office evaluation dermatology services in excess of five (5) visits per Contract Year, the Plan requires that the treating Contracted Provider (Dermatologist) coordinate the Covered Medical Service through the Member's PCP subject to referral and authorization requirements.

### Eye Examination and Vision Services

You do not need a referral from PCP and authorization by Plan to receive Covered Medical Services from a Contracted Provider (Optometrist or Optician). You can call directly and schedule an appointment for your care.

Eye Examination (including refractive services) are covered by an Optometrist, subject to the Coverage and limitations in the Schedule of Benefits. Vision Services (Glasses or Contact Lenses) are covered by an Optometrist or Optician, subject to the Coverage and limitations in the Schedule of Benefits.

## **Second Opinions**

As a Care Access Member, you have the right to a second medical opinion if you disagree with the Contracted Provider's opinion or necessity of procedures relating to a severe illness or injury, per Florida Statute 641.51 (5) (a) & (b).

If you should desire a second opinion, there are two methods by which this second opinion may be obtained. The options and associated Member cost sharing are as follows:

- You may select a Contracted Provider from the Provider directory. You or your PCP will then make an appointment with the selected Contracted Provider and you will pay the standard office Co-payment fee as specified in the Schedule of Benefits. Any diagnostic test requested by the second opinion Provider must be approved in advance and arranged for by Care Access in accordance with your Contract, or
- You may select a non-Contracted Provider. You or your PCP will make an appointment with the selected Provider. You will be responsible under this option to pay 40 percent of the cost of the second opinion. The cost will be based upon the usual, customary and reasonable charges for Providers in the community for a second opinion visit. Any diagnostic tests requested by the second opinion Provider must be approved in advance and arranged for by Care Access in accordance with your Contract.

The results of the second opinion visit will be provided to your PCP, and the ultimate decision on your treatment will be his or her responsibility. Care Access may deny reimbursement for second opinion if the Member has sought in excess of 3 per Contract Year. If you have any questions regarding your Second Opinion Options, please call the Care Access Member Service Department.

## **Urgent Care when you are out of the Service Area within the United States**

If you are traveling out of the Plan's Service Area within the United States, and need Urgent Care as defined in this Certificate of Coverage, you can seek immediate medical care for Covered Medical Services without a referral from your PCP. See your Schedule of Benefits for Co-payments and limitations.

## **Ambulatory Surgical Center Services and Other Non-Hospital Outpatient Facilities**

Your Plan offers you Covered outpatient surgery services routinely performed in an Ambulatory Surgical Center (ASC) and other non-hospital outpatient settings. Notwithstanding any Covered Medical Services determined by a Contracted Provider to be Medically Necessary, Covered outpatient surgery services are Covered subject to the limitations described in the Schedule of Benefits.

Your PCP will make a referral for you to see a Contracted Specialist or Contracted Provider to provide a Covered surgical procedure in a Contracted Ambulatory Surgical Center, other Contracted non-hospital outpatient medical treatment facility or in his/her office. The Contracted Specialist or Contracted Provider will request an authorization from the Plan to provide the Covered Medical Service.

An authorization will be given by the Plan for Medically Necessary, Covered Medical Services in a Contracted Ambulatory Surgical Center (ASC), other Contracted non-hospital outpatient medical treatment facility or a Contracted Provider's office. The following Covered Medical Services listed below will be considered Covered Medical Services when provided as part of the outpatient surgical procedure, subject to the limitations described in the Schedule of Benefits:

- Use of non-hospital operating and recovery rooms;
- Respiratory therapy (e.g., oxygen)
- Drugs and medications administered during the visit;
- Intravenous solutions;
- Dressings, casts, splints or other supplies necessary for the procedure;
- Anesthetics and their administration;
- Diagnostic services, including radiology, ultrasound, laboratory, pathology, electrocardiogram (EKG), medically necessary during the surgical procedure;
- Chemotherapy treatment for proven malignant disease; and
- Other Medically Necessary, Covered Medical Services.

## **In an Emergency**

Care Access does not cover Emergency Medical Conditions performed or provided in a hospital setting including an emergency room. Therefore, in the event of an Emergency Medical Condition, regardless of non-coverage by Care Access it is in your best medical interests to proceed directly to the nearest appropriate medical facility equipped to treat your emergency or dial 911. When an Emergency Medical Condition no longer exists, call your PCP so that he or she may make arrangements for any Medically Necessary, Covered Medical Services. Your PCP will know your medical history and direct treatment appropriate to your medical needs.

Remember, ambulance service is not a Covered benefit.

## **YOUR CARE ACCESS HEALTH PLAN DOES NOT COVER INPATIENT OR OUTPATIENT HOSPITAL SERVICES.**

However, if you are admitted to a hospital, you are responsible to notify your PCP so he/she may make arrangements for Medically Necessary, Covered Medical Service(s) after you have been discharged from the hospital.

# COVERED MEDICAL SERVICES AND LIMITATIONS/PRESCRIPTION DRUG BENEFITS AND LIMITATIONS/NON-PHARMACY DRUG BENEFITS AND LIMITATIONS/ ALLERGY TREATMENT BENEFITS AND LIMITATIONS/ EXCLUSIONS

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## Covered Medical Services and Limitations

The Covered Medical Services listed below will be considered Covered Medical Services, if Medically Necessary, if referred by your PCP, authorized by the Plan, and performed by a Contracted Provider:

**Allergy Treatment**, including allergy testing, desensitization therapy and allergy immunotherapy, including hypo sensitization serum. This benefit is explained in the Section – Allergy Treatment and Limitations of this Certificate of Coverage. Coverage limitations and benefits are described in the Schedule of Benefits

**Ambulatory Surgical Center Services and Other Non-Hospital Outpatient Facilities** are Covered, as set forth in this Contract and the Schedule of Benefits.

**Anesthesia Services**, when administered in a Covered setting and necessary for Covered Medical Services.

**Annual Well Woman Examination** allows a female Member one annual visit, without referral or authorization from Plan, to a Contracted Provider who is a Gynecologist; and, for Medically Necessary, Covered Medical Services for follow-up care from that visit with a referral and authorization from Plan, when coordinated through the Member's PCP.

**Bones or Joints of the Jaw and Facial Region** are Covered, when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury as diagnostic or outpatient surgery after authorization by Plan.

**Cancer Diagnosis and Treatment**, is Covered in an outpatient non-hospital setting, when providing chemotherapy treatment, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests or any lab tests or analysis made for diagnosis or treatment. This benefit is subject to the limitations set forth in the Section - Non-Pharmacy Drug Benefits and Limitations of this Certificate of Coverage.

**Casts, Splints and Trusses** when part of a Covered treatment in a non-hospital (outpatient) setting or Urgent Care Center.

**Child Health Supervision Services** for health maintenance and preventive care are Covered. Covered Medical Services include Provider-delivered or Provider-supervised visits by a Contracted Provider from birth to 16 years, which include a history, a physical examination, developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

**Chiropractic Services**, consisting of non-surgical spine and back disorder treatments, must be the result of, or related to, distortion, misalignment or subluxation of, or in the vertebral column.

**Consultations** from a Contracted Provider are Covered. For more details, see Section - Access to Care.

**Diabetes Treatment Services**, are payable for Medically Necessary, Covered outpatient treatment, equipment and supplies, including diabetes outpatient self-management training and educational services used to treat diabetes, if the Member's PCP or Contracted Provider who specializes in the treatment of diabetes certifies that such services are Medically Necessary. This benefit is subject to the limitations set forth in the Section - Non-Pharmacy Drug Benefits and Limitations of this Certificate of Coverage.

**Durable Medical Equipment** that is determined by the Plan and the Member's PCP to be Medically Necessary for care and treatment. Durable medical equipment will not, in whole or in part, serve as a comfort or convenience item for the Member. Care Access' allowance for durable medical equipment is based on the most cost-effective durable medical equipment which meets the Member's needs, as determined by the Plan. All durable medical equipment must be arranged through the Plan's Contracted Provider, authorized by Plan and the Plan will decide if the equipment should be purchased or rented, subject to the Schedule of Benefits and Exclusions in this Contract.

**Eye Examination and Vision Services** covers (1) routine eye exam per Contract Year, including refractive services and Glasses or Contact Lenses, subject to Contract Year limitations as set forth in the Schedule of Benefits.

**Hearing Services and Hearing Aids** covers (1) hearing test per Contract Year and an external hearing aid only and services related to the fitting or provision of external hearing aid, subject to Contract Year limitations as set forth in the Schedule of Benefits.

**Home Health Services** are Covered and subject to the limitations set forth in the Schedule of Benefits, when provided by or arranged through a Contracted Home Health Agency, which may use a licensed nurse registry or independent nurses licensed under Florida Statutes Chapter 464, if:

PCP refers and the Plan authorizes:

- The Member is confined at home and requires Home Health Care Visits;
- The treating Contracted Provider, the Plan, and the Member's PCP agree on a home health care plan of treatment; and,
- Care Access and the Member's PCP approve the plan of treatment in writing as being Medically Necessary and that the services are being provided in the appropriate medical setting.

Home health services include:

- Part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse. For the purpose of this benefit only, part-time and intermittent care visits means up to 2 hours per day of Medically Necessary care. Each visit of two (2) hours (or less) per day is considered one visit.
- Physical Therapy, by a Registered Physical Therapist; Occupational Therapy, by an Occupational Therapist; and Speech Therapy, by a Speech Therapist.
- Medical appliances, equipment, laboratory services, supplies, drugs, medicines prescribed, and other services provided in the home.
- Drugs and medicines administered are subject to the limitations set forth in the Section -Non-Pharmacy Drug Benefit and Limitations described in this Certificate of Coverage.

This benefit is not to be used for the purpose of treating long term, chronic conditions whereby significant improvement in the Member's condition is not foreseeable or that would require indefinite home health care.

**Immunizations and Vaccines** are Covered ONLY when administered by your PCP and recommended by the Advisory Committee on Immunization Practices, American Academy of Pediatrics and the American Academy of Family Physicians except those related to work or travel.

**Insulin**, including the needles and syringes needed for insulin administration when provided by a Contracted Provider. This benefit is subject to the limitations set forth in the Section - Non-Pharmacy Drug Benefits and Limitations of this Certificate of Coverage.

**Laboratory Services and Radiology Services (Routine or High Tech Exams)** for the treatment in a non-hospital (outpatient) setting.

**Mammography** is a Covered Medical Service.

**Maternity Services** under this Plan cover only pre and post-natal services in a Contracted Provider's office. See Schedule of Benefits, and Exclusion Section of this Certificate of Coverage to determine the benefits and limitations unique to this benefit.

**Mental Health Services** when part of a treatment plan from a Contracted Provider after referral from your PCP and approval by the Plan in a non-hospital (outpatient) setting, and limited to twenty (20) visits, individual or group, per Contract Year.

**Newborn Care provided in Contracted Provider's office.** These services include post-delivery outpatient care which includes newborn assessments, physical assessments, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards. The care provided for newborn children who have been accepted for enrollment includes:

- Well child visits
- Treatment for minor injury or sickness
- Preventive Pediatric Health Care
- Newborn hearing screening and any outpatient (non-hospital) Medically Necessary follow-up reevaluation leading to diagnosis is Covered through age 12 months. Treatment for Covered Medical Services under this Certificate of Coverage and delivered or authorized by the child's Primary Care Physician will be provided to any Covered dependent child diagnosed as having a permanent hearing impairment.

Non-Pharmacy Drug Benefit includes injectibles, intravenous medications and any other non-pharmacy drugs and non-pharmacy medications. This benefit is explained in the Section – Non-Pharmacy Drug Benefits and Limitations of this Certificate of Coverage. Coverage limitations and benefits are described in the Schedule of Benefits.

**Oxygen** is Covered including the use of equipment for its administration. Care Access reserves the right to monitor a Member's use of oxygen to assure its safe and medically appropriate use.

**Pre-Ambulatory Surgical Center Tests**, when ordered by PCP and authorized by the Plan subject to the following:

- The tests must be performed within seven (7) days before Member arrives at the Contracted ASC or the Covered non-hospital (outpatient) surgery facility.
- The tests are performed in an outpatient (non-hospital) facility Contracted with the Plan.
- The tests are not duplicated in the Contracted ASC to confirm diagnosis, unless there is a change in the Member's condition.

**Prescription Drug Benefit** is explained in the Section - Prescription Drug Benefit of this Certificate of Coverage. Coverage limitations and benefits are described in the Schedule of Benefits.

**Preventive Health Care Services** include well-child care from birth; periodic health evaluations for adults; eye and ear screenings by a Contracted Provider for children through age 17 to determine the need for vision or hearing correction; and, pediatric and adult immunizations and vaccines as recommended by the Advisory Committee on Immunization Practices, American Academy of Pediatrics and the American Academy of Family Physicians except those related to occupation or travel.

**Prosthetic or Orthotic Devices** if Medically Necessary, including the initial placement of the most cost-effective prosthetic or orthotic device, fitting, adjustments, and repair. Plan will also cover the replacement of such prosthetic or orthotic devices limited to pediatrics or if injured while on the Plan, and determined by the Member's PCP to be Medically Necessary and authorized by the Plan. For more details, see Section - Exclusions in this Certificate of Coverage.

**Rehabilitative Services** are Covered in a non-hospital (outpatient) setting, subject to the limitations described in the "Schedule of Benefits." The limitation is a combined visits limitation regardless of the Covered therapy.

**Second Opinions** are Covered and for more details and limitations, see Section - Access to Care.

**Surgical (Covered) Procedures** are Covered when performed in a non-hospital (outpatient) setting when Medically Necessary, Covered Medical Services.

**Urgent Care Services** are Covered within the Service Area when performed by a Contracted Provider. Urgent Care services provided outside of the Service Area within the United States are Covered Medical Services under the Plan, subject to the limitations described in the "Schedule of Benefits."

## **Prescription Drug Benefits and Limitations**

Your Plan offers you a Prescription Drug Benefits (see Schedule of Benefits for your monthly Benefit limitation and more information) administered by the Plan's Contracted pharmacy provider. As part of your new Member enrollment packet, you will receive information describing how to use your Prescription Drug Benefit, a Plan Formulary and a list of Participating Pharmacies. Also, as a Member, you have different Co-payments for generic and non-generic (brand) drugs that are on the Plan Formulary. These Co-payments are in your Schedule of Benefits and will be on your ID Card.

**Plan or Drug Formulary** is the list of drugs, drug products and insulin that will be Covered under your Prescription Drug Benefit. Drugs and drug products are generally reviewed by a medical committee comprised of Providers and pharmacists for safety, effectiveness and affordability prior to placement on the Plan Formulary list of available drugs.

**Generic Drugs** are copies of brand-name drugs. Only those generic drugs that have been proven to be just as safe and effective as their brand-name counterparts are listed on the Plan Formulary. In order to be on our Plan Formulary, all generic drugs must be approved by the U.S. Food and Drug Administration (FDA) for proven safety and effectiveness. The Co-payment for these drugs is always the lower Co-payment listed in your Schedule of Benefits and on your ID Card.

**Non-Generic or Brand Name Drugs** are those drugs, which have been patented with a specific name. When the brand-name patent expires, the drug becomes a generic drug. As a Member, your Co-payment is greater for brand-name drugs that are included in the Plan Formulary. A brand name drug is Covered by the Plan only if: 1) there is no generic equivalent, and 2) it is in the Plan Formulary. As a Member, you will be responsible for the total cost of the drug unless you meet the above criteria.

We may receive rebates for certain drugs included in our Plan Formulary or accessed through the Plan. We do not consider these rebates in calculating any percentage Copayments. We are not required to pass on to you, and we do not pass on to you, amounts payable to us under rebate programs or other such discounts.

To have a prescription from a Contracted Provider filled, simply go to any participating pharmacy, show your ID Card and pay the required Co-payment indicated on your ID Card. The Pharmacist will dispense the generic counterpart unless there is no generic counterpart to the brand name drug your Contracted Provider prescribed. If the cost of the generic drug is less than your Co-payment, you will pay the lesser of the two amounts. This benefit is subject to a **monthly Benefit maximum of one hundred dollars (\$100.00) excluding co-payments with no monthly carry-over**. When you have used your **monthly benefit maximum of one hundred dollars (\$100.00)**, you will be responsible for any additional costs.

### **Included:**

All drugs listed in the Plan Formulary only  
Prescription drugs related to all Covered Medical Services  
Oral contraceptives under generic co-payment only  
Twenty-four (24) hour a day, seven (7) days a week

### **Excluded:**

Contraception  
Diaphragms, contraceptive foams, abortifacients (i.e. drugs to induce abortions) and menstrual induction drugs  
Insertion or removal of implantable drugs and devices, including but not limited to, pain control, Norplant and other contraceptive drugs and devices, drug infusion pumps and release devices.  
Nicotine withdrawal programs that include Nicorette gum or patch  
All prescription drugs related to non-Covered Medical Services

## **Non-Pharmacy Drug Benefits and Limitations**

Your Plan offers you a Non-Pharmacy Drug Benefit (see Schedule of Benefits for more information) when administered by the Plan's Contracted Providers. This non-pharmacy drug benefit includes injectibles, intravenous medications and any other non-pharmacy drugs and non-pharmacy medications. (excluding immunizations and vaccines). This benefit is subject to a **monthly Benefit maximum of one hundred dollars (\$100.00) excluding co-payments with no monthly**

**carry-over.** When you have used your **monthly benefit maximum of one hundred dollars (\$100.00) excluding co-payments,** you will be responsible for any additional costs.

## **Allergy Treatment Benefits and Limitations**

Your Plan offers you an Allergy Treatment Benefit (see Schedule of Benefits for more information) when administered by the Plan's Contracted Providers. This Allergy Treatment includes allergy testing, desensitization therapy and allergy immunotherapy, including hypo sensitization serum. This benefit is subject to a **monthly benefit maximum of one hundred dollars (\$100.00) excluding co-payments with no monthly carry-over.** When you have used your **monthly benefit maximum of one hundred dollars (\$100.00) excluding co-payments,** you will be responsible for any additional costs.

## **Exclusions**

The following services, treatments, items or supplies are excluded from Coverage and are not Covered Medical Services:

**Abortion:** Elective abortions (termination of pregnancy) performed at anytime during a pregnancy; or services in connection with the pregnancy of eligible children.

**Accidents/Injuries:** Medical services resulting from accidental bodily injuries arising out of any type of motor vehicle accident, watercraft accident, aircraft accident, or any type of accident on public transportation.

**Alcoholism, Substance Abuse and Drug Dependency (including Detoxification):** all related services including prescription drugs are excluded.

**Ambulance Services and/or Ambulance Services by boat, airplane or helicopter**

**Amniocentesis:** Amniocentesis, except when Medically Necessary to determine a genetic disorder.

**Athletic Event-Related:** Care and treatment for injuries sustained by a Member in the course of any athletic event, or while training for such athletic event, for which the Member is to receive remuneration in cash or in kind.

**Blood/Blood Products:** including but not limited to whole blood, blood plasma, blood components and blood derivatives.

**Complications:** Resulting from non-Covered Services, including the diagnosis or treatment of any condition which arises as a complication of a non-Covered Service, including but not limited to services rendered for cosmetic purposes including ear or any other body piercing, gastric bypasses, gastric stapling, breast reductions, breast implants, and Complications of Pregnancy, as well as, any other emergency room, outpatient and inpatient hospital services.

**Congenital or Developmental Abnormality Treatment**

**Cosmetic Surgery:** Cosmetic surgery (plastic and reconstructive), and any other service and supply to improve the Member's appearance or perception, normal bodily functions, including, but not limited to, mammary reduction or augmentation, face lifts, varicose veins, correction of baldness, gastric bypass, gastric stapling and related procedures for the treatment of obesity; includes the diagnosis or treatment which arises as a complication of a non-Covered cosmetic surgery. Cosmetic implantations are excluded. Other cosmetic, services including but not limited to, ear or other body piercing and any complications derived as a result of such service.

**Counseling:** Related to a psychiatric diagnosis, marriage or relationship counseling, services or adoption agencies, pastoral counseling, family counseling, social, occupational, religious, or other social maladjustment's; chronic behavior disorders; codependency; impulse control disorders, organic disorders, learning disabilities, hyperkinetic syndromes, are excluded, including any prescription medications prescribed for treatment associated with any of the above conditions.

**Court-Ordered Services:** Court ordered care or treatment.

**Criminal Activities:**

-Care and treatment incurred in connection with injuries which occurred during a crime committed by a Member or which the Member tries to commit including, without limitation, treatment and care for any injuries sustained when the Member's blood alcohol content is in excess of the legal limit whether or not the Member is charged with or convicted of any criminal offenses.

-Care and treatment for injuries sustained while the Member is under the influence of any illegal or illicit drug.

**Custodial Care:** 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 home facilities, nursing homes, skilled nursing facilities, home health aids (sitters), home mothers, domestic maid services and respite care, and private duty nursing.

**Dental Care and all Dental Services:** Dental care means treatment on or to the teeth; extraction of teeth; treatment of dental abscess or granuloma; treatment of gingival tissues other than for tumors, dental examinations; and conventional or surgical orthodontics or orthognathics, as well as general anesthesia for dental procedures.

**Dental Services for the Treatment of an Accidental Dental Injury**

**Durable Medical Equipment:** Power Scooters, Ventilators and Clinitron Beds are excluded from Coverage, and any other equipment not a Medically Necessary, Covered Medical Service.

**Experimental Procedures:** Procedures determined by the U.S. Food and Drug Administration, the American Medical Association or the Plan's Medical Director to be experimental or investigational.

**Eye Corrective Surgery,** including but not limited to, Refractory Keratoplasty, Radial Keratotomy, LASIK, Myopic Keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

**Foot Care including Orthotics:** Routine foot care, including any service or supply in connection with foot care in the absence of a circulatory condition; including, but not limited to, treatment of bunions, extracorporeal lithotripsy, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails.

**Hearing Services and Hearing Aids** related to inner ear devices or enhancements including, but not limited to, Cochlear implants, tinnitus masker.

#### **Hemodialysis for Renal Disease**

**High Risk Activities:** Care or treatment for injuries/conditions directly related to a Member's avocation/hobby that is considered to be one of high risk; including but not limited to, sky-diving, operating on an all-terrain vehicle, parasailing, bungee jumping, scuba diving, operating small aircraft.

#### **Hospice Services**

**Hospital Services** are not Covered by this Contract. This includes any and all services (professional, facility, technical or otherwise) performed in a hospital either through inpatient, outpatient or emergency room.

#### **Hypnotism or Hypnotic Anesthesia**

**Illegal Actions:** Treatment of a condition resulting from participating in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony; includes care and treatment incurred in connection with injuries suffered in a fight in which the Member is the Aggressor or while the Member is under the use of an illegal substance.

**Illegal Occupation:** Treatment of a condition resulting from engaging in an illegal occupation.

**Immediate Relatives and Self Imposed Treatment:** Charges for Providers' services imposed by an immediate relative or Member of the Member's household, even if the bill is submitted by another individual or by an entity such as a partnership or a professional corporation, are excluded from Coverage. This exclusion also precludes a Member that is also a Provider from treating himself and submitting claims to the Plan for such Coverage.

For the purpose of this exclusion "Immediate Relative" means any of the following:

- Husband or wife
- Natural or adoptive parent, child or sibling
- Stepparent, stepchild, stepbrother or stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law
- Grandparent or grandchild
- Spouse of grandparent or grandchild

**Immunizations and Vaccines** related to your occupation or travel are not Covered.

**Infertility Services** including but not limited to:

- Services and supplies for the purpose of diagnosing the cause of infertility, including examinations, diagnostic surgical services and related hospital or facility costs in connection with such surgery, are excluded.
- Treatment for infertility, including Pergonal (or other like drug) therapy, artificial insemination or plastic repair of the Fallopian tubes, is excluded.
- All charges incurred for in-vitro fertilization, any procedure involving combining ovum and sperm outside the body, embryo transfers, and any services and supplies related to donor sperm or sperm preservation for artificial insemination are excluded.
- Services and supplies in connection with the reversal of voluntary sterilization are excluded.

- All charges incurred by a surrogate mother whose services were Contracted by or on behalf of the Member, spouse or dependent.

**Maternity Services:** Delivery and related maternity/obstetrical services.

**Medical Services** (outside of the United States) including Prescription Drugs, are excluded.

**Mental and Nervous Disorders**, unless part of a treatment plan from a Contracted Provider after referral from PCP and authorized by Plan in a non-hospital outpatient setting, are excluded.

**Military-Related:** military service-related medical care, for which the Member is legally, entitled to service from military or government facilities and for which facilities are reasonably accessible.

**Not Medically Necessary:** Services or supplies determined by the Plan not to be Medically Necessary.

### **Obesity Treatment**

**Organ Donor, Harvesting and Transplants (including Tissue Transplants):** All medical and hospital services for an organ donor or prospective donor, as well as the harvesting and processing of organs or transplants.

**Orthomolecular Therapy (including nutrients, vitamins and food supplements)** are excluded.

**Osteopathic Services:** Inpatient and outpatient services from hospitals accredited by the American Osteopathic Association.

**Personal Comfort, Hygiene or Convenience Items**, including services and supplies deemed to be not Medically Necessary by the Plan and not directly related to the care of the Member, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, or travel expenses related to medical condition.

**Physical Examinations** specifically for obtaining or continuing employment or required for enrolling in educational institutions, insurance, government licensing or premarital purposes, and immunizations for purposes of travel.

**Provider Services** when rendered in a hospital, emergency room, or nursing facility, or when rendered by a non-Contracted Provider or when not authorized by the Plan. The following provided are excluded Naturopaths' treatments or services and Chelation therapy (EDTA).

**Rehabilitative Services:** Treatment provided while the Member is in a Hospital or Nursing Facility, and services of a licensed speech-language pathologist to aid in the restoration of speech loss or swallowing disorders or an impairment resulting from injury, stroke or a surgical procedure are excluded.

Rehabilitative Services include other therapy types, or any service or supply, including but not limited to, Cognitive Rehabilitation Therapy.

**Self-Inflicted/Suicide:** Treatment for a condition resulting from intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Member.

**Sexual Reassignment:** Sexual reassignment, reproduction or modification services; including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prosthesis, genetic test to determine paternity or sex of a child; or the insertion of a penile prosthesis, except when necessary in the treatment of organic impotencies resulting from a medical disease.

### **Skilled Nursing Facility Services**

**Smoking Cessation:** 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 programs and Nicorette gum or patch.

**Specific Therapies and Treatments:** hypnotherapy; biofeedback; acupuncture; sleep therapy and sleep apnea therapy (including diagnosis and treatment); behavioral training; sex therapy; and hair analysis.

**State/Local Requirements:** Care for conditions that State or local law requires to be treated in a public facility.

**Sterilization-Reversals:** Reversal of voluntary, surgically-induced sterility, including but not limited to the reversal of Tubal Ligations, Vasectomies and complications thereof.

**Surgery** performed in a hospital setting to including but not limited to cleft lip and cleft palate.

**Surrogate Costs (refer to Infertility Services exclusion)**

**Temporomandibular Joint Syndrome (TMJ)**

**Transportation Services**

**Vocational Rehabilitation**

**Veteran's Affair (VA):** Treatments or services provided to veterans in Veteran's Affairs (VA) facilities. Refer to Military-related exclusion for additional details.

**War-Related Treatment:** Treatment of any condition resulting from war or an act of war, whether declared or not.

**Weight Control/Loss:** Weight control and weight loss programs; including, but not limited to food supplements, appetite suppressants, dietary regimens or treatments, exercise programs or equipment, gastric stapling, gastric bypass, liposuction and related procedures for the treatment of obesity, surgical or invasive treatment including gastric balloon, or reversal thereof, including treatment of the complications resulting from surgical treatment of obesity; regardless of associated medical or psychological conditions.

**Work-Related Treatment:** Care and treatment for any injury, illness, or condition which arises out of, or in the course of, any occupation for wage or for-profit, any injury, illness, or condition for which the Member is paid benefits under any Workers' Compensation policy law, employer's liability policy, or any similar policy.

# GRIEVANCE PROCEDURE

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At Care Access, we are committed to Member satisfaction. 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 to voice your concerns and have them reviewed and addressed at the Plan.

Care Access' Grievance Procedure is designed to provide prompt, meaningful and confidential resolution of Member concerns regarding quality of care, Provider behavior, office waiting times, claims payment, and other similar matters.

The following procedures govern adverse determinations, complaints, grievances and appeals (if applicable) made or submitted by Members. A Member must exhaust the procedures set forth herein, including all appeals (if applicable), prior to bringing any action whatsoever, court or otherwise, based upon any issue or matter relating to or arising from Coverage with Care Access, including but not limited to any action for rescission of such Coverage with Care Access.

## Definitions

**Adverse Determination** means a Coverage determination by Care Access that availability of care or a health care service has been reviewed and, based upon the information provided, does not meet Care Access' requirements for medical necessity, appropriateness, level of care or effectiveness, and Coverage for the requested service is therefore denied, reduced or terminated.

**Agency** is the Agency for Health Care Administration.

**Inquiry** is a Member's *verbal* request for administrative service, information, or to express an opinion.

**Complaint** means any *verbal* expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practice, or provision of services, which relates to the quality of care provided by a Provider pursuant to the Contract and which is submitted to Care Access or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined below.

**Grievance** is a *written* complaint submitted by or on behalf of a Member to Care Access or to 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 health care services; or (c) matters pertaining to the Contract and Certificate of Coverage.

## Grievance Process

### **Inquiry**

A Member should call Care Access to discuss any questions or concerns. A Care Access Member Service representative can be reached at 305-614-5050 or toll-free 1-866-429-2882. Representatives can immediately respond to most inquiries. If they cannot respond immediately, they will investigate and either respond to the inquiry within a targeted response time of 2 working days, or notify the Member that they need more time to respond. The response to an inquiry should not exceed 15 working days from the date of that inquiry.

### **Complaint**

The majority of complaints communicated to Care Access may be resolved at the point of contact. However, if the issue requires investigation or the involvement of other departments or outside parties, the Member will be notified of such within a targeted response time of 2 working days. At the time of the initial complaint, the Member will be notified that s/he has the option of filing a written complaint (i.e. grievance), with the assistance of the Member Service representative, if needed.

## Grievance

1. If a Member files a written complaint from the onset, or is not satisfied with the response to their inquiry or complaint and then chooses to file a written complaint, the issue is automatically elevated to the category of a grievance. The grievance must include the following information: (1) Member's name, address and identification number, (2) a summary of the facts surrounding the grievance, including a description of all efforts to resolve the grievance with Care Access, (3) a description of the relief sought, (4) Member's signature or other authorized person's signature as set forth herein along with the date such grievance is signed. The grievance must be addressed to:

Care Access Health Plan  
Grievance/Appeals Department  
P. O. Box 4276  
Hallandale, FL 33008-4276

In the event a Member is unable to submit a written complaint (i.e. grievance), Care Access shall assist the Member in preparing the grievance and communicating back a final decision in writing.

Except in the case of an urgent care grievance or as otherwise specifically set forth below, Care Access shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if Care Access notifies the Member, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After Care Access receives the required information the time allowed for completion of the grievance process resumes.

Notwithstanding the foregoing time frames, decisions on those types of claims set forth below shall be within the following time frames except that Care Access may request one 15 day extension for pre-service and post-service claims:

- **72 hours** for urgent care grievances
- **15 calendar days** for pre-service grievances
- **30 calendar days** for post-service grievances

A Member must submit a grievance within one (1) year after the occurrence of the action that initiated the grievance, and may submit the grievance for review to the Statewide Provider and Subscriber Assistance Panel as provided under law after receiving a final disposition of the grievance through Care Access's grievance process. However, a Member may submit a copy to the Agency or contact the toll-free telephone hotline of the Agency at any time during the process.

2. After receipt of a grievance by Care Access, a written notice shall be sent by Care Access to the Member that documents all the following:

- Acknowledgement of each grievance by the grievance manager that the grievance will be investigated and a final decision will be communicated in writing.
- Invitation to the Member to provide any additional information to assist the Care Access in handling and deciding the grievance, and
- Information of the Member's grievance rights and the grievance process.

3. In the event a grievance concerns an Adverse Determination the following shall apply. Care Access shall make available an internal review panel to review such grievance provided such Member has requested in the grievance a review by an Adverse Determination internal review panel within 30 days after Care Access' transmittal of the final determination notice of such Adverse Determination. A majority of the panel will be persons who were not previously involved in the initial adverse determination. A person who previously was involved in the Adverse Determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind Care Access to the panel's decision. A majority of persons reviewing such an Adverse Determination grievance shall be Providers who have appropriate expertise. In cases where there has been a denial of Coverage of service, the reviewing Provider shall not be a Provider previously involved with the Adverse Determination.

Care Access shall issue a copy of the written decision of the review panel to the Member and to the Provider, if any, who submits such a grievance on behalf of the Member.

Care Access shall establish written procedures for a review of an Adverse Determination as set forth above. Review procedures shall be available to the Member and to a Provider acting on behalf of a Member.

In any case when the review process of an Adverse Determination as set forth above does not resolve a difference of opinion between Care Access and the Member or the Provider acting on behalf of the Member, the Member or the Provider acting on behalf of the Member may submit a written grievance to the Statewide Provider and Subscriber Assistance Panel.

4. In the event a grievance concerns an urgent grievance requiring expedited review the following shall apply. A request for an expedited review may be submitted orally or in writing and shall be subject to the following review procedures if the request meets the following criteria. Unless the request for expedited review is submitted in writing, for purposes of the grievance reporting requirements, the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a Member and to the Provider acting on behalf of the Member. For purposes of an expedited review herein, Member includes the legal representative of a Member.

- Expedited review shall be evaluated by an appropriate clinical peer or peers. Care Access shall forward the expedited review request, within a time period not to exceed 24 hours, to a clinical peer who can perform the expedited review.
- The clinical peer or peers shall not have been involved in the initial Adverse Determination.
- In an expedited review, all necessary information, including Care Access' decision, shall be transmitted between Care Access and the Member, or the Provider acting on behalf of the Member, by telephone, facsimile, or the most expeditious method available.
- In an expedited review, Care Access shall make a decision and notify the Member, or the Provider acting on behalf of the Member, as expeditiously as the Member's medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the Member until the Member has been notified of the determination.
- Care Access shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.
- In any case when the expedited review process does not resolve a difference of opinion between Care Access and the Member or the Provider acting on behalf of the Member, the Member or the Provider acting on behalf of the Member may submit a written grievance to the Statewide Provider and Subscriber Assistance Panel.

5. For any grievance, whether or not related to an Adverse Determination or an urgent grievance requiring expedited review, Care Access shall forward a written notice stating the result of the grievance to the Member. Such notice shall include:

- The decision, in clear terms, and
- A notice that in the event the Member is not satisfied with the grievance result of an Adverse Determination or an urgent grievance requiring expedited review, a notification that the next level is to request a review by the Statewide Provider and Subscriber Assistance Panel.
- A notice that in the event the Member is not satisfied with the grievance result of a grievance other than an Adverse Determination or an urgent grievance requiring expedited review, a notification that the next level is to request a review of the grievance by the Grievance Appeal Hearing Panel within 180 calendar days of the date of the letter notifying them of the determination.

## **Appeal Hearing**

Care Access shall send an acknowledgement letter to the Member filing the request for a review of a grievance (other than an Adverse Determination or an urgent grievance requiring expedited review) by the Grievance Appeal Hearing Panel, in order to explain the exact procedures that govern appeals before the Grievance Appeal Hearing Panel.

The Grievance Appeal Hearing Panel shall establish a hearing date.

The Grievance Appeal Hearing Panel shall hold the hearing within no more than 30 calendar days of the receipt of the request for the hearing, however within the time prescribed by law to resolve such a grievance.

The appeal hearing shall be informal. The Grievance Appeal Hearing Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing.

The deliberations of the Appeal Hearing Panel shall be confidential and shall not be transcribed.

The Appeal Hearing Panel shall render a written decision within 5 working days of the conclusion of the appeal hearing.

The decision shall contain:

- The decision, in clear terms, and
- A statement of the Member's right to request a review of the organization's decision concerning the grievance by Statewide Provider and Subscriber Assistance Program which must be done within 365 days after receipt of the final decision letter, and explanation of how to initiate such a review, and the addresses and toll-free numbers of the agency and the Statewide Provider and Subscriber Assistance Program.

### **Agency for Health Care Administration**

Fort Knox Building 1 No. 306  
2727 Mahan Drive  
Tallahassee, FL 32308-5403  
850-921-5458 or Toll Free: 800-226-1062

### **Statewide Provider and Subscriber Assistance Program**

Fort Knox Building 1 No. 343  
2727 Mahan Drive  
Tallahassee, FL 32308-5403  
850-921-5458 or Toll Free: 800-226-1062

## **Fees and Costs**

Nothing herein shall be construed to require Care Access to pay counsel fees or any other fees or costs incurred by a Member in pursuing a grievance or appeal.

## **OTHER COVERAGE**

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### **Other Coverage by another Health Plan**

You may be covered by other insurance, for example, auto insurance, workers' compensation, or another health plan or health insurance. If, in addition to Care Access, you have another health plan or other insurance covering medical services, you are still required to use the Plan's Contracted Providers to obtain all Covered Medical Services. This will enable the Plan to maximize the benefits available to you under both your Care Access Plan and any other plan or insurance you may have, and minimize your out-of-pocket expenses, unless the medical services were non-Covered Medical Services under the Plan. Care Access is entitled to receive payment for all services and supplies to the extent that you are eligible to be reimbursed or are otherwise Covered by another plan or other insurance (except any insurance Coverage that pays you for the loss of income or time away from work). The Plan is only entitled to recover for the cost of Covered Medical Services it has provided on your behalf.

### **Coverage when Accidents Occur**

In the event you require medical services as a result of an accident, if Care Access covers those services, you should obtain Covered Medical Services from Care Access' Contracted Providers to ensure you will be Covered for Medically Necessary Covered Medical Services. If you use non-Contracted Providers to obtain Covered Medical Services and expect those medical services to be reimbursed by another health plan or other insurance, you may find that the other health plan or insurance has a limit on the amount they will pay for medical services. Care Access will not pay non-Contracted Providers for Covered Medical Services which were not reimbursed by the other plan or insurance. Care Access will pay for Medically Necessary Covered Medical Services provided by Contracted Providers and will coordinate your benefits with those of the other plan or insurance.

If you receive Covered Medical Services which have been determined to be the responsibility of a third party or for which you receive compensation, Care Access is entitled to be reimbursed for its expense of providing those Covered Medical Services.

### **Coordination of Benefits**

The Covered Medical Services provided under this Certificate of Coverage and Contract are not intended to and do not duplicate any medical service to which you are entitled under a Medicare policy, any medical services or benefits obtained through your automobile policy, or any medical services provided for injuries Covered under a liability insurance policy. Such other policies or health plans will be referred to below as "Other Coverage."

If any Member is eligible for Covered Medical Services or benefits under Other Coverage, the Coverage under such Other Coverage will be coordinated so that up to, but no more than, 100 percent of the Contract allowance for any Covered Medical Services will be paid for, or provided by, this Plan and all Other Coverage combined. Responsibility for the provision or payment of Covered Medical Services will be determined in the following order:

The benefits of a Medicare plan, if applicable, will pay or provide its benefits before the benefits of this Plan.

For treatment of automobile accident related injuries for which "Other Coverage" exists, the automobile no-fault and/or medical payment Coverage under the Automobile policy will pay or provide its benefits before the benefits of this Plan.

For treatment of any other injury for which medical payment Coverage exists (Liability Insurance), the medical payment Coverage under the liability insurance policy will pay or provide its benefits before the benefits of this Plan. In addition, prior to the Plan being deemed liable, the Member must have exhausted all available benefits under Other Coverage and must have followed the rules, advice and instruction, and executed any and all forms, applications and procedures as required, to secure all available Coverage from such Other Coverage. Failure of Member to do

whatever was necessary to take maximum advantage of the benefits offered by Other Coverage which causes such Other Coverage to deny otherwise available Coverage, will deem such benefits to be excluded benefits under the Plan and thereby are not Covered or payable by the Plan.

Whenever services which have been paid or provided by the Plan exceed the maximum amount that the Plan was obligated for under Coordination of Benefits, the Plan will have the right to recover payments to the extent of such excess from among one or more of the following, as the Plan determines:

Any persons to or for whom such payments were made; or

Any Other Coverage which owes payments for such services Covered under such Other Coverage.

The ordinary deductible or coinsurance included under the benefits of Other Coverage which is paid or provided before the benefits of this Plan, will be paid by the Plan, but not in excess of the benefits of this Plan.

Coverage provided under this Plan will be primary to Coverage provided by the State of Florida Medicaid Program.

### **Subrogation**

Upon the delivery of Covered Medical Services or payment for such services by the Plan, the Plan will be subrogated to any Member's rights against an employer or other third party alleged to be legally responsible for bodily injury or illness to you, to the extent of the reasonable value on a fee for service basis of the health services or payments provided and to the extent that compensation or damages were recovered. The right of subrogation provided to the Plan under this paragraph will be determined in accordance with Florida Statutes or the courts of Florida.

The Plan may, at its option, take such action as may be necessary and appropriate to preserve its rights to recover such compensation or damages, including the right to bring suit in the name of the Member. You agree to cooperate fully with the Plan in protecting its legal rights under this section, including cooperating in obtaining information about the injury or illness and its cause.

## General Legal Provisions

This section provides you with information about certain legal provisions concerning the Contract and Certificate of Coverage, however not all legal provisions are contained within this section and may also be found in other sections of the Certificate of Coverage and the Contract.

### Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's benefit plan and how it may affect you. We do not provide medical services or make treatment decisions. This means we communicate to you decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that you receive. The Plan pays for certain medical costs, which are fully described in this Certificate of Coverage. The Plan may not pay for all treatments you or your Provider may believe are necessary. If the Plan does not pay, you will be responsible for the cost. This means we do not decide what care you need or will receive. You and your Provider make those decisions.

### Our Relationship with Providers and Enrolling Groups

Care Access does not directly provide Covered Medical Services to its Members. It does make available certain Covered Medical Services, ***excluding care in a hospital setting*** to its Members through the Plan's Contracted Providers, who are not agents or employees of Care Access. These Contracted Providers provide Covered Medical Services to Care Access Members based upon their knowledge and expertise in the areas of practice for which they are licensed and/or trained. Our credentialing process confirms public information about the provider's licenses and other credentials, but does not assure the quality of the services provided. Contracted Providers maintain the physician/patient relationship with the Member and are solely responsible for all Covered Medical Services which they provide to Members. Therefore, Care Access shall not be liable for any negligent act or omission committed by any independent practicing Providers, nurses, medical personnel, and/or health care facility that may from time to time provide Covered Medical Services to Members of Care Access, whether Contracted or not Contracted. Furthermore, Care Access shall not be vicariously or otherwise liable for any negligent act or omission of any Contracted Providers or other Providers who treat a Member of Care Access Health Plan.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan. We are not a plan administrator or named fiduciary of any benefit plan, as those terms may be used under any laws.

### Provider Network

You will be given a directory of Contracted Providers. However, before obtaining services you should always verify the Contracted provider status of a provider. A provider's status may change. You can verify the provider's status by calling Member Services. It is possible that you may not be able to obtain services from a particular Contracted Provider. Contracted providers are subject to change. Or you might find that a particular Contracted Provider may not be accepting new patients. If a provider is no longer contracted with the Plan or is otherwise not available to you, you must choose another Contracted Provider. Do not assume that a Contracted Provider's agreement with us includes all Covered Medical Services. Some Contracted Providers contract with us to provide only certain Covered Medical Services, but not all Covered Medical Services. Some Contracted Providers choose to be a Contracted Provider for only some of our products. Refer to your provider directory or contact us for assistance.

### Notice

When we provide written notice regarding the administration of the Contract to the Enrolling Group, that notice is deemed notice to all affected Members and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

### Statements by Enrolling Group or Member

All statements made by the Enrolling Group or by a Member, shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Contract after it has been in force for a period of two years. Except for fraudulent statements, we will not use any

statement made by the Subscriber or Member to rescind or void Coverage after Coverage has been in force for a period of two years for that Subscriber or Member.

### **Incentives to Providers**

We pay Contracted Providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care. Examples of financial incentives for Contracted Providers are: (1) bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness, and (2) capitation which is where Contracted Providers receive a monthly payment from us for each Covered person who selects or is assigned to such Contracted Provider to perform or coordinate certain Covered Medical Services. The Contracted Provider receives the monthly payment regardless of whether the cost of providing or arranging to provide those certain Covered Medical Services is less than or more than the payment.

### **Interpretation of Benefits**

We have sole and exclusive discretion to do all of the following: (1) interpret Benefits under the Contract, (2) interpret the other terms, conditions, limitations and exclusions set out in the Contract, including this Certificate of Coverage and any Riders or Amendments, and (3) make factual determinations related to the Contract and its Benefits. In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole and absolute discretion, offer Benefits for services that would otherwise not be Covered Medical Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

### **Clerical Error**

If we commit a clerical error or other mistake, that error will not create a right to Benefits.

### **Administrative Services**

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regards to the Contract. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

### **Information and Records**

At times we may need additional information from you. You agree to furnish us with all information and proofs that we may reasonably require regarding any matters pertaining to the Contract. If you do not provide this information when we request it we may delay or deny payment of your Benefits. By accepting Benefits under the Contract, you authorize and direct any person or entity that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered persons, including Enrolled Dependents whether or not they have signed the Member's enrollment form. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Contract, for appropriate medical review or quality assessment, or as we are required to do by law. For a complete listing of your medical records we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records. If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing forms or providing the records.

### **Examination of Covered Person**

In the event of a question or dispute regarding your right to Benefits, we may require that a Contracted Provider of our choice examine you at our expense.

### **Worker's Compensation Not Affected**

Benefits provided under the Contract do not substitute for or do not affect any requirements for coverage by worker's compensation insurance.

## **Refund of Overpayments**

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or entity that was paid, must make a refund to us if either of the following apply: (1) all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person, or (2) all or some of the payment we made exceeded the Benefits under the Contract. The refund equals the amount we paid in excess of the amount should have paid under the Contract. If the refund is due from another person or entity, the Covered Person agrees to help us get the refund when requested.

## **Time Limit for Certain Defenses**

You cannot bring any legal action against us for any reason unless you first complete all the steps in the complaint and grievance process described in this Certificate of Coverage. After completing that process, if you want to bring a legal action against us you must do within five years of the date we notified you of our final decision on your complaint or you lose any rights to bring such an action against us.

## **Entire Contract**

The Contract issued to the Enrolling Group, including this Certificate of Coverage, the Schedule of Benefits, the Enrolling Group's Application, Amendments and Riders, constitutes the entire Contract.

# NOTICE OF PRIVACY PRACTICES

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## Notice of Privacy Practices

*Para recibir esta notificación en español, por favor llamar al número incluido en este documento.  
Si ou vle kòpi an kretyol, rele nimero telefòn ki nan dokiman sa-a.*

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.***

Care Access considers personal information confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies. This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information. When we use the term “personal information,” we mean financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance Coverage. By “health information,” we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care).

## How Care Access Uses and Discloses Personal Information

In order to provide you with insurance Coverage, we need personal information about you, and we obtain that information from many different sources from you – particularly your employer or benefits plan sponsor, other insurers, HMOs or third-party administrators (TPA's), and health care Providers. In administering your health benefits and providing mail order pharmacy services, we may use and disclose personal information about you in various ways, including:

**Operations:** We may use and disclose personal information during the course of operating our health business – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for Members with specific conditions, such as diabetes, asthma, or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or Contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Care Access with another health plan (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and Member service.

**Payment:** To help pay for your Covered Medical Services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your Provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the Member. In addition, we may make claims information contained on Care Access' health site and telephonic claims status sites available to the Member and all Covered dependents.

**Treatment:** We may disclose information to doctors, pharmacies, and other health care Providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

**Disclosures to Other Covered Entities:** We may disclose personal information to other Covered entities, or business associates of those entities for treatment, payment, and for certain health care operations purposes. For example, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

**Additional Reasons for Disclosure** We may use or disclose health information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

**Plan Administration** – to your employer, when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.

**Research** – to researchers, provided measures are taken to protect your privacy.

**Business Associates** – to persons who provide services to us and assure us they will protect the information.

**Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.

**Law Enforcement** – to federal, state and local law enforcement officials.

**Legal Proceedings** – in response to a court order or other lawful process.

**Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

## **Disclosure to Others Involved in Your Health Care**

We may disclose health information about you to a relative, a friend, another Member of your family who has a Care Access Plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family Member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Care Access Member Service Department number on your ID Card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Care Access Member Service Department number on your ID Card or have your Provider contact us.

## **Uses and Disclosures Requiring Your Written Authorization**

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Member Services number on your ID Card.

## **Your Legal Rights**

The federal privacy regulations give you the right to make certain requests regarding health information about you. You may ask us to:

Communicate with you in a certain way or at a certain location. For example, if you are Covered as an adult dependent, you might want us to send health information to a different address from your Member's address. We will accommodate reasonable requests.

Restrict the way we use or disclose health information about you in connection with health care operations, payment, and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.

Obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making an application, payment, claims adjudication, medical management, and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies, and, in certain cases, may deny the request.

Amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.

Provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee. You may make any of the requests described above, or may request a paper copy of this notice, by calling the toll-free Member Services number on your ID Card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please follow the complaint procedures described in your plan documents. You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

## **Care Access's Legal Obligations**

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

## **This Notice is Subject to Change**

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your Coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your Coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

**For More Information:** If you have questions regarding this notice, please contact Care Access by mail at P.O. Box 4276 Hallandale, FL 33008-4276. **Please include your name, and return contact information; including your mailing address, telephone and/or fax number.**

## **Confidentiality / Release of Information**

When you sign an Enrollment Application, you give consent to Care Access to use your health information to carry out the payment, treatment and other health care operations necessary to provide Covered Medical Services to you. Care Access may also use information to conduct quality assessment and improvement activities, evaluations of Provider performance and activities to detect fraud and abuse. In any instance where Care Access has Contracted with a business associate to conduct any of these activities, we require that a confidentiality statement be included in the written Contract. There are also agencies and other entities that also have regulatory authority to request copies of your records.

You are under no obligation to give your written authorization to allow Care Access to release information about your medical records or Providers where you have received care other than as was explicitly indicated on your Enrollment Application and for the reasons provided above.

Information from your medical records and information from all health care Providers shall be kept confidential in accordance with the guidelines set forth in the Health Insurance Portability and Accountability Act (HIPAA). It will not be shared with anyone without your written authorization, except as expressly permitted by applicable State and Federal laws or requirements. This includes your employer, if you are currently employed. Additional written authorization from you is required in order for Care Access to release any personally identifiable health information for the following conditions: HIV/AIDS, addiction treatment (i.e. drugs, alcohol) or any psychiatric treatment or care.

Any personal information that you give us when you enroll in this Plan is also protected and will remain confidential. We will make sure that unauthorized individuals cannot see or change your records.

## **Confidentiality of Your Medical and Personal Information**

We value the trust you have placed in Care Access. Just as you have placed your trust in us to provide access to quality Covered Medical Services, we give you our commitment to treat all the information you give us responsibly. We understand your personal information is private and we promise you that your privacy will be protected.

## **Information we share**

Health information needs to flow freely among health care professionals to ensure that you and your eligible dependents receive the best preventive, diagnostic and treatment options. In order to provide you access to quality Covered Medical Services, we share your information with those who need it to render the most appropriate care. We may share information in order to give you and your PCP or Provider the material you need to weigh all the options and make the best decisions regarding your health.

We may share the personal information we collect about Members and former Members with non-affiliated third parties with whom we contract to administer or provide selected functions for our plan. Non-affiliated third parties include organizations such as medical groups, pharmacies, and other non-hospital facilities that are not part of Care Access. These entities must agree to comply with stringent privacy and security policies and procedures. We do not sell or rent your personal information to any organization or individual.

## **How we defend your privacy?**

We have strict standards of security to safeguard the confidentiality of your information. We restrict access to your information to authorized individuals who need to know this information to provide services to you. We follow these standards to safeguard your personal health information:

We maintain physical, electronic, and procedural safeguards that protect your information.

We do not disclose this information about you or any former Members to anyone, except as permitted by law.

Employees do not share your information outside the company unless authorized by you or for a specific business purpose.

All Care Access employees sign a confidentiality statement that prohibits the release of personal information about Members, including medical files, medical conditions, or claims data. Employees who are granted access to your information are held accountable to follow established standards, policies, and laws.

### **Your consent**

A Member's routine consent is given at the time of application and applies for all Members and dependents Covered by the Member's plan. The routine consent allows Care Access to release identifiable health information to Providers involved in the Member's treatment or to law enforcement, regulatory or accrediting agencies for the purposes of investigating fraud or overseeing the payment of claims or for other Care Access operational activities such as utilization review, grievance and appeals resolution, quality assurance programs, and Member satisfaction surveys.

Any other disclosures of individual identifiable health information shall require the express, special consent of the Member. The consent must specify the individual or organization to whom the information is to be disclosed and the purpose of the disclosure.

If a Member is unable to give consent, Care Access will release individual identifiable health information to the Member's authorized representative, unless Care Access determines in its discretion that such release may be harmful to the Member, in which case it may release the information to the Member's Provider.

### **Access to Medical Records**

Members have the right to access their personal information, such as name, address, and medical records held by Care Access. A Member or his/her authorized representative may submit a written request for copies of the Member's personal information.

### **Other Agencies**

Pursuant to Florida law, Care Access may not provide information to you concerning the outcome of quality of care complaints.

If you need further assistance, you may contact:

The Florida Agency for Health Care Administration  
Statewide Provider and Subscriber Assistance Program  
2727 Mahan Drive  
Tallahassee, Florida 32308  
Tel: (888) 419-3456

The Office of Insurance Regulation (OIR)  
Larson Building  
200 Gaines Street  
Tallahassee, Florida 32399  
Tel: (800) 342-2762

## Contact Information

<b>Department/Service</b>	<b>Phone Number</b>	<b>Hours of Operation</b>
<b>Member Service Department</b> (Eligibility Verification, Benefits, Order ID Cards, PCP Changes)	1-866-429-2882 305-614-5050	Monday – Friday 9:00 am – 5:00 pm
<b>Member Service Department –Fax Only</b>	305-614-5051	
<b>Member Service Department TDDY</b>	305-614-5006	
<b>Member Service IVR (Interactive Voice Response System)</b> (Eligibility Verification, Co-payments, Order ID Cards, PCP Changes)	305-614-5005	24 hours a day / 7 days a week
<b>Premium Billing Status IVR (Interactive Voice Response System)</b>	305-614-5008	24 hours a day / 7 days a week
<b>Dental Services Provider</b> (If benefit purchased as a Rider)	1-800-813-5269	Monday – Friday 8:00 am – 6:00 pm
<b>Mental Health Services Provider</b>	1-800-835-2094	24 hours a day / 7 days a week
<b>Prescription Drugs (Pharmacy) Provider</b>	1-866-240-4912	Monday – Friday 9:00 am – 5:30 pm
<b>Vision Services Provider</b>	1-877-571-4188	Monday – Friday 8:00 am – 5:30pm

### Premium Payment Address

Care Access (Premium Payment Dept.)  
PO Box 4276  
Hallandale, FL 33008-4276

### Grievance and Appeals Department

Care Access (Grievance/Appeals Dept.)  
PO Box 4276  
Hallandale, FL 33008-4276

### Medical Claims Address

Care Access (Claims Dept.)  
PO Box 4276  
Hallandale, FL 33008-4276