



**Town of Surfside  
Special Town Commission Meeting  
September 22, 2010  
6:00 p.m.**

Town Hall Commission Chambers - 9293 Harding Ave, 2<sup>nd</sup> Fl  
Surfside, FL 33154

**AGENDA**

**1. Opening**

- A. Call to Order
- B. Roll Call of Members
- C. Pledge of Allegiance
- D. Public Comments

**2. Employee Benefits Contract Ratification for Fiscal Year 2010-2011**

**3. Town Manager Separation Agreement**

**4. Adjournment**

Respectfully submitted,

Gary L. Word,  
Town Manager

THIS MEETING IS OPEN TO THE PUBLIC. IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1990, ALL PERSONS ARE DISABLED; WHO NEED SPECIAL ACCOMMODATIONS TO PARTICIPATE IN THIS MEETING BECAUSE OF THAT DISABILITY SHOULD CONTACT THE OFFICE OF THE TOWN CLERK AT 305-893-6511 EXT. 226 NO LATER THAN FOUR DAYS PRIOR TO SUCH PROCEEDING. HEARING IMPAIRED PERSONS MAY CONTACT THE TDD LINE AT 305-893-7936.

IN ACCORDANCE WITH THE PROVISIONS OF SECTION 286.0105, FLORIDA STATUTES, ANYONE WISHING TO APPEAL ANY DECISION MADE BY THE TOWN OF SURFSIDE COMMISSION, WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING OR HEARING, WILL NEED A RECORD OF THE PROCEEDINGS AND FOR SUCH PURPOSE, MAY NEED TO ENSURE THAT A VERBATIM RECORD OF THE PROCEEDINGS IS MADE WHICH RECORD SHALL INCLUDE THE TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

AGENDA ITEMS MAY BE VIEWED AT THE OFFICE OF THE TOWN CLERK, TOWN OF SURFSIDE TOWN HALL, 9293 HARDING AVENUE. ANYONE WISHING TO OBTAIN A COPY OF ANY AGENDA ITEM SHOULD CONTACT THE TOWN CLERK AT 305-861-4863. A COMPLETE AGENDA PACKET IS ALSO AVAILABLE ON THE TOWN WEBSITE AT [www.townofsurfsidefl.gov](http://www.townofsurfsidefl.gov)

**TWO OR MORE MEMBERS OF OTHER TOWN BOARDS MAY ATTEND THIS MEETING.**

**THESE MEETINGS MAY BE CONDUCTED BY MEANS OF OR IN CONJUNCTION WITH COMMUNICATIONS MEDIA TECHNOLOGY, SPECIFICALLY, A TELEPHONE CONFERENCE CALL. THE LOCATION 9293 HARDING AVENUE, SURFSIDE, FL 33154, WHICH IS OPEN TO THE PUBLIC, SHALL SERVE AS AN ACCESS POINT FOR SUCH COMMUNICATION.**



## Commission Communication

**Agenda #:**

**Date:** September 22, 2010

**Subject:** Employee Benefits contract ratification for Fiscal Year 2010-2011.

**Objective:** To provide all employees with Health, Dental, Life and Disability insurance coverage(s) for Fiscal Year 2010-2011.

**Recommendation:** In consideration that general healthcare rates are on the rise this year between 15%-25% due to new federal healthcare mandates imposed by President Obama and Congress and the fact that we have been able to obtain reduced rates, it is recommended that the Surfside Town Commission adopt the attached resolution approving UHC/NHP and Mutual of Omaha as our insurance contract carriers based on the terms of the attached proposals for the Fiscal Year 2010 – 2011.

**Background:** Our current contract with AvMed and Mutual of Omaha expires on September 30<sup>th</sup> 2010. The Town has had continuous coverage with AvMed since October 1, 2006 and most notably has contracted with AvMed for seven of the past twelve years. Although employees have found the AvMed plan to their satisfaction, their proposed renewal contract rate increase of approximately 16% was deemed unacceptable to Staff.

The new Insurance Agent of Record as chosen & confirmed by the Town Commission on May 11, 2010 for Employee Health, Disability, Life, Dental, and all other related benefits programs is Stan Bershad, CLU. Stan was directed by Staff to seek to renegotiate the existing plan or find an acceptable plan bearing in mind that it would be difficult under existing budgetary constraints for The Town to pay anything greater than a 10% increase over the current premium rates.

Stan Bershad, CLU met and worked with Staff to find alternatives. He gathered a great amount of historical data and medical history applications from all of the Town's present and

several of the Town's retired/COBRA eligible Employees. He then submitted it to all the Major Carriers in the market and was able to obtain numerous quotes.

Bids were solicited from Aetna, AvMed, BlueCross, CIGNA, Florida League of Cities, Humana, UHC/NHP, and Vista Coventry. Stan and Staff analyzed all bids and shortlisted the options to two providers-AvMed and UHC/NHP. Finally, representatives of AvMed and UHC/NHP were interviewed and it was determined that UHC/NHP was the most favorable. Not only did UHC/NHP give us up to a 7.7% decrease per employee it also provided for better coverage and options.

### **SUPPLEMENTAL BENEFIT PLANS:**

Staff is proposing that we remain with and would therefore be in the fourth year with Mutual of Omaha for our Dental, Life insurance, Short-Term and Long-Term disability. Stan Bershad, CLU and Staff were able to obtain a two year rate guarantee with net rate reductions of 12% for the Dental and 18.5% for the Life and Disability plans. Additionally, employees have been satisfied with Mutual of Omaha.

One major reason for all the above rate reductions is attributable to Staff restructuring and Stan Bershad agreeing that employee benefit contracts are exempt from sales commission. In consideration, the Town Commission has independently contracted with Stan Bershad, CLU in the amount of \$15,000 annually.

### **Analysis:**

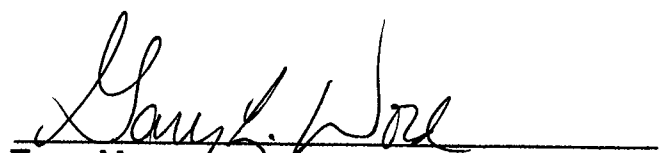
### **SUMMARY BENEFIT RECAP:**

1. A Town contribution employee only coverage decrease in monthly health insurance cost (from \$382.05 to \$373.23);
2. Additional coverage selection/options available to employees (three vs. two choices);
3. Rate reductions with a two year rate guarantee for Dental, Life and Disability insurance;
4. An Employee Assistance Program (EAP) fully integrated with Mutual of Omaha;
5. No cost Flexible spending accounts benefit services provided by United HealthCare/Neighborhood Health Plan.

**Budget Impact:** The contract totals (employee contribution + Town contribution) is estimated at \$665,700. However, contingent on final personnel action as determined by our FY 2011 budget process and the impact/changes which occur during our open enrollment period, the Towns contribution/budget impact is estimated at \$619,737 which has already been budgeted within the FY 2011 budget documents.

**Staff Impact:** The computer set-up and employee conversion/election process to implement and change to new insurance provider(s) will impose an increased short-term burden to the Human Resource coordinator and all Finance staff during the month of October.

  
Finance Support Services Dept. Head

  
Town Manager

RESOLUTION NO. 2010 - \_\_\_\_

**A RESOLUTION OF THE TOWN COMMISSION FOR THE TOWN OF SURFSIDE, FLORIDA, APPROVING GROUP HEALTH, DENTAL, LIFE, AND DISABILITY PLANS BETWEEN THE TOWN OF SURFSIDE, FLORIDA AND UNITED HEALTHCARE/ NEIGHBORHOOD HEALTH PLAN AND MUTUAL OF OMAHA**

**WHEREAS**, the Town Commission of the Town of Surfside, Florida (“TOWN”) on May 11, 2010 by Resolution 10-1939 retained the Stanton M. Berchad, CLU to become agent of record and secure and analyze the best proposals from competitive health care benefit providers for the Town of Surfside employees; and

**WHEREAS**, this task has been completed and the Town of Surfside wishes to engage United Healthcare/Neighborhood Health Plan and Mutual Of Omaha to arrange for the delivery of health, dental, life, and disability plans for qualified Town of Surfside Subscribers (“Subscribing Group”); and

**WHEREAS**, the Town Commission believes that it is in the best interest of the Town to accept the proposals of these companies attached as Composite Attachment “A”; and

**NOW THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, AS FOLLOWS:**

**Section 1. Recitals.** The above and foregoing recitals are true and correct and are incorporated herein by reference.

**Section 2. Authorization.** The Town Commission hereby authorizes the Town Manager and the Town Attorney to enter into an agreement with the Subscribing Group for group health, dental, life, and disability between the Town Of Surfside, Florida and United

Healthcare/Neighborhood Health Plan and Mutual Of Omaha and the Subscribing Group based on the terms of the proposals attached hereto as Composite Attachment "A" and authorizes the Town Manager and Town Attorney to do all things necessary to effectuate this Contract.

**Section 3. Effective Date.** This Resolution shall become effective October 1, 2010.

**PASSED** and **ADOPTED** on this \_\_\_\_\_ day of \_\_\_\_\_, 2010

Motion by Commissioner \_\_\_\_\_, second by Commissioner \_\_\_\_\_.

**FINAL VOTE ON ADOPTION**

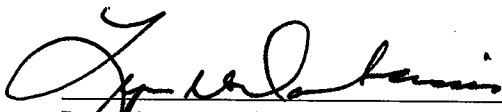
Commissioner Michael Karukin	_____
Commissioner Edward Kopelman	_____
Commissioner Marta Olchyk	_____
Vice Mayor Joseph Graubart	_____
Mayor Daniel Dietch	_____

\_\_\_\_\_  
Daniel Dietch, Mayor

**ATTEST:**

\_\_\_\_\_  
Debra E. Eastman, MMC  
Town Clerk

**APPROVED AND TO FORM AND  
LEGAL SUFFICIENCY FOR THE TOWN OF SURFSIDE ONLY:**

  
\_\_\_\_\_  
Lynn M. Dannheisser  
Town Attorney

**UNITEDHEALTHCARE**



# Product and Benefit Selection Form for Small Business



1a. Group Name Town of Surfside  
 1b. Identify primary business location 9298 HARDING AVE, SUNNYSIDE, FL 33154  
 1c. List all other locations besides primary business location \_\_\_\_\_

2. Medical Plan Code(s) EVC  
DVD  
TEF  
 2b. Will this plan co-exist with another health plan?  
 Yes  No If yes, name of carrier \_\_\_\_\_  
 2c. Prescription Benefit Plan Number (Rx) AK, AL, SU  
 2d. Deductible Administration  
 Calendar Year (from Jan. 1 to Dec. 31)  
 Policy/Contract Year (from effective date to renewal date) [(Not applicable to NHP)]

I acknowledge that the health plan selected includes coverage for substance abuse and mental health that is equal to or exceeds coverage as required by Florida Statutes 627.669 and 627.668. This acknowledgement does not apply to Standard or Basic plans.

3. Dental Plan Code(s) N/A  
 3b. Has this group been covered for major dental services for the previous 12 consecutive months?  
 Yes  No If yes, name of carrier \_\_\_\_\_

4. Vision Plan Code(s) V008 *voluntary*

5. Life Amount(s)  
 Employee \$ N/A  
 Spouse \$ N/A  
 Child(ren) \$ N/A  
 Yes  No Acceptance of this application will replace existing life insurance coverage.

6. Supplemental Coverage(s)  
 Life \$ N/A  
 AD&D \$ N/A  
 STD \$ N/A  
 LTD \$ N/A

7. Optional Services  
 COBRA Administration Service  
 Yes  No  
 Section 125 Pre-Tax Premium Plan Service FSA  
 Yes  No  Other

8. Other Notes \_\_\_\_\_

UnitedHealthcare Standard  
 Copayment Plan  
 Coinsurance  
 UnitedHealthcare Basic  
 Copayment Plan  
 Coinsurance  
 Group waives right to select Standard or Basic plans, high deductible savings account plans or a health reimbursement arrangement, unless noted in 2.

YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF 1-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature [Redacted]  
\_\_\_\_\_  
 Title TOWN MANAGER  
 Date 9/1/10

Coverage Provided by "UnitedHealthcare and Affiliates":  
 Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.  
 Dental coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.  
 Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company  
 Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company



# Benefit Summary

Florida - Choice Plus  
Traditional with Deductible - 15/250/100% Plan 7EF

We want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- Check personalized data: Find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals using [www.myuhc.com](http://www.myuhc.com)®.
- Researching health information: Find resources by calling Care24<sup>sm</sup> or NurseLine<sup>®</sup> or by logging on to [www.myuhc.com](http://www.myuhc.com).
- Get help: Contact Customer Care at the telephone number on the back of your ID card when you need assistance locating physicians and other health care professionals in your network or when you have coverage or benefit questions.

## PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Annual Deductible</b>		
Individual Deductible	\$250 per year	\$500 per year
Family Deductible	\$500 per year	\$1,000 per year

> Member Copayments do not accumulate towards the Deductible.

<b>Out-of-Pocket Maximum</b>		
Individual Out-of-Pocket Maximum	\$250 per year	\$3,000 per year
Family Out-of-Pocket Maximum	\$500 per year	\$6,000 per year

> The Out-of-Pocket Maximum includes the Annual Deductible.

> Member Copayments do not accumulate towards the Out-of-Pocket Maximum.

<b>Benefit Plan Coinsurance - The Amount We Pay</b>		
	100% after Deductible has been met.	80% after Deductible has been met.

<b>Maximum Policy Benefit</b>		
The maximum amount we will pay during the entire period of time you are enrolled under the Policy.	Combined Network and Non-Network Maximum of \$5,000,000 per Covered Person.	

<b>Prescription Drug Benefits</b>		
Prescription drug benefits are shown under separate cover.		

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

FLNGL7EF07

Item#	Rev. Date	Benefit Accumulator
213-2586	0607_rev01	Calendar Year

UnitedHealthcare Insurance Company

## Information on Benefit Limits

- > The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- > All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.
- > When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

## MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Physician's Office Services - Sickness and Injury</b>		
Primary Physician Office Visit	100% after you pay a \$15 Copayment per visit.	80% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a \$15 Copayment per visit.	80% after Deductible has been met.

> In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

## Preventive Care Services

Covered Health Services include but are not limited to:

Primary Physician Office Visit Child Health Supervision Services are not subject to any Annual Deductible. Benefits are limited to one visit, payable to one provider, for all of the services provided at each visit.	100% after you pay a \$15 Copayment per visit.	Non-Network Benefits are not available, except for Child Health Supervision Services, one annual female physical, including a pap smear and a mammogram.
Specialist Physician Office Visit Child Health Supervision Services are not subject to any Annual Deductible. Benefits are limited to one visit, payable to one provider, for all of the services provided at each visit.	100% after you pay a \$15 Copayment per visit.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	

## Urgent Care Center Services

	100% after you pay a \$35 Copayment per visit.	80% after Deductible has been met.
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- > In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

## Emergency Health Services - Outpatient

100% after you pay a \$100 Copayment per visit. <i>Pre-service Notification is required if results in an Inpatient Stay.</i>	100% after you pay a \$100 Copayment per visit. <i>Pre-service Notification is required if results in an Inpatient Stay.</i>
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## Hospital - Inpatient Stay

100% after Deductible has been met.	80% after Deductible has been met.  <i>Pre-service Notification is required.</i>
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**ADDITIONAL CORE BENEFITS**

**YOUR BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Ambulance Service - Emergency and Non-Emergency</b>		
<p>Ground Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered up to \$1,000 per transport.</p>	<p>100% after Deductible has been met.</p>	<p>100% after Network Deductible has been met.</p>
<p>Air Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered up to \$1,000 per transport.</p>	<p>100% after Deductible has been met.</p>	<p>100% after Network Deductible has been met.</p>
	<p><i>Pre-service Notification is required for Non-Emergency Ambulance.</i></p>	<p><i>Pre-service Notification is required for Non-Emergency Ambulance.</i></p>
<b>Congenital Heart Disease (CHD) Surgeries</b>		
	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met.</p>
		<p><i>Pre-service Notification is required.</i></p>
<b>Dental Services - Accident Only</b>		
<p>Benefits are limited as follows: \$3,000 maximum per year \$900 maximum per tooth</p>	<p>100% after Deductible has been met.</p>	<p>100% after Network Deductible has been met.</p>
	<p><i>Pre-service Notification is required.</i></p>	<p><i>Pre-service Notification is required.</i></p>
<b>Diabetes Services</b>		
<p>Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p>	
<p>Diabetes Self Management Items</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider</p>	
		<p><i>Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of \$1,000.</i></p>
<b>Durable Medical Equipment</b>		
<p>Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met. <i>Pre-service Notification is required for Durable Medical Equipment in excess of \$1,000.</i></p>
<b>Home Health Care</b>		
<p>Benefits are limited as follows: 60 visits per year</p>	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met. <i>Pre-service Notification is required.</i></p>
<b>Hospice Care</b>		
	<p>100% after Deductible has been met.</p>	<p>80% after Deductible has been met. <i>Pre-service Notification is required for Inpatient stays.</i></p>

## ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	80% after Deductible has been met.
<b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
	100% after Deductible has been met.	80% after Deductible has been met.
<b>Ostomy Supplies</b>		
Benefits are limited as follows: \$2,500 per year	100% after Deductible has been met.	80% after Deductible has been met.
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	100% after Deductible has been met.	80% after Deductible has been met.
<b>Physician Fees for Surgical and Medical Services</b>		
	100% after Deductible has been met.	80% after Deductible has been met.
<b>Pregnancy - Maternity Services</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	<i>Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Prosthetic Devices</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of each type of prosthetic device every three years.	100% after Deductible has been met.	80% after Deductible has been met.
<b>Reconstructive Procedures</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		<i>Pre-service Notification is required.</i>
<b>Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment</b>		
Benefits are limited as follows:	100% after you pay a \$15 Copayment per visit.	80% after Deductible has been met.
20 visits of chiropractic treatment		<i>Pre-service Notification is required for certain services.</i>
20 visits of physical therapy		
20 visits of occupational therapy		
20 visits of speech therapy		
20 visits of pulmonary rehabilitation		
36 visits of cardiac rehabilitation		
30 visits of post-cochlear implant aural therapy		

**ADDITIONAL CORE BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy	100% after Deductible has been met.	80% after Deductible has been met.
For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	100% after Deductible has been met.	80% after Deductible has been met.
		<i>Pre-service Notification is required.</i>
<b>Surgery - Outpatient</b>		
	100% after Deductible has been met.	80% after Deductible has been met.
<b>Therapeutic Treatments - Outpatient</b>		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	100% after Deductible has been met.	80% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
<b>Transplantation Services</b>		
	100% after Deductible has been met.	80% after Deductible has been met.
	For Network Benefits, services must be received at a Designated Facility.	
	<i>Pre-service Notification is required.</i>	<i>Pre-service Notification is required.</i>
<b>Vision Examinations</b>		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a \$15 Copayment per visit.	80% after Deductible has been met.

## STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Bones or Joints of the Jaw and Facial Region</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	<i>Pre-Service Notification is required.</i>	<i>Pre-Service Notification is required.</i>
<b>Cleft Lip/Cleft Palate Treatment</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	<i>Pre-Service Notification is required.</i>	<i>Pre-Service Notification is required.</i>
<b>Clinical Trials</b>		
Participation in a qualifying clinical trial for the treatment of:	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Cancer		
Cardiovascular (cardiac/stroke)		
Surgical musculoskeletal disorders of the spine, hip and knees		
	<i>Pre-service Notification is required.</i>	<i>Pre-service Notification is required.</i>
<b>Dental Services - Anesthesia and Hospitalization</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	<i>Pre-Service Notification is required.</i>	<i>Pre-Service Notification is required.</i>
<b>Mental Health and Substance Abuse (MH/SA) Services - Inpatient and Intermediate</b>		
Benefits are limited as follows:	100% after Deductible has been met.	80% after Deductible has been met.
30 days per year for Mental Health Services and 30 days per year for Substance Abuse Services.		
	<i>Prior Authorization is required from the MH/SA Designee.</i>	<i>Prior Authorization is required from the MH/SA Designee.</i>
<b>Mental Health and Substance Abuse (MH/SA) Services - Outpatient</b>		
Benefits are limited as follows:	100% after you pay a \$15 Copayment per visit.	80% after Deductible has been met.
30 visits per year for Mental Health Services and 44 visits per year for Substance Abuse Services.		
	<i>Prior Authorization is required from the MH/SA Designee.</i>	<i>Prior Authorization is required from the MH/SA Designee.</i>

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Osteoporosis Treatment</b>	100% after Deductible has been met.	80% after Deductible has been met.
	<i>Pre-Service Notification is required.</i>	<i>Pre-Service Notification is required.</i>

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## MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

### Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnosis; massage therapy; rolfing; art, music, dance, horseback therapy; and other forms of alternative treatment, as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

### Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing

equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

### Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

### Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are

## MEDICAL EXCLUSIONS CONTINUED

provided as described under Durable Medical Equipment in Section 1 of the COC.

- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

### Mental Health / Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol, Cyclazocine, or their equivalents). Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

### Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are

provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

### Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; speech generating devices; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

### Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemoablation and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

### Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for

## MEDICAL EXCLUSIONS CONTINUED

documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea. This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs.

### Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters.

### Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

### Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law. Examples include coverage paid by workers' compensation, no-fault auto insurance, or similar legislation. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

### Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another

person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

### Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true: no skilled services are identified; skilled nursing resources are available in the facility; the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

### Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

### All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy.

**NEIGHBOR HEALTH  
PARTNERSHIP, INC.**

**NEIGHBORHOOD HEALTH PARTNERSHIP, INC.  
GROUP SERVICE AGREEMENT**

**THIS AGREEMENT** sets forth the health services and benefits provided by **NEIGHBORHOOD HEALTH PARTNERSHIP, INC.** (hereinafter referred to as the "Plan") to the extent herein defined, excluded or otherwise limited.

In consideration of the Application made by

Town of Surfside

(Hereinafter referred to as the "Group")

and accepted by Plan and in consideration of payment by the Group of the appropriate premiums, the Plan hereby agrees to provide the services and benefits described herein to Group commencing on the Effective Date shown hereon and having an initial term of one (1) year therefrom; thereafter, this Agreement shall automatically renew for additional terms of one (1) year each, unless terminated as provided herein. The initial term and each renewal term of this Agreement are sometimes referred to herein as a "Contract Year".

The obligation of the Plan to provide the services and benefits described herein to the Group is expressly conditioned upon the Plan's acceptance of the Group's Application and Enrollment Forms and approval of same in accordance with the Plan's policies and procedures, as well as Group's payment of Premium and Group's compliance with the terms and conditions of this Agreement.

The Group may be required to provide tax records and/or other records to verify status as a bona fide employer group and to verify the employment of employee participants. Such records may be requested periodically, as deemed necessary by the Plan, to verify continuing eligibility for coverage. Failure to provide such records to the Plan within a reasonable amount of time, not to exceed 10 calendar days after request, may result in automatic termination of this Agreement.

**IN WITNESS WHEREOF**, the Plan has caused this Agreement to be executed this 30<sup>th</sup> day of August, 2010 ("Execution Date") with an Effective Date for coverage of 10/1/10.

*Please Check All that Apply*

POS Rider    POS Plus Rider    4-Tier Prescription Drug Rider    Access Option Rider    Other (specify) \_\_\_\_\_

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

\_\_\_\_\_  
(Signature)

Daniel I. Rosenthal  
CEO for South Florida Region

Gary L. Word  
\_\_\_\_\_  
(Signature on behalf of Group)

GARY WORD TOWN MANAGER  
(Print Name & Title)

*Si desea una copia de este documento en español, por favor llene la información a continuación:*

Nombre del Grupo: \_\_\_\_\_ Persona que se debe contactar: \_\_\_\_\_

Dirección: \_\_\_\_\_

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.  
**ACUERDO DE SERVICIO DEL GRUPO**

**ESTE ACUERDO** expone los servicios de salud y las prestaciones proveídas por **NEIGHBORHOOD HEALTH PARTNERSHIP, INC.** (A partir de ahora referido como el "Plan") hasta el punto que aquí se define, excluye, o de otra manera limita.

En consideración de la Solicitud hecha por

\_\_\_\_\_ (A partir de ahora llamado el "Grupo")

y aceptado por el Plan y en consideración del pago por el Grupo de las primas apropiadas, el Plan por este medio se compromete a proveer los servicios y las prestaciones descritas por este documento al Grupo, comenzando en la Fecha de Efectividad demostrada aquí y teniendo un periodo de validez inicial de un (1) año a partir de allí; después, este Acuerdo se renovará automáticamente para términos adicionales de un (1) año cada uno, a menos que se termine como previsto aquí. Al periodo inicial y a cada periodo de renovación de este Acuerdo se les refiere algunas veces aquí como un "Año de Contrato".

La obligación del Plan de proveer los servicios y las prestaciones descritas aquí al Grupo está expresamente condicionada en la aceptación del Plan de los Formularios de Solicitud e Inscripción y en la aprobación de los mismos conforme con las normas y los procedimientos del Plan, así como también en el pago de la Prima del Grupo y la conformidad del Grupo con los términos y las condiciones de este Acuerdo.

El Grupo puede estar obligado a proveer registros arancelarios y/u otros registros para verificar su estado como un grupo empleador de buena fe y para verificar el empleo de los empleados participantes. Tales registros pueden ser solicitados periódicamente, cuando se considere necesario por el Plan, para verificar la continuidad de la elegibilidad para la cobertura. El incumplimiento en proveer tales registros al Plan dentro de un tiempo razonable, a no exceder 10 días naturales después de la petición, puede resultar en la terminación automática de este Acuerdo.

**EN FE DE LO CUAL**, el Plan ha causado que este Acuerdo se ejecute este \_\_\_\_\_ día de \_\_\_\_\_, 200\_\_\_\_ ("Fecha de Ejecución") con una Fecha de Efectividad para la cobertura de \_\_\_\_\_.

*Por Favor, Seleccione Todo lo que Aplique*

- Cláusula Adicional del POS    Cláusula Adicional del POS Plus    Cláusula Adicional de Drogas de Prescripción de 4-Gradas  
 Cláusula Adicional de la Opción de Acceso    Otro (especifique) \_\_\_\_\_

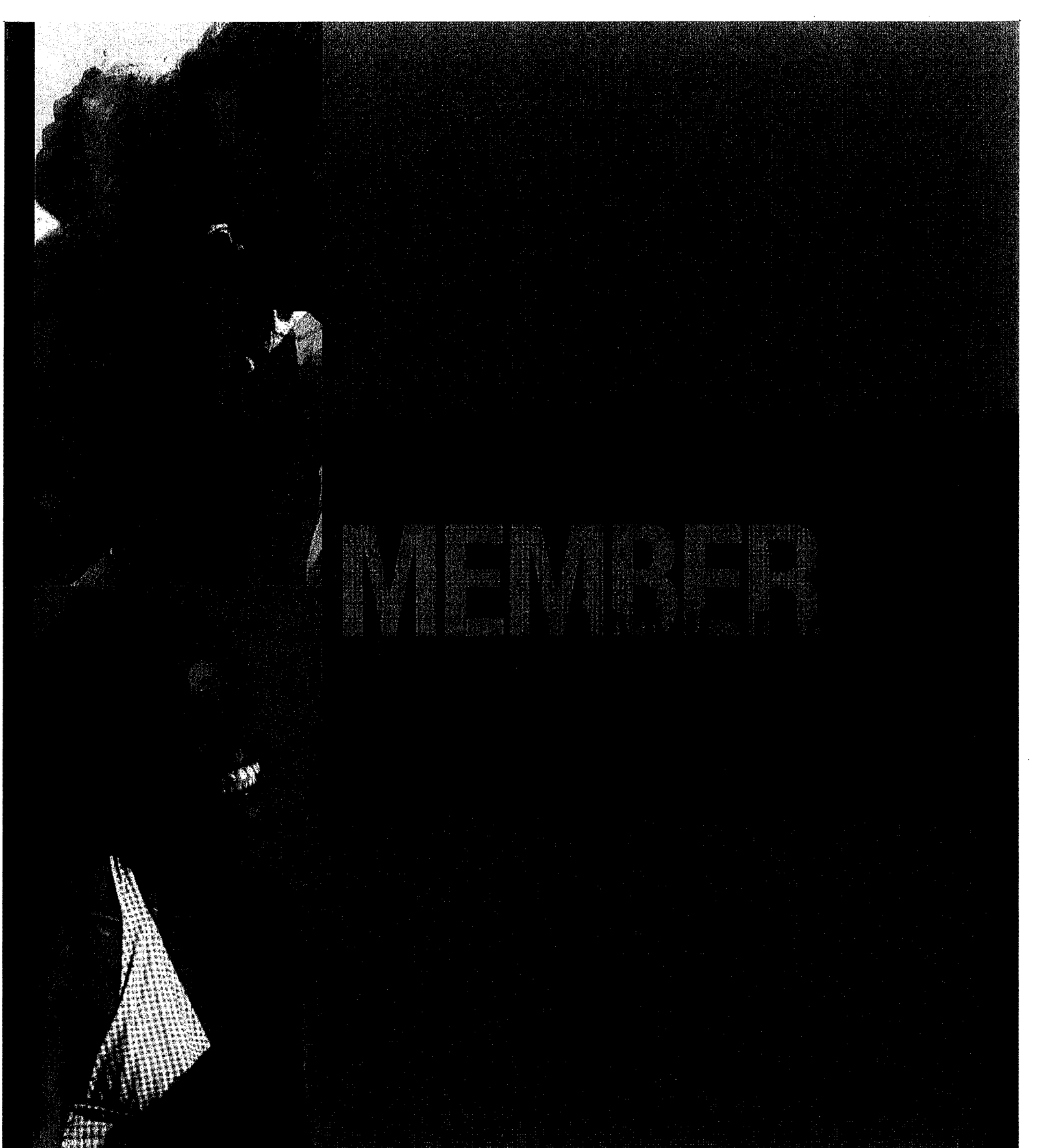
NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

\_\_\_\_\_  
(Firma)

Daniel I. Rosenthal  
DG de la Región del Sur de Florida

\_\_\_\_\_  
(Firma en Nombre del Grupo)

\_\_\_\_\_  
(Imprima el Nombre y el Título)



MEMBER

 Neighborhood Health Partnership

This Member Handbook contains helpful information relating to your coverage for health insurance benefits under the Group Service Agreement between Neighborhood Health Partnership and your employer. The provisions of the Group Service Agreement are included in this Member Handbook.

*Your must refer to the Group Service Agreement for a detailed explanation of available benefits. In the event of a conflict between this Member Handbook and the Group Service Agreement, the Group Service Agreement shall control.*

Si desea una copia de esta Guía del Miembro en español, por favor llame a nuestro Departamento de Servicios al Miembro.



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# IMPORTANT

## Neighborhood Health Partnership

7600 Corporate Center Drive  
Miami, FL 33126

Mailing Address  
PO Box 025680  
Miami, FL 33102-5680

Member Services  
305-715-2500  
1-800-354-0222  
TTY 305-715-2322

Monday through Friday between 8am and 6pm

Online directory and member information  
[www.myNHP.com](http://www.myNHP.com)

## YOUR NHP HMO PLAN

We work hard to make Neighborhood Health Partnership (NHP or Plan) an HMO from which it is easy for you to benefit. A few simple steps will make sure that the Plan works best for you.

### CHOOSING A PRIMARY CARE PHYSICIAN

At the time of enrollment, you should have selected a Primary Care Physician ("PCP"). If you do not select a PCP, NHP will select one for you. A listing of PCPs is contained in the Provider Directory. The Directory lists doctors, hospitals, and other healthcare providers who have agreed, by contract, to render covered services to NHP Members (referred to as Plan Providers). All of the Plan Providers meet NHP's standards.

Your PCP will coordinate, arrange, or provide all of your covered services as described in this Handbook. You will feel secure knowing that the PCP who treats you in good health is there to provide support and expert medical care when you need it.

### NHP MEMBER ID CARD

You must keep your NHP identification card ("ID Card") with you at all times. You should present it to all providers, including your pharmacy. Your ID Card will provide you with prompt access to healthcare. Please inform NHP of any changes that must be made to keep the information on your ID Card current.

### PRIMARY CARE PHYSICIAN APPOINTMENTS

When making an appointment with your PCP, be familiar with your benefits. Services provided or arranged by your PCP include:

- Routine check-ups and preventive care
- Medical treatment when you are injured or ill
- Routine diagnostic tests and studies, such as lab work and X-rays

- Referrals to Specialists
- Hospitalization or outpatient treatment, when needed

### CHANGING YOUR PRIMARY CARE PHYSICIAN

The ability to choose a PCP from our network of Plan Physicians and Specialists is a vital part of your NHP Membership. If for any reason you want to change your PCP, NHP will allow you to do so once every thirty days. The change will be effective the first day of the next month. To change your PCP, call NHP Member Services. The NHP Member Services phone number is on your ID Card.

### YOUR PROVIDERS

Plan Providers and other providers providing healthcare services and supplies to you are independent contractors who are not the agents, servants, or employees of NHP. NHP is not responsible for the judgment or conduct of Plan Providers and other providers who are required to exercise independent medical judgment on your behalf. Under the Group Service Agreement, NHP makes benefit determinations only relating to Covered Services. NHP does not provide healthcare services or make medical decisions on behalf of Members.

If you would like to obtain information about NHP Plan Providers, such as schools attended or board status, please call NHP Member Services at 800-354-0222 or 305-715-2500 or TTY 305-715-2322 Monday through Friday between 8am and 6pm.

### CLAIMS


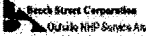

Your PCP is in charge of managing your treatment and submitting claims. You should not receive a bill for treatment for Covered Services received from a Plan Provider. If you receive a bill for other than co-payments or non-Covered Services, contact NHP Member Services.

## YOUR NHP HMO ID CARD

Carry your NHP ID Card with you at all times. It has vital information about your coverage including co-payment information, instructions for emergency situations and NHP Member Services phone numbers.

Please periodically review the information contained on your ID Card and notify NHP of any changes that need to be made.

Check your ID Card carefully. If it is not correct, it needs to be updated, or if you lose your card, call NHP Member Services for a new card.

 <b>Neighborhood Health Partnership</b>		 Beach Street Cooperative Outside NHP Service Area	
<b>HMO</b> ■ NAME: <b>JOHN DOE</b> ■ ID #: <b>12345678900</b> ■ GRP #: <b>B04037 / MY EMPLOYER, INC.</b> ■ PCP: <b>DR. MEDICAL PCP</b> ■ HMO: <b>\$10-OV \$250-HSP \$50-ER</b>		■ DOB: <b>01/01/1970</b> ■ TEL #: <b>(305) 715-2500</b>	
■ RX: <b>\$10G \$20PB \$35NP</b>		 Express Scripts Div. 00393 Rx Group #NPLA	
<b>THIS CARD DOES NOT GUARANTEE COVERAGE OR PAYMENT</b> <b>SERVICES MUST BE AUTHORIZED BY THE PRIMARY CARE PHYSICIAN</b> EMERGENCIES: Please contact the Primary Care Physician (PCP), and if possible use an NHP hospital emergency room. If this is not possible, seek care at the nearest emergency room and notify your PCP as soon as possible.			
For Customer Service: In Miami-Dade (305) 715-2500 All Other Counties 1-800-354-0222 TTY/TDD# (305) 715-2322 www.myNHP.com		For Provider Authorizations and Admissions: In Miami-Dade (305) 715-2600 All Other Counties 1-800-550-5588	
Pharmacy Customer Service: 1-800-306-5557 P.O. Box 300873 Bloomington, MN 55439-0873 www.express-scripts.com		Submit all Claims to NHP: P.O. Box 025680 Miami, FL 33102-5680 NHP Fraud Hotline: (305) 715-2286	
Visit us on the web @ <a href="http://www.myNHP.com">www.myNHP.com</a>			

## DEFINITIONS

To understand your NHP coverage, please review the Definitions section of the Group Service Agreement. Many of the capitalized terms used in this Member Handbook are defined in the Group Service Agreement.

## PRIMARY CARE PHYSICIAN (PCP)

Your NHP PCP is the key to managing your medical care. Your PCP and his/her phone number are listed on your ID Card. Keep your ID Card with you at all times.

When making an appointment with your PCP, be sure to let him or her know whether it is a routine visit or an emergency. If you are not able to keep your appointment, make sure you notify your PCP prior to your scheduled time. Your PCP is responsible for arrangements for the services of a Specialist and certain other Plan Providers. The services your PCP will provide or arrange for are set forth on Page 31 of the Group Service Agreement.

## SPECIALTY MEDICAL CARE

Your Group Service Agreement provides coverage of a range of specialists' services to meet your healthcare needs. Your PCP can refer you to a Specialist as needed. Hospital services can be arranged by your PCP and/or an NHP Specialist. Hospital services must be authorized by NHP.

A referral is needed in order to go to a Specialist. You may obtain an annual well-woman exam and needed follow-up care from a Plan obstetrician or gynecologist. You may also go to a podiatrist, dermatologist and a chiropractor without a referral, subject to certain limitations.

Specialty Services are set forth on Page 31 of the Group Service Agreement.

## CHRONIC ILLNESS

NHP provides members with certain chronic illnesses educational programs to help manage their conditions. For information on specific programs, please contact Member Services. In addition, NHP has adopted nationally recognized guidelines for managing several common medical conditions. A copy of the guidelines is available upon request from Member Services.

## HOSPITAL CARE

Hospital care and services are an NHP benefit. It is important to remember that all hospital admissions should be arranged by your PCP or Specialist. The hospital must be a Plan Hospital, except in the case of an Emergency Medical Condition. Your PCP or Specialist will determine the length of your stay. Your hospital benefits are set forth on Page 28 of the Group Service Agreement.

## ORGAN TRANSPLANT SERVICES

NHP will provide coverage of services for certain organ transplant expenses when pre-authorized. Such transplants must be performed at a facility approved by NHP. Your benefits for transplants are set forth on Page 30 of the Group Service Agreement.

## EMERGENCY SERVICES AND CARE

Emergency Services and Care are covered by NHP, no matter where you are or when you need immediate emergency medical care. However, so that we may better manage your care, you must notify your PCP or NHP within 48 hours, or as soon as possible, that you are in a hospital due to an Emergency Medical Condition.

The following procedures should be followed in the event of an emergency:

1. Try to contact your PCP before going to the emergency room.
2. If you do have an Emergency Medical Condition, go to the nearest emergency room immediately.

Emergency Medical Condition means:

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

3. Do not use the emergency room as an alternative to your physician's office. If your problem is not an emergency, you will be liable for all charges incurred in excess of the charges for the screening, evaluation, and examination required to determine if an Emergency Medical Condition exists.
4. If you have an urgent problem during your PCP's office hours, contact your doctor. Explain your problem so he or she can tell you if you need to go to the emergency room or an Urgent Care Center, or if you should schedule an office visit. **IMPORTANT:** If your condition requires immediate care, be sure to tell your doctor's office it is urgent!

If you or a covered family member is away from home and need Emergency Services and Care, treatment should be sought at the

nearest emergency medical treatment facility. Your benefits relating to an Emergency Medical Condition are set forth on Page 34 of the Group Service Agreement.

## URGENT CARE

Urgent Care Centers provide care for minor injuries and illnesses that require immediate attention, but are not severe enough for a trip to the emergency room, including cuts, sprains, eye injuries, colds, flu, fever, insect bites, and simple fractures. Urgent Care Centers are also helpful when your family pediatrician or primary care physician's office is closed or unavailable. Patients are seen on a walk-in basis, with no appointments necessary. An Urgent Care Center is not an emergency room. If you are in doubt as to the severity of a medical condition that needs attention, please call 911 or go to an emergency room. Urgent Care Center benefits can be found on Page 30 of the Group Service Agreement.

## PREVENTIVE CARE

A principal part of our mission at NHP is to help our Members maintain their wellness and prevent disease, both by early detection and by controlling modifiable risk factors. This will not be possible without the active participation of you, the NHP Member. Scheduling an appointment with your PCP to begin your schedule of screening tests and preventive measures is the first step in our common objective of helping you maintain health and enjoy a full, productive life. NHP regularly sends out preventive care guidelines, which NHP strongly recommends you follow.

## EXCLUSIONS AND LIMITATIONS

Certain services, treatment, and supplies are not covered by NHP. In addition, there are other limitations on benefits available to you. These exclusions and limitations are set forth on Page 35 of the Group Service Agreement.

## ELIGIBILITY

You can enroll in NHP if you are an Eligible Employee. You may also enroll your Eligible Dependents, such as your legal spouse and dependent, minor children. Eligibility provisions can be found on Page 24 of the Group Service Agreement.

## EFFECTIVE DATE AND CANCELLATION

Guidelines concerning the Effective Date of the Group Service Agreement are set forth on Page 22 of the Group Service Agreement. Provisions relating to the termination of your coverage are set forth on Page 22 of the Group Service Agreement. If you have any questions, contact Member Services.

## CONVERSION CONTRACT

A change in your eligibility status may cause you and your dependents to be converted to individual coverage. If your coverage or the eligibility of your dependents for coverage should end, you have the right to convert your coverage to individual healthcare in certain circumstances. The terms and conditions relating to your right to convert your coverage are set forth on Page 26 of the Group Service Agreement.

## CONTINUATION OF COVERAGE

### *Applicable to employer groups of 20 or more eligible employees*

Upon termination of your coverage due to the occurrence of certain qualifying events, you are able to continue under the Agreement in accordance with the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Details of your rights to elect COBRA coverage are set forth on Page 26 of the Group Service Agreement. Your employer will send you information regarding COBRA if you experience a qualifying event.

### *Applicable to employer groups of 19 or fewer employees*

You are entitled to elect continuation coverage in the event you lose coverage under the Agreement due to the occurrence of certain events. Details of your rights to elect to continue coverage are set forth on Page 27 of the Group Service Agreement.

## SUBROGATION AND REIMBURSEMENT

NHP may withhold payment of benefits when the Member suffers injury, disease, or illness by virtue of the negligent act or omission of a third party until such third party's liability has been determined. In the event that the Member recovers damages attributable to any such negligent act or omission, NHP shall, to the extent of medical benefits or payments provided to or on behalf of the Member, retain a right of reimbursement or be subrogated to all of the Member's rights of recovery arising out of any claim or cause of action related to such third party's negligent act or omission. Details as to subrogation and reimbursement are set forth on Page 40 of the Group Service Agreement.

## GENERAL MEMBER INFORMATION

### CONFIDENTIALITY

NHP will maintain the confidentiality of your medical diagnosis, treatment or care received from a Plan Physician or Plan Hospital. Please see NHP's Statement of Privacy Practices for more information. If you need a copy of the Statement of Privacy Practices, you may request one from NHP Member Services.

### COORDINATION OF BENEFITS

If you are enrolled in more than one healthcare plan, one is held as primary and the other is secondary. You are required to provide NHP with updated information regarding your other coverage. Coordination

of these plans and benefits are directed by the terms of your plan. The Coordination of Benefits Section on Page 39 of the Group Service Agreement governs how claims payment is handled by the plans involved. Contact NHP Member Services if you need more information.

## **YOUR RIGHTS AND RESPONSIBILITIES**

*NHP is committed to provide you with quality healthcare. It is important that you know your rights and responsibilities.*

### **MEMBER RIGHTS**

1. You have the right to be treated with courtesy and respect and in a manner that respects your dignity and your right to privacy.
2. You have the right to complete confidentiality involving medical diagnosis, treatment and care received from an NHP Provider. Any information about treatment and/or diagnosis cannot be released without your written consent.
3. You have the right to refuse the release of identifiable personal information, except when such release is required by law.
4. You have the right to have your medical situation explained to your satisfaction and complete understanding and to participate with practitioners in making decisions regarding your healthcare.
5. You have the right to prompt and reasonable responses to questions and requests.
6. You have the right to be given information on all alternate treatments available to you and their potential values and risks.
7. You have the right to a discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
8. You have the right to refuse any treatment.
9. You have the right to receive prompt courteous and appropriate treatment and assistance.
10. You have the right to be provided with information about your benefits, exclusions and limitations of the plan and any charges for which you will be responsible.
11. You have the right to be provided with a directory of participating providers, to select a Primary Care Physician (PCP) of your choice and to change your PCP for any reason.
12. You have the right to voice a complaint or file an appeal regarding NHP, the provider, or the care you have received and to receive a response in a timely manner. If you are not satisfied with the decision regarding your complaint, you may initiate the formal grievance or appeal process.
13. You have the right to know who is providing medical services and who is responsible for your care.
14. You have the right to receive information about NHP, its services, its practitioners and providers and member rights and responsibilities.
15. You have the right to know what rules apply to you.
16. You have the right to make recommendations regarding members' rights and responsibilities policies.
17. You have the right to receive a complete copy of the Florida Patient's Bill of Rights.

### **MEMBER RESPONSIBILITIES**

1. You are responsible for selecting a PCP within thirty days of the effective date of your enrollment. If you do not pick a PCP, one will be picked for you.
2. You are responsible for keeping your appointments with your PCP at their scheduled time and date.
3. You are responsible for presenting your NHP ID card prior to receiving services.
4. You are responsible for conducting yourself in an appropriate manner when seeking medical assistance.
5. You are responsible for following the care and treatment recommended by your providers and agreed upon by you.
6. You are responsible for keeping up to date on all co-payments or fees.
7. You are responsible for following instructions and guidelines for care you have agreed upon with your practitioner.
8. You are responsible for providing as much as possible, any information that NHP or its practitioners and providers need in order to care for you.
9. You have a responsibility to understand your benefits, exclusions and limitations of your health plan.
10. You have a responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
11. You are responsible for your actions if you refuse treatment.

Failure to follow these guidelines can result in cancellation of your coverage.

## **HEALTHCARE CHOICES— YOUR RIGHT TO DECIDE**

All adult individuals in healthcare facilities such as hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations, have certain rights under Florida law.

You have a right to fill out a form known as an "advance directive". The form stipulates what kind of treatment you want or do not want for special or serious medical conditions. For example, if you were taken to a healthcare facility in a coma, would you want the facility staff to know your wishes about decisions affecting your treatment?

### **WHAT IS AN ADVANCE DIRECTIVE?**

An advance directive is a written or oral statement which is made and witnessed prior to a serious illness and injury. It says how you want medical decisions made. Two forms of advance directives are:

- A Living Will
- Healthcare Surrogate Designation

An advance directive allows you to state your choices about healthcare or to name someone to make those choices for you, in the event you are not able. For more information, contact NHP Member Services.



## COMPLAINTS AND GRIEVANCES

There are times when Members have questions about their coverage or are not satisfied with NHP services. Any Member who has an inquiry or complaint should call NHP Member Services for verbal resolution. An NHP HMO Member Services representative will respond to the Member's inquiry/complaint promptly. In the event the Member's problem has not been settled at the informal level and the Member is still not satisfied, he or she will be advised to file a formal written grievance. Grievances may be filed by letter or on a grievance form. A grievance form is available from NHP by writing to the address below. You may contact Member Services for further information. Details regarding the complaint and grievance process is set forth on Page 42 of the Group Service Agreement.

The written grievances must be mailed to the following address:

Neighborhood Health Partnership  
P.O. Box 526646  
Miami, FL 33152  
Attn: Grievance Coordinator

## CUSTOMER SERVICE

NHP's goal is to answer all of your questions regarding healthcare coverage for you and your family and the Group Service Agreement efficiently and accurately.

Our Member Services can be reached between 8am and 6pm Monday through Friday during normal working days by calling 305-715-2500 or toll free at 800-354-0222 or TTY 305-715-2322, or by visiting NHP online at myNHP.com.

Please have your ID Card available when you call. If you are calling to report and replace a missing ID Card, have your PCP's name and phone number available.

## ANSWERS TO FREQUENTLY ASKED QUESTIONS

**Q. Who do I call for assistance?**

**A.** You may call Neighborhood Health Partnership (NHP) Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322. Our peak call time is from 11am to 2pm, so you may want to avoid that time if possible.

**Q. Does NHP have a website, and can I e-mail my questions?**

**A.** Yes. Our website address is [www.myNHP.com](http://www.myNHP.com). Our website offers helpful information about NHP and your coverage. The NHP homepage offers a useful link for contacting us (click on "contact us"), with e-mail addresses and telephone numbers for other NHP departments, such as marketing.

**Q. What is on the NHP webpage?**

**A.** NHP's website provides members with useful tools and guidelines. The website contains Preventive Health Guidelines, Members' Rights & Responsibilities Statement, Notice of Privacy Practices, Referral Reminder, Preferred Drug List, Behavioral Health Benefit Information, the latest member newsletters, Provider Lookup, and Provider Directories. If you would like a summary of the tools and/or guidelines please contact Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. How do I order a new ID card, change my Primary Care Physician (PCP) or order a new Provider Directory?**

**A.** Please call Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. How can I add a dependent to my NHP coverage?**

**A.** You need to coordinate adding dependents through the HR department of the employer group through which you are covered. Your HR department can provide you with an NHP enrollment form. There are special rules regarding when dependents can be added. Your HR department can help you with this.

**Q. How do I obtain a referral?**

**A.** Unless you are a member of the Access Option plan, you must coordinate all of your care through your PCP. You will need a referral from your PCP to visit an NHP specialist. However, you may access the following specialties without a referral from your PCP:

- Podiatry
- Chiropractic (12 visits per calendar year)
- Gynecology (one well-woman visit annually plus related follow-up care)
- Dermatology (5 visits annually)
- Alcohol/substance abuse treatment (benefits through Psych/Care 1-800-221-5487)
- Mental Health (benefits through Psych/Care 1-800-221-5487)

**Q. What is included in a referral?**

- A. A referral is a written recommendation from your Primary Care Physician (PCP) for you to see a specialist or receive certain healthcare services. Your PCP must issue the referral through NHP's automated referral system or by contacting NHP directly prior to your visit. Please discuss with your practitioner the tests and services which are included in the referral.

Test and services, not included in the referral or performed outside the specialist's office, require a separate authorization.

**Q. Who do I contact if I have a complaint?**

- A. If you have an inquiry or complaint about the service you received, your coverage or a provider, you may call Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. What if I'm still not satisfied with the resolution of the complaint?**

- A. If you are not satisfied with the resolution of your complaint you may file a formal written grievance within one year of the occurrence of the incident. Written grievances must be mailed to:

Neighborhood Health Partnership, Inc.  
Grievance and Appeals Department  
PO Box 526646  
Miami, Florida 33152

If you need assistance preparing your grievance, you may call NHP Member Services at 305-715-2500 or 1-800-354-0222. Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. How do I add my newborn baby to my coverage?**

- A. Please complete and return an NHP enrollment form within 60 days of your baby's date of birth. You can obtain enrollment forms through the HR department of the employer group through which you are covered. If NHP receives your baby's enrollment form within 30 days of birth, NHP will not charge an additional premium for the first 30 days of coverage. NHP must receive your completed enrollment form within 60 days of your baby's date of birth.

**Q. Does NHP have a Quality Improvement program?**

- A. Yes. To request a summary of the NHP Quality Improvement program's progress and achievements, you may call our Quality Improvement department at 305-715-4528, Monday through Friday between 8:30am and 5pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. What should I do if a drug that was prescribed to me is not covered?**

- A. NHP carefully selects drugs for coverage based on safety, quality, and effectiveness so that most often the drugs that members will need to take are covered. Sometimes, a drug may be prescribed that is not covered, but NHP has a procedure to address these infrequent situations based on medical necessity.

NHP evaluates requests for coverage of a non-covered drug based on medical necessity whenever a request is made through Member Services. A member or the prescribing practitioner can make the request either by a phone call or in writing. Member Services then coordinates with the Utilization Management department where clinical information is gathered and a physician reviewer makes a determination. As always, members can take advantage of the grievance process if they are not satisfied with the determination.

**Q. What drugs are generally not covered?**

- A. In general, the following categories of drugs are either excluded, or have limitations:
- Appetite suppressants
  - Erectile dysfunction drugs
  - Infertility drugs
  - Drugs used for cosmetic purposes
  - Smoking cessation products
  - Some injectables

**Q. How do I get care after my doctor's office hours?**

- A. If it is not an emergency, you may call your doctor's office and work with his/her answering service to put you in contact with your doctor. If you have an emergency, go to the nearest emergency room. If you need urgent care services (minor injuries or illnesses that require immediate attention, but are not severe enough to go to the emergency room), go to one of the urgent care centers in NHP's network. If you are not sure you are experiencing an emergency, go to the nearest emergency room or call 911.

**Q. Does NHP have a Utilization Management program?**

- A. Yes. NHP has a Utilization Management (UM) program to ensure that utilization decisions affecting the members' healthcare are done in a fair, impartial and consistent manner. The UM program components are pre-authorization, concurrent review, retrospective review and case management. The UM program is designed to make healthcare services available to members in a medically appropriate, accessible, cost-effective manner. These UM program components coordinate their efforts to (a) evaluate service and care, and (b) make decisions regarding benefit coverage.

The following are brief summaries of each UM program component: Pre-authorization is the process of health services being reviewed before services are approved through the referral process. Concurrent Review is the process of continuous medical monitoring while the member is in an inpatient facility or receiving a plan of care. This review assures that all the days in the facility

are medically appropriate. If services were needed after discharge, NHP would assist with the coordination of care in an alternative setting. Retrospective Review is the review of care rendered to a member without providing NHP appropriate notification or clinical data. NHP reviews the care rendered by requesting clinical information from the provider or facility. The review assures that services provided would have been approved as through the pre-authorization process. Case Management is the process where medical cases that are serious or medically complex are flagged and reviewed to assure that appropriate care is rendered to the member through a plan of treatment and the status of the member condition is updated. Close communication with the practitioner and the member are maintained.

The NHP Medical Management staff is accessible to practitioners and members to discuss UM issues, including UM decisions and questions about the program and process.

The Medical Management staff is available during normal business days from 8:30am to 5pm. Calls received after hours, weekends and holidays are automatically forwarded to an after hours vendor that has access to NHP's Medical Director.

You may also call Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm, for questions about the UM process or to request a summary of the UM program. For the hearing impaired (TTY), call 305-715-2322.

**Q. How can I get copies of my medical records?**

**A.** You should request copies of your medical records from your PCP and your other providers.

**Q. What are the rules for changing my PCP?**

**A.** You may change your PCP once every month, and the change will be effective the first of the month following the request of the change.

**Q. How does NHP secure the confidentiality of my Protected Health Information (PHI)?**

**A.** NHP takes many steps to ensure that your Protected Health Information (PHI) remains confidential. Our routine notifications of our privacy practices includes: our commitment to your privacy; how NHP uses and discloses your PHI; other uses and disclosures permitted or required by law; your rights regarding your PHI; how to obtain further information; and how to file a complaint. NHP must ask for your authorization before disclosing your PHI for non-routine purposes. NHP also allows you access to your PHI upon written request. Employees of NHP receive education and training to ensure that your written, oral, and electronic PHI is kept confidential. PHI transmitted electronically is encrypted and any documents containing your PHI are stored in a secure area with access limited to designated individuals. NHP uses, discloses and requests only the minimum amount of information necessary. NHP does not disclose PHI to your employer for employment-related

purposes without your authorization, but may disclose PHI for plan administrative purposes. To obtain a complete Privacy Notice outlining all of NHP's privacy practices, call Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. How does NHP evaluate new technology for inclusion as a covered benefit?**

**A.** NHP reviews new technologies to determine their appropriate and safe application. NHP reviews literature developed by recognized medical and research groups, government agencies and the Hayes Technology Directory. This information is presented to NHP's Utilization Management committee, composed of primary care and specialist physicians, to determine if new technologies should be included in benefit packages. If you have questions on whether a new technology is covered by NHP, call Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday from 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.

**Q. How do I obtain information about practitioners that participate in the NHP network (i.e. professional qualifications, specialty, address)?**

**A.** Call Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322. Member Services can provide you with important information about NHP's network providers.

**Q. Does NHP provide incentives for Utilization Management decisions?**

**A.** NHP does not use incentives that encourage barriers to care and/or service, or that reward inappropriate restriction of care. Rather, NHP encourages appropriate utilization while discouraging any under-utilization. NHP affirms that utilization management decision-making is based only on appropriateness of care and services and existence of coverage. NHP does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage of service or care. No incentives are offered to encourage decisions that might result in under-utilization.

**Q. Why have an Advance Medical Directive?**

**A.** You can plan ahead by writing an Advance Medical Directive, also called an Advance Directive. This statement outlines the medical treatment you would want or names the person you would want to make healthcare decisions for you if you can no longer express your wishes. You can obtain additional information by contacting your Primary Care Physician's office or by calling NHP's Member Services at 305-715-2500 or 1-800-354-0222, Monday through Friday between 8am and 6pm. For the hearing impaired (TTY), call 305-715-2322.



**Neighborhood Health Partnership, Inc.**  
**GROUP SERVICE AGREEMENT**



## ARTICLE I — DEFINITIONS

For purposes of this Agreement, the following terms shall have the meanings set forth below:

- A. **ACTIVELY AT WORK** and **ACTIVE WORK** means a Subscriber who is on the job and working at least 20 hours per week (25 hours per week for Groups with 1 to 50 employees) for the Group doing all of his or her normal job duties at the Group's usual place of business (or at a place to which the Group's business requires the Subscriber to travel). The Subscriber is considered to be Actively at Work on all work holidays, vacations, and scheduled non-work days if the Subscriber is at work on the day before and the day after any such period of time. The Subscriber is also considered to be Actively at Work if the Subscriber is absent from work due to Illness, Injury, or any other health reason. The Subscriber is not considered Actively At Work until the Subscriber actually commences his or her employment. A Group with 51 or more employees may designate in its Application a longer number of hours per week a Subscriber must be on the job to be Actively At Work which will be applied to Subscribers in such Group.
- B. **ADOPTED CHILD(REN)** means a child who is adopted by the Subscriber in accordance with Chapter 63, Florida Statutes.
- C. **ADVERSE DETERMINATION** means a coverage determination by the Plan that an admission, availability of care, continued stay, or other healthcare service or healthcare supply has been reviewed and, based upon the information provided, does not meet the Plan's requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.
- D. **APPLICATION** means the Application for this Agreement completed on behalf of the Group and signed by an authorized agent of the Group.
- E. **CALENDAR YEAR** means a period of one year starting on January 1 and ending on December 31.
- F. **COMPLAINT** means any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provisions of services, which relate to the quality of care provided by a provider pursuant to this Agreement. Members may submit a Complaint to the Plan 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.
- G. **CO-PAYMENT** means a specified dollar amount established by Plan which the Member must pay directly to the Plan Provider for specified Covered Services at the time services are rendered. Co-payment amounts are set forth in the Summary of Benefits and are subject to Out-of-Pocket Maximum established by Plan.
- H. **COVERED SERVICES** means those Medically Necessary services and supplies described in this Agreement that are not otherwise excluded or limited by this Agreement. To be a Covered Service, a service must be provided by a Plan Provider in accordance with the Plan's referral and approval procedures described in this Agreement, except in the case of an Emergency Medical Condition or as otherwise expressly stated in Article V. Services provided by a Non-Plan Provider are not Covered Services unless receipt of services from such provider was approved in advance by Plan or in the case of an Emergency Medical Condition.
1. **CREDITABLE COVERAGE** means, with respect to an individual, coverage of the individual under any of the following:
1. A group health plan, as defined in section 2791 of the Public Health Service Act;
  2. Health insurance coverage consisting of medical care, provided directly, through insurance, reimbursement, or otherwise and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer;
  3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
  4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
  5. Chapter 55 of Title 10, United States Code (CHAMPUS);
  6. A medical care program of the Indian Health Service or of a tribal organization;
  7. The Florida Comprehensive Health Association or another state health benefit risk pool;
  8. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program);
  9. A public health plan as defined by rules adopted by the Florida Department of Insurance. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services; or
  10. A health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code, 2504(e)).

Creditable Coverage does not include coverage that consists solely of one or more or any combination thereof of the following excepted benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics, including prepaid health clinics under Part II, Chapter 641, Florida Statutes; or
8. Other similar insurance coverage, specified in rules adopted by the Florida Department of Insurance, under which benefits for medical care are secondary or incidental to other insurance benefits.

J. **CUSTODIAL CARE** means care that serves to assist an individual for the purpose of meeting personal needs and which could be provided by persons without professional skills or training. Custodial Care includes assistance with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. In determining whether a person is receiving Custodial Care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

K. **ELIGIBLE DEPENDENT** or **DEPENDENT** means the Subscriber's:

1. spouse by legal marriage;
2. unmarried child under age 19, until the end of the Premium Month in which the child reaches age 19;
3. unmarried child age 19 or older, until the end of the Premium Month in which the child reaches age 25, who:
  - a. is dependent upon the Subscriber for support; and
  - b. is a full-time student; or
4. unmarried child, who maintains his/her primary residence in the Service Area and is age 19 years or older and who, in the determination of Plan, is chiefly dependent on the Subscriber for support and maintenance and incapable of self-sustaining employment as a result of mental

retardation or physical handicap which commenced prior to the time such child reached his or her 19th birthday. Satisfactory proof of such incapacity, certified by a physician, and dependency must be furnished to Plan by the Subscriber within 30 days of such child's 19th birthday and within 30 days of each birthday thereafter. In addition to a physician's certification of incapacity, Plan may make an independent assessment of incapacity. In the event the child ceases to be incapable of self-sustaining employment as set forth above, eligibility automatically terminates as of the end of the Premium Month in which the child ceases to be so incapable.

"Child" means the Subscriber's natural child, legally adopted child, step-child dependent upon Subscriber for support, or a foster child placed in the Subscriber's custody temporarily or otherwise by a court order, who is, except as otherwise provided above, supported solely by the Subscriber and residing in the Subscriber's household. "Child" includes a court ordered, non-custodial child of the Subscriber due to dissolution of marriage under Chapter 61, Florida Statutes, if such child resides in the Service Area.

"Full-time student" means a person who is enrolled in and attending School on a full-time basis. A Registrar's letter of full-time status confirmation as evidence thereof must be provided upon the Plan's request. Full-time status is determined in accordance with the standards set forth by the School, but at a minimum, to be considered a full-time student, the student must be enrolled and attending school for at least twelve credit hours per semester. A person is no longer a full-time student at the end of the Premium Month during which the person graduates or is otherwise no longer enrolled and in attendance at the School on a full-time basis. A person continues to be a full-time student during periods of vacation as established by the School.

Eligible Dependents do not include any spouse or child:

1. whose principal place of residence is not the same as the Subscriber's, or in the case of a non-custodial child under Florida Statutes, Chapter 61, who resides outside the Service Area;
2. who spends more than 90 days (consecutive or non-consecutive) in any Calendar Year outside the United States for any reason, except when enrolled as a full-time student or Eligible Dependent who has been temporarily assigned for a period of less than six months by his/her employer;
3. who is in the military forces of any country; or
4. who is unable to receive routine care within the Service Area due to any reason.

L. **ELIGIBLE EMPLOYEE** means a person Actively at Work with the Group who works or resides in the Service Area and is eligible to enroll as a Subscriber under this Agreement. An



individual is considered to work within the Service Area when the physical location from which he/she performs substantially all of his/her work-related activities is physically located within the Service Area.

An Eligible Employee does not include any person:

1. who spends more than 90 days (consecutive or non-consecutive) in any Calendar Year outside the United States for any reason;
2. who is a seasonal or temporary employee;
3. who no longer works or resides in the Service Area; or
4. who is unable to receive routine care within the Service Area due to any reason.

M. **EMERGENCY MEDICAL CONDITION** means:

1. 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 medical attention could reasonably be expected to result in any of the following:
  - a. serious jeopardy to the health of a patient, including a pregnant woman or fetus;
  - b. serious impairment of bodily functions;
  - c. serious dysfunction of any bodily organ or part;
2. With respect to a pregnant woman, an Emergency Medical Condition also means:
  - a. that there is inadequate time to effect safe transfer to a Plan Hospital prior to delivery;
  - b. that such a transfer may pose a threat to the health and safety of the patient or fetus; or
  - c. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

N. **EMERGENCY SERVICES AND CARE** means medical screening, examination, and evaluation by a Physician, or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a Physician, to determine if any Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Physician necessary to relieve the Emergency Medical Condition, within the service capability of a Hospital.

O. **ENROLLED DEPENDENT** means an Eligible Dependent who is properly enrolled for coverage under this Agreement.

P. **ENROLLMENT DATE** means the date of enrollment of the individual covered under this Agreement or, if earlier, the first day of the Waiting Period of such enrollment.

Q. **ENROLLMENT FORM** means the enrollment application completed and signed by the Subscriber providing necessary information for the Plan, listing all Eligible Dependents who are to become Members hereunder on the Individual

Effective Date, and showing the Members' choices of Primary Care Physicians.

R. **EXPERIMENTAL, INVESTIGATIONAL, OR OBSOLETE SERVICES** means, unless otherwise required by law, any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds (hereinafter, collectively referred to as "services"); any hospitalization in connection with such services; or any complication thereof if, as determined solely by the Plan, such services are experimental, investigational or obsolete. Experimental or investigational means that Plan determines the service is:

1. not of proven benefit for the diagnosis or condition at issue; or
2. not generally recognized by the medical community as reflected in the published peer-review medical literature as effective or appropriate for this particular diagnosis or treatment of Member's particular condition.

Obsolete means that the service is not generally used or recognized by the medical community as effective for the particular diagnosis or treatment of Member's condition.

Governmental approval of a service will be considered, but is not necessarily controlling, in making a determination as to whether a service is of proven benefit or appropriate or effective for a particular diagnosis or treatment of Member's particular condition.

S. **GENERAL PATIENT INFORMATION** means routine medical, clinical and demographic information about Members. Examples of General Patient Information include, without limitation, clinical information on claims forms, any Member information loaded and maintained in computer systems, telephone logs, demographic information from Groups, medical histories, and information obtained about Members from Plan Providers and Non-Plan Providers.

T. **GRIEVANCE** means a written Complaint submitted by or on behalf of a Member to the Plan regarding:

1. availability, coverage for the delivery, or quality of healthcare services, including a Complaint regarding an Adverse Determination made pursuant to utilization review;
2. claims payment, handling, or reimbursement for healthcare services; or
3. matters pertaining to the contractual relationship between a Member and the Plan.

Only those providers who have been directly involved in the treatment or diagnosis of the Member relating to the Grievance may submit a Grievance on behalf of a Member.

- U. **HOME HEALTH CARE** means Home Health Services provided by a Home Healthcare Agency for the care and treatment of the patient who is confined to home and under the direct care and supervision of a Physician.
- V. **HOME HEALTH CARE AGENCY** means an organization duly licensed as a Home Healthcare Agency under the laws of the state in which it is located. An agency operated by state or local government, which provides Home Health Services in the home in accordance with applicable laws, is also considered a Home Healthcare Agency.
- W. **HOSPICE** means an agency or organization that is licensed, accredited or approved under the laws of the jurisdiction in which services are provided, to provide counseling and medical services (and may include room and board) to a Terminally Ill person.
- X. **HOSPITAL** means an institution that:
  1. is licensed and operated as a hospital under the laws of the state where it is located; and
  2. is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organization or by the American Osteopathic Association.

In no event shall the term "Hospital" include a convalescent nursing home or any institution, or part thereof, which is used primarily as a convalescent facility, rest facility or nursing facility for the aged, an ambulatory surgery center, a facility for the care and treatment of mental disorders, alcoholism and drug dependency, or a facility which primarily provides custodial or rehabilitative care.
- Y. **IDENTIFICATION CARD** means the document of identification issued to Members by the Plan.
- Z. **ILLNESS** means a physical, mental or nervous disorder, or any condition determined by the United States Center for Disease Control (CDC) to be predictive of an immune disorder, including all related or resulting diseases and conditions.
- AA. **INDIVIDUAL EFFECTIVE DATE** means the first date as of which a Member is entitled to obtain Covered Services under this Agreement.
- AB. **INITIAL ENROLLMENT PERIOD** means the first 30 day period for which an individual is eligible to enroll for coverage under the Plan, whether or not such individual chooses to enroll.
- AC. **INJURY** means an accidental bodily injury sustained by the Member that is the direct cause of the need for Covered Services under this Agreement. Such injury must be independent of disease, bodily infirmity or other cause.
- AD. **INPATIENT** or **INPATIENT HOSPITAL SERVICE** means admission to a Hospital for bed occupancy for the purpose of receiving

Medically Necessary Inpatient Hospital Services. A Member is considered a Hospital Inpatient if formally admitted to the Hospital as an Inpatient by a Physician's order. An Inpatient admission occurs when accompanied by the expectation that the Member will remain in the Hospital at least overnight and occupy a bed even though he/she may be discharged or transferred the same day.

- AE. **LARGE EMPLOYER** means an employer that is actively engaged in business, has its principal place of business in the State of Florida, and employed 51 or more Eligible Employees on one or more business days during the preceding calendar year.
- AF. **LATE ENROLLEE** means an Eligible Employee or Eligible Dependent who requested enrollment after his or her initial enrollment period (i.e., after the first 30 days of his or her eligibility to enroll for coverage under this Agreement).
- AG. **MAXIMUM LIFETIME BENEFIT** means the total dollar limit paid on behalf of a Member during his/her lifetime for any Covered Service or set of Covered Services.
- AH. **MEDICALLY NECESSARY** means a Covered Service that the Plan determines: (1) is appropriate, consistent and necessary for the symptoms, diagnosis or treatment of a medical condition; (2) is likely to result in demonstrable medical benefit; (3) is not provided primarily for the convenience of the Member, the Member's family, attending or consulting Physician, or other healthcare provider; (4) is not custodial or supportive care or rest cures; (5) is in accordance with standards of good medical practice in the medical community; (6) is approved by the Food and Drug Administration (FDA) or the appropriate medical body or board for the condition in question; and (7) is the most appropriate, efficient and economical medical supply, service, level of care or location which can be safely provided to treat the Member. When used in relation to Hospital Inpatient Service, Medically Necessary services only include those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, as an outpatient, or in any lesser facility. Medical Necessity, when used in relation to services or supplies, shall have the same meaning as Medically Necessary.
- AI. **MEMBER** means the Subscriber, and if dependant coverage is in force, his or her Enrolled Dependents.
- AJ. **MENTAL AND NERVOUS DISORDERS** means mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.
- AK. **NEWBORN CHILD(REN)** means the first 60 days of life from and including the date of birth of the child(ren).
- AL. **NON-PLAN PROVIDER** means a Hospital, Physician or other provider of healthcare goods and services that is not a Plan Provider at the time the healthcare service or supply is provided.

AM. **OPEN ENROLLMENT PERIOD** means: (1) for Groups with less than 2 employees, Open Enrollment must occur from August 1st through August 31st of each year the Agreement is in effect; (2) for Groups with 2 to 50 employees, a 30 day time period immediately prior to the anniversary date of the Effective Date; and (3) for Groups with 51 or more employees, a 30-day time period immediately prior to and a 30-day time period directly after the anniversary date of the Effective Date. During the Open Enrollment Period, Eligible Employees and Eligible Dependents who have not previously enrolled with the Plan may enroll. The Open Enrollment Period occurs at least once every 12 months.

AN. **OUT OF POCKET MAXIMUM** means a specified limit to the amount of Co-payments a Member or a Member's family covered under this Plan, as the case may be, are obligated to pay in a Calendar Year. The Out Of Pocket Maximum are set forth in the Summary of Benefits.

AO. **OUTPATIENT** or **OUTPATIENT SERVICES** means Covered Services that are not of Inpatient Hospital Services. A Member is considered to be an Outpatient when he/she is a patient of an organized medical facility or distinct part of such facility and, in the judgment of the Plan, is expected to receive professional services, including observation services, on an outpatient basis for less than a 24-hour period, regardless of the time of admission, whether or not a bed is used, or whether or not the Member remains in the facility past midnight.

AP. **PHYSICIAN** means an individual who is duly licensed to provide medical services by the state(s) in which he or she is practicing and who is acting within the scope of such license. A Physician shall include a doctor of medicine licensed under the following Florida statutes: Chapter 458, a doctor of osteopathy licensed under Chapter 459, a doctor of podiatry licensed under Chapter 458, an ophthalmologist licensed under Chapter 458 or Chapter 459, and a chiropractic physician licensed under Chapter 460, Florida Statutes.

AQ. **PHYSICIAN'S SERVICES** means professional services or medical care rendered by a Physician when Medically Necessary for the diagnosis or treatment of an Illness or Injury. To the extent a Physician employs or engages a nurse practitioner or physician assistant to provide services under the Physician's supervision, directly or indirectly, these providers may provide Covered Services consistent with their scope of practice.

AR. **PLAN HOSPITAL** means a Hospital that has a written contract in force with the Plan to render Covered Services to Members.

AS. **PLAN MEDICAL DIRECTOR** means a Physician employed by the Plan, or his or her appointed designee.

AT. **PLAN PROVIDER** means Hospitals, Physicians, and other providers of healthcare goods and services who have written contracts in force with the Plan to render such goods and services that they are licensed, certified or otherwise authorized

by the Plan to provide to Members. Plan Providers may also include the following Providers licensed under Florida Statutes: psychologists licensed pursuant to Chapter 490, mental health counselors licensed pursuant to Chapter 491, marriage and family therapists licensed pursuant to Chapter 491, clinical social workers licensed pursuant to Chapter 491, optometrists licensed under Chapter 463, certified nurse anesthetists and nurse midwives licensed under Chapter 464, nurse practitioners licensed under Chapter 464, and physician assistants licensed under Chapter 458, Florida Statutes.

AU. **PLAN PHYSICIAN** means a Physician who has a written contract in force with the Plan to render Covered Services to Members.

AV. **PLAN PHYSICIAN OFFICE(S)** means the offices and clinical facilities operated by or for Plan Physicians to provide Covered Services to Members under this Agreement.

AW. **PLAN SPECIALIST** means a Specialist who has a written contract in force with the Plan to render Covered Services to Members, and to whom a Member is referred for consultation or treatment by the Member's Primary Care Physician or the Plan.

AX. **PRE-EXISTING CONDITION**, as set forth in Article VII Exclusions and Limitations, means:

For groups with 2 to 50 employees and groups having fewer than 2 employees with Creditable Coverage, a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six month period immediately prior to the Individual Effective Date.

For groups having fewer than 2 employees without Creditable Coverage, a condition that, during the 24-month period immediately preceding the Effective Date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, including a pregnancy existing on the effective date of coverage.

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

AZ. **PREMIUM DUE DATE** means either the first or the fifteenth day of the calendar month when the Premium under this Agreement is due in full, as selected by the Group on its Application and approved by the Plan.

BA. **PREMIUM MONTH** means the period of time which runs from one Premium Due Date to the next Premium Due Date.

BB. **PRIMARY CARE PHYSICIAN** is a Plan Physician who has a written contract in force with the Plan and is responsible for providing, prescribing, authorizing and coordinating the medical care and treatment of the Member.

BC. **PRIOR AUTHORIZATION OR PRE-AUTHORIZATION OR PRE-CERTIFICATION** means that the Plan has determined that the admission, surgery, care, treatment or other service or supply is Medically Necessary and appropriate for the diagnosis and condition of the patient and, therefore, is eligible for coverage under the Agreement. Pre-Certification/Prior Authorization does not, however, guarantee or confirm benefits under this Agreement. Benefits are subject to eligibility at the time charges are actually incurred and all other terms, provisions, exclusions and limitations under this Agreement. Pre-Certification/Prior Authorization decisions are decisions concerning reimbursement and do not replace nor are they intended to influence the treatment decisions of the Member's Physician.

BD. **SCHOOL** means a public or private secondary school, accredited college or university, or licensed trade school.

BE. **SERVICE AREA** means Miami-Dade, Broward, and Palm Beach Counties, Florida.

BF. **SKILLED NURSING FACILITY** means an institution that:

1. is licensed by the state laws where it is located and operated as a Skilled Nursing Facility as defined by those state laws;
2. provides skilled nursing services and is not primarily a place for rest, Custodial Care, senility care, drug addiction, alcoholism, mental retardation, psychiatric disorders, or chronic brain syndromes, nor a nursing home or place for the aged; and
3. is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations, as a Certified Acute Rehabilitation Facility, or approved by Medicare.

BG. **SMALL EMPLOYER** means any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in the state of Florida, employed not more than 50 Eligible

Employees on business days during the preceding calendar year, and employs at least one employee on the first day of the Agreement Year and throughout the Agreement Year.

BH. **SPECIALIST** means a Physician who specializes in a particular field of medicine.

BI. **SUBSCRIBER** means the Eligible Employee who has enrolled under this Agreement.

BJ. **TERMINALLY ILL** means that the Member has a medical prognosis, as certified by a Plan Physician, of a life expectancy of six months or less.

BK. **URGENT GRIEVANCE** means a Grievance regarding an Adverse Determination when the standard time frame of the Grievance procedure would seriously jeopardize the life or health of a Member or would jeopardize the Member's ability to regain maximum function.

BL. **URGENT CARE SERVICES** means services for an unforeseen illness, injury, or condition, that, although not an Emergency Medical Condition, (i) could result in serious injury or disability unless medical attention is received or (ii) substantially restricts the member's activities..

BM. **USUAL, CUSTOMARY AND REASONABLE** or **UCR** means charges for Covered Services which, as determined solely by the Plan, are representative and reasonable charges for the geographic area in which the Covered Service was rendered. The Plan may consult the Medicare fee schedule, Health Insurance Association of America data, the Florida Relative Value Study, and other available sources to make usual, customary and reasonable fee determinations. For reimbursement purposes, in no event will a provider be reimbursed UCR when provider's actual charges are less than the UCR established by the Plan.

BN. **WAITING PERIOD** means the period of time specified in writing by the Group, which must follow the date a Subscriber is employed by the Group before such Subscriber and his/her Eligible Dependents, if any, may be entitled to receive Covered Services under this Agreement.

## ARTICLE II — GROUP EFFECTIVE DATE AND TERMINATION

A. **EFFECTIVE DATE.** This Agreement shall become binding upon the parties hereto upon the Execution Date. It becomes effective as a Group Service Agreement on the Effective Date indicated on page one of this Agreement, subject to the conditions precedent listed thereon.

### B. TERMINATION OF AGREEMENT

1. **Termination by Group.** This Agreement may be terminated by the Group upon not fewer than 30 days written notice to the Plan. Such termination shall become effective at the end of the Premium Month for which the last Premium payment was made in full.

2. **Termination by Plan.** This Agreement may be terminated by the Plan for any of the following reasons: 1) failure to pay Premiums or contributions in accordance with the terms of this Agreement or failure to make timely Premium payments; 2) fraud or intentional misrepresentation or omission of material fact by the Group in its Application or any other documents or communications to the Plan; 3) failure by Group to comply with a material provision of the Agreement relating to rules for employer contributions or to Group participation and eligibility; 4) the Plan is ceasing to offer a particular type of coverage in a market; or 5) the Group no longer has any enrollees who reside or work in the Service Area. Except for non-payment of Premium or termination due to reasons relating to eligibility, the Plan may cancel, terminate or fail to renew this Agreement upon 45 days prior written notice to the Group. Such notice shall state the reason or reasons for the cancellation, termination, or non-renewal. Upon such termination by the Plan, the Group shall notify all Members of the effective date of termination. When the grounds for termination are based upon fraud or intentional misrepresentations or omission of material fact or when Group may not be lawfully covered under the Agreement, the Agreement shall be cancelable by Plan retroactive to the Effective Date.

3. **Discontinuance of Group Agreement.** The Plan may discontinue offering a particular group health insurance contract upon not less than 90 days notice prior to the date of nonrenewal to the Group, and to each Member, of such discontinuation. Upon discontinuation, the Group will be provided the option to purchase any other group health insurance coverage then currently offered by the Plan in the relevant market.

If the Plan elects to discontinue offering all health insurance coverage offered to Small Employers and/or Large Employers in this state, notice to the Small and/or Large Group, as applicable, and to each Member, of such discontinuation will be given at least 180 days prior to the date of non-renewal of such coverage.

C. **EFFECT OF TERMINATION.** If this Agreement is terminated with respect to the entire Group, Members' entitlement to the services and benefits covered by this Agreement shall cease as of the effective date of termination. After the termination date, this Agreement shall be of no further force or effect. However, Members who are hospitalized or confined in a Skilled Nursing Facility at the time of such termination shall be entitled to continued services hereunder: (1) for a period not to exceed 30 days; (2) until the Plan determines the hospitalization or confinement to be no longer Medically Necessary; (3) until the Member's benefits are exhausted; or (4) until the Member is discharged, whichever first occurs.

D. **PAYMENT OF PREMIUMS AND GRACE PERIOD.** Premiums are due and payable in full to the Plan in advance of the Premium Due Date. The Group shall have a "Grace Period" of not more than 30 days after the Premium Due Date for payment

of Premiums. However, for the first effective month of the Agreement, a portion of the estimated Premium may be paid on the first of the said month to bind the parties hereto. If any required Premium is not paid on or before the Premium Due Date, it may be paid during the Grace Period. This Agreement will stay in force during the Grace Period, however, if payment in full is not received by the Plan during the Grace Period, this Agreement shall automatically terminate back to the end of the last Premium Month for which Premiums were paid in full upon expiration of the Grace Period. Claims for benefits incurred during such Grace Period will be paid only if the Plan receives all due and unpaid Premiums in full, including Premium due for the Grace Period, prior to the expiration of the Grace Period. All due and unpaid Premium, including Premium for the Grace Period, must be paid to the Plan by the Group as set forth herein to avoid termination of the Agreement.

E. **REINSTATEMENT.** After the Grace Period, the Group may apply in writing to the Plan for reinstatement of this Agreement. The request must be received by the Plan within ten (10) calendar days after the end of the applicable Grace Period. The Plan's acceptance of the reinstatement request shall be in writing. Upon acceptance, the Group must make payment of all due and unpaid Premiums. Premium payments made prior to Plan's acceptance of reinstatement, even if cashed by the Plan, shall not be deemed to be acceptance by the Plan. This Agreement will be reinstated retroactive to the effective date of termination. Requests for reinstatement received more than ten (10) calendar days after the end of the Grace Period will not be considered. Reinstatement decisions shall be at the sole discretion of the Plan.

F. **DISHONORED CHECKS.** If the Group's check for Premium payment is dishonored, the Group must tender payment for such month's Premium due plus a service charge as follows: \$25, if the face value does not exceed \$50; \$30, if the face value exceeds \$50 but does not exceed \$300; \$40, if the face value exceeds \$300, or 5 percent of the face amount of the check, whichever is greater. The Premium payment, including applicable service charge, must be paid in full within the Grace Period in order for the Agreement to remain in force.

G. **PREMIUM CHANGES.** Premium rates charged by the Plan may be changed upon not less than thirty (30) days advance written notice to the Group. The Group shall notify all Members of such change in Premiums. Plan may change monthly Premiums hereunder whenever the terms of the Agreement are changed by endorsement.

H. **AGREEMENT CHANGES.** The Plan may modify Co-payments and Out of Pocket Maximums or delete, amend, or limit any benefits under this Agreement upon not less than 45 days written notice to the Group prior to renewal of this Agreement. The Plan may otherwise amend the Agreement with the Group, with such amendment to be effective immediately at the time of coverage renewal. It is the responsibility of the Group to notify all Members of any changes to the Agreement.

## ARTICLE III — INDIVIDUAL ENROLLMENT, EFFECTIVE DATE, TERMINATION OF COVERAGE AND CONVERSIONS

### A. SUBSCRIBER AND DEPENDENT ENROLLMENT AND EFFECTIVE DATE

1. During the Initial Enrollment Period prior to the Individual Effective Date, in order to enroll for coverage under this Plan, all Eligible Employees must accurately complete and sign an Enrollment Form listing Eligible Dependents. Upon request by Plan, during the Initial Enrollment Period and while this Agreement is in effect, Eligible Employee shall provide additional information needed by Plan to determine eligibility.
2. All statements on the Enrollment Form must be accurate and complete. Providing false or misleading information or omitting required information in the enrollment process or at any other time gives rise to termination of the Eligible Employee's/Subscriber's coverage under the Plan.
3. Eligible Employees and their Eligible Dependents whose Enrollment Forms are received by the Plan:
  - i. within 30 days prior to or for 30 days after the date such individual first becomes eligible for coverage; or
  - ii. during an Open Enrollment Period,

will become effective under this Agreement on the Individual Effective Date, as provided in paragraph 4 below.

4. The Individual Effective Date shall be the first day of the Premium Month after the date the individual first becomes eligible for coverage. Covered Services rendered to Members on or after the Individual Effective Date and prior to termination of the Members' coverage hereunder are subject to Article VII – Exclusions and Limitations, and all other terms and conditions set forth in this Agreement.
5. **Late Enrollment.** A Late Enrollee may only enroll for coverage under this Agreement during an Open Enrollment Period.

For Groups with 51 or more employees, a Late Enrollee may only enroll for coverage under this Agreement during an Open Enrollment Period.

6. **Special Enrollment.** An individual is not a Late Enrollee if:
  - a) the individual was covered under another employer health plan during his or her Initial Enrollment Period; and:
    - i. the individual lost coverage under such plan as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage

- ii. the individual requests enrollment under this Agreement and the Enrollment Form is submitted to the Plan within 30 days after termination of his or her prior coverage;

OR

- b) the person was covered under a COBRA continuation provision or continuation of coverage pursuant to Section 627.6692, Florida Statutes, and the coverage under such provision was exhausted, and the Enrollment Form is submitted to the Plan within 30 days of such exhaustion;

OR

- c) the person becomes a dependent through marriage, birth, adoption, or placement for adoption and submits an Enrollment Form to the Plan within 30 days of such marriage, birth, adoption, or placement for adoption;

OR

- d) in the case of the birth or adoption of a child, the individual or spouse submits an Enrollment Form to the Plan within 30 days of such birth or adoption, if such person is otherwise eligible for coverage.

7. **Adopted Children.** All benefits applicable to children under this Agreement shall also be payable with respect to a Subscriber's Adopted Child. The Plan will not exclude coverage for any Pre-Existing Condition of the Adopted Child. Coverage for an Adopted Child begins when the child is placed in the residence of the Subscriber in compliance with Florida law. If a written Agreement to adopt such child has been entered into by the Subscriber prior to the birth of the child, coverage for a newborn Adopted Child begins at the moment of birth whether or not such contract is enforceable. However, coverage is not available for an Adopted Child if the child is not ultimately placed in the residence of the Subscriber in Compliance with Chapter 63, Florida Statutes. The Subscriber must enroll such child within 30 days of the birth or placement of the Adopted Child.

8. **Newborn Children.** All benefits applicable for children will be payable with respect to a child born to the Subscriber or the Subscriber's Enrolled Dependents after the Individual Effective Date and while the Agreement is in force. Coverage for a Newborn Child will begin as of the date of birth if a completed and signed enrollment form is received by the Plan within 30 days following the date of birth (the "Birth Notice Period"). If timely notice is given, the Plan will not charge an additional premium for the 30 day Birth Notice Period. If the enrollment request is not received by the Plan within 60 days of the birth of the child, such child will be a Late Enrollee and subject to the provisions of Late

Enrollment described in Article III, section A(5). Coverage for an enrolled Newborn Child of a Member, other than the Subscriber's spouse, will automatically terminate 18 months after the birth of such Newborn Child.

9. **Marriage.** Upon marriage recognized as a marriage by the laws of the state in which the marriage occurred, the spouse of a Subscriber must submit an Enrollment Form within 30 days of the marriage. If the Enrollment Form is timely submitted, the Individual Effective Date shall be the date of the marriage. If the spouse is not enrolled during this period, the spouse may be enrolled: (i) for Groups with 1 to 50 employees, in the next month after receipt of the Enrollment Form on the date assigned by the Plan; or (ii) for Groups with 51 or more employees, during the next Open Enrollment period.

10. **Non-Discrimination.** The Plan shall not expel, refuse to renew the coverage of, or refuse to enroll any Eligible Employee or Eligible Dependents on the basis of race, color, creed, marital status, sex or national origin. Moreover, the Plan shall not expel or refuse to renew the coverage of a Member on the basis of such Member's age, health status, healthcare needs or expected cost of healthcare services of the Member.

B. **ACTIVELY AT WORK.** In the event a Subscriber is not Actively at Work on his or her Individual Effective Date, coverage will not be effective until the Premium Month following the month in which he or she returns to Actively at Work status and for which Premium is paid.

C. **RE-ENROLLMENT AFTER TERMINATION.** A Subscriber and/or Enrolled Dependent(s) whose coverage under this Agreement is terminated by such Subscriber shall be entitled to apply for re-enrollment only during an Open Enrollment Period.

D. **TERMINATION OF COVERAGE.** The coverage of any Member shall terminate:

1. at the end of the Premium Month during which a Member no longer qualifies as an Eligible Employee or Eligible Dependent. The Group must notify the Plan within 30 calendar days of the date a Member no longer qualifies as an Eligible Employee or Eligible Dependent. If notice is not given to the Plan within 30 calendar days, then termination of such individual will become effective at the end of the Premium Month in which notice is received by the Plan. The Group is responsible for payment of any required Premiums until the end of the Premium Month in which notice was received. Coverage will terminate automatically and without notice.

2. at the end of the Premium Month for which the last Premium was paid in full by the Group to the Plan, if the Premium was not paid by the end of the Grace Period. The Group shall be responsible for providing notice to Members in accordance with Article II, Section B herein.

3. on the last day of the Premium Month during which the Plan has terminated the Member's coverage for cause. Cause for termination shall include, but is not limited to: i) fraud or intentional misrepresentation or omission of material fact in applying for eligibility or seeking any benefits under this Agreement; ii) disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior towards a healthcare provider or administrative staff that, in the Plan's sole discretion, impairs the Plan's ability to arrange for Covered Services according to this Agreement; iii) failure to pay, upon notice, fees or Co-payments which are the responsibility of the Member; iv) misuse of the Identification Card by any person; v) a Member's refusal to follow his or her Physician's treatment plan; vi) failure to provide any signed releases, consents, assignments, or other documents and information reasonably requested by the Plan; or vii) failure to cooperate with the Plan in the administration of this Agreement, including failure to abide by utilization review and case management. The Plan will notify the Member in writing 45 days prior to the date of termination; provided, however, when the grounds for termination are based upon fraud or intentional misrepresentations or omission of material fact or when Members may not be lawfully covered under the Agreement, the Agreement shall be cancelable by Plan retroactive to the Individual Effective Date of the Member and Plan may recover from Member any and all amounts paid on behalf of Member for this period.

4. on the last day of the Premium Month during which the Member becomes eligible for coverage under Medicare, Title XVIII of the Social Security Act, as amended.

No Member shall have his/her coverage terminated under this provision because of the amount, variety or cost of services required by such Member.

#### E. EXCEPTIONS TO TERMINATION OF COVERAGE

1. The Plan will not terminate a Subscriber's coverage solely because he or she ceases to be Actively at Work if:

a. the absence from work is due to Illness or Injury. In such event, the Subscriber's coverage can be continued for up to 12 months if the Group continues to make Premium payments for the Subscriber's coverage, except as may be otherwise prohibited in this Agreement; or

b. the absence from work is due to a temporary lay-off or leave of absence approved by the Group. In such event, the Subscriber's coverage can be continued for up to 2 months, if the Group continues to make Premium payments for the Subscriber, except as may be otherwise prohibited in this Agreement.

2. If coverage for an Enrolled Dependent child would terminate because of that child's attainment of the applicable limiting age as set forth in Article I, Section K, of this Agreement (the "Limiting Age") but at such time the child is incapable of self-support due to mental retardation or physical

disability and is chiefly dependent upon the Subscriber for support and maintenance, that child's coverage may be continued during such incapacity as long as:

- a. Premiums are paid for such child's coverage according to the terms and conditions of this Agreement;
- b. the Subscriber's coverage under this Agreement remains in effect;
- c. when a claim is denied due to the child's attainment of the Limiting Age, the Plan is provided with required proof of such child's incapacity and dependency for support and maintenance and
- d. all other requirements set forth in Article I, Section K are met.

F. **CONVERSION COVERAGE.** In the event a Member's coverage terminates, such person may have the right to convert, without evidence of insurability, to a direct pay, non-group contract. Only Members who: 1) were continuously covered under this Agreement, and under any group health maintenance contract providing similar benefits for which this Agreement replaced, for at least 3 months immediately prior to termination; and 2) work or reside in the Service Area, are eligible for conversion coverage. Conversion coverage must be applied for and the first Premium must be received by the Plan within 63 days of the date that coverage terminates under this Agreement. If the Agreement terminates as the result of failure to pay any required Premium by the Group, the conversion coverage must be applied for and the first Premium must be paid to the Plan within 63 days after notice of termination is mailed by the Plan to the Member's last known address.

A Member shall not be entitled to conversion coverage if coverage under this Agreement terminated for any of the following reasons: (1) failure to pay any required Premium or contribution unless such nonpayment of premium was due to acts of the Group or person other than the Member; (2) replacement of any discontinued group coverage by similar group coverage within 31 days from the date of termination of this Agreement; (3) the Member was terminated under this Agreement for a Cause, as described in Article III, Section D.3; (4) a Member (who does not work within the Service Area) has left the Service Area with the intent to relocate or establish a new residence outside the Service Area; (5) fraud or intentional misrepresentation or omission of material fact in applying for any benefits under this Agreement; (6) willful and knowing misuse of the Plan's Identification Card by the Member; or (7) willfully and knowingly furnishing to the Plan by the Member of incorrect or incomplete information for the purpose of obtaining coverage or benefits from the Plan.

G. **COBRA COVERAGE CONTINUATION.** A Group subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (i.e., Groups with 20 or more employees) is required to provide the Member a notice of continuation of coverage rights under COBRA. The Group is responsible for meeting all of the obligations under COBRA, including, without limitation, notifying all Members of their rights under COBRA. If the Group fails to meet its obligations under

COBRA, the Plan will not be liable for any claims incurred by a Member following the termination of coverage.

The following is a brief summary of the Member's rights under COBRA and the general conditions necessary to qualify for such COBRA continuation benefits.

A Member may be entitled to elect continuation of coverage under COBRA in the event of the occurrence of any of the following "qualifying events" where such event results in the Member's loss of coverage under this Agreement:

1. Termination of the Subscriber's employment for any reason other than gross misconduct.
2. A reduction in the Subscriber's work hours.
3. The Subscriber's death.
4. The Subscriber's divorce or separation.
5. The Subscriber's or Enrolled Dependent's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare").
6. The Subscriber's Enrolled Dependent Child ceasing to be an Eligible Dependent as defined in this Agreement.

The Member must elect to continue coverage under COBRA within the election period determined by the Group. An election period must be for at least 60 days. It shall begin no later than the date the Member would have otherwise lost coverage under this Agreement due to a qualifying event. A Member who elects COBRA continuation of coverage is subject to all the same terms and conditions of this Agreement as a Member who has not had a qualifying event.

Such continuation of coverage shall be made available at the Premium specified in the Agreement, which shall not exceed: (1) one hundred and two percent (102%); or (2) one hundred and fifty percent (150%) for allowed extensions after the 18-month continuation period, of the total Premium charged for such period of coverage for a similarly situated Member who has not had a qualifying event. The Member must pay any required Premiums directly to the Group.

If the qualifying event is due to termination of employment or reduction of hours, the maximum COBRA continuation period is 18 months. The maximum COBRA continuation period is 29 months if disabled at time of the qualifying event or if the disability arises within the first 60 days of COBRA continuation. For all other qualifying events the maximum COBRA continuation period is 36 months.

Any Member who elects COBRA continuation coverage may, at the end of such coverage and, if otherwise eligible, exercise conversion rights pursuant to Article III, Section F of this Agreement.



## H. CONTINUATION RIGHTS FOR GROUPS WITH 19 OR FEWER EMPLOYEES.

A Small Employer who employs 19 or fewer employees is required to provide its Members with continuation coverage. Each Member who would lose coverage under this Agreement due to a qualifying event, as defined below, is entitled to elect continuation coverage without evidence of insurability. The following is a brief summary of the Member's rights and general conditions necessary to qualify for such continuation coverage.

A Member may be entitled to elect continuation coverage in the event of the occurrence of any of the following qualifying events where the qualifying event results in the Member's loss of coverage under the Agreement:

1. Termination of the Subscriber's employment for any reason other than gross misconduct.
2. A reduction in the Subscriber's work hours.
3. The Subscriber's death.
4. The Subscriber's divorce or separation.
5. A Member's entitlement to benefits under either Part A or Part B of Title XVIII of the Social Security Act ("Medicare").
6. An Enrolled Dependent Child ceasing to be an Eligible Dependent as defined in the Agreement.
7. A retired Subscriber or the Enrolled Dependent spouse or child of a retired Subscriber losing coverage within one year before or after commencement of a bankruptcy proceeding under Title XI of the United States Code by the Employer from whose employment the Subscriber retired.

The Member must elect to continue coverage in writing within the 30-day election period as set out in Section 627.6692, Florida Statutes. It is the Member's responsibility to notify the Plan in writing of his/her desire to elect continuation coverage. Unless otherwise specified, notice by one Member constitutes notice on behalf of all Members residing in the same household who remain eligible for coverage. The written notice must include: (1) the identity of the Employer; (2) the Group health plan number; and (3) the name and address of all Members. Within 14 days of receipt of written notice by the Plan, the Plan shall send each Member an election and Premium notice form. A Member who wishes to elect continuation coverage must do so in writing and pay the initial Premium within 30 days from receipt of the election and Premium notice form. The election period shall begin on the date the Member would have otherwise lost coverage due to a qualifying event. A Member who elects continuation coverage under this section is subject to all the same terms and

conditions of this Agreement as a Member who has not had a qualifying event.

Such continuation coverage shall be made available at the premium specified in the Agreement, which in no event shall exceed: (1) one hundred and fifteen percent (115%); or (2) one hundred and fifty percent (150%), for allowed extensions after the 18-month continuation period, of the total Premium charged for such period of coverage for a similarly situated Member to whom a qualifying event has not occurred. The Member must pay the Premium amount required on the first of the month directly to the Plan, to continue benefits. The maximum period for continuation of coverage shall be eighteen (18) months. If disabled at the time of the qualifying event, the maximum period for continuation of coverage is twenty-nine (29) months.

Any Member who elects continuation coverage may, at the end of such coverage and, if otherwise eligible, exercise conversion rights pursuant to Article III, Section F of this Agreement.

## I. EXTENSION OF BENEFITS.

In the event Plan terminates this Agreement for Group, coverage for benefits terminate as of the termination date, except as set forth below.

For any Illness or Injury that commenced while this Agreement was in force which results in the continuous total disability of the Member, there shall be an extension of benefits beyond the date that coverage under this Agreement terminates for Covered Services necessary to treat the disabling condition only. A Member who is pregnant as of the termination date of the Group is also entitled to an extension of benefits for Covered Services necessary to treat the pregnancy only, so long as the pregnancy commenced while the Member was covered under the Agreement.

1. **Due to total disability.** The extension of benefits due to total disability is limited to the first to occur of the following events: (i) the expiration of twelve (12) months from the date of termination of this Agreement; (ii) such time as the Member is no longer totally disabled; (iii) a succeeding carrier provides replacement coverage without limitation as to the disability condition; or (iv) the maximum benefits payable under this Agreement have been paid.

For the purposes of this section, a Member is totally disabled if the Member has a condition resulting from an Illness or Injury that prevents the Member from engaging in any employment or occupation for which the Member is or may become qualified by reason of education, training, or experience; is not in fact engaged in any employment or occupation for wage or profit; and is under the regular care of a Physician.

2. **Due to pregnancy.** An extension of benefits due to pregnancy is limited to Covered Services relating to such pregnancy. An extension of benefits does not include coverage for services relating to the Newborn. Benefits will continue until the first to occur of the following events: (i) the end of such pregnancy; or (ii) the date the Member becomes covered under another plan and the succeeding carrier assumes liability for such pregnancy coverage.
3. **Exceptions to Extension of Benefits.** No Member is entitled to an extension of benefits, as provided in Article III, Section I. of this Agreement, if the Plan has terminated this Agreement for any of the following reasons: (i) fraud or misrepresentation or omission of material fact in applying for coverage or any benefits under the

Agreement; (ii) disenrollment for cause, as described in Article III, section D.3 of this Agreement; (iii) the Member has left the Service Area of the Plan with the intent to relocate or establish a new residence outside the Plan's Service Area.

#### J. **BENEFIT ELIGIBILITY**

Certification or authorization, including Pre-Certification or Prior Authorization, for services by the Plan does not guarantee or confirm benefits under this Agreement. Benefits are subject to eligibility at the time services are rendered and to all other terms, provisions, conditions, exclusions, and limitations of this Agreement.

## **ARTICLE IV — HOSPITAL AND RELATED SERVICES**

The following hospital and related services must be medically necessary and must be provided or arranged by the primary care physician and prior authorized by the plan, except in the case of an emergency medical condition. Services provided by non-plan providers are not covered unless prior authorization from plan is obtained, except in the case of an emergency medical condition. It is the member's responsibility to determine if a provider is a plan provider and whether plan prior authorization was obtained before services are rendered. Services that do not receive prior authorization from the plan as required and which were not referred by the member's primary care physician shall be at the member's own expense. Any services, care or supplies which are not medically necessary, as determined by plan, are not covered services.

Coverage is subject to any applicable co-payment and to all terms, conditions, exclusions and limitations under this agreement.

All benefits available under this agreement are subject to article vii, exclusions and limitations

#### A. **HOSPITAL SERVICES**

1. Hospital Services provided on an inpatient or outpatient basis may include the following:
  - a. semi-private room and board;
  - b. use of specialized units within the facility to include operating, recovery, delivery rooms, intensive care and nursery;
  - c. anesthesia services, administration and supplies;
  - d. laboratory services;
  - e. diagnostic services, including x-rays, nuclear medicine, sonography, and magnetic resonance imaging;
  - f. medical and surgical services and supplies including: medications, intravenous therapy, radiation therapy, supplies and dressings, and blood and blood products

when participation in a blood replacement program is not available and administration by the Hospital;

- g. rehabilitation and therapeutic services (including: physical therapy as described in Article IV, Section H below; respiratory therapy, cardiac therapy; occupational therapy and speech therapy) in connection with a Covered Service; and
- h. nursing care provided by hospital staff.

2. Hospital Services must be provided by a Plan Hospital, unless otherwise approved in advance by Plan, or when Emergency Services or Care is necessary.

#### B. **ALCOHOLISM AND DRUG DEPENDENCY**

The Plan covers inpatient and outpatient care for alcoholism and chemical dependency, subject to a maximum benefit of \$2,000 per Calendar Year for all such services combined. Inpatient care is limited to crisis intervention for medical detoxification only.

#### C. **AMBULATORY SURGERY SERVICES**

Ambulatory surgery services are covered services when provided by a Plan Provider (i.e., an outpatient department of a Plan Hospital or a Plan free standing ambulatory surgery center). If Member has Ambulatory Surgery Services, Member's coverage is the same as would be provided if Member was an inpatient, except semi-private room and Inpatient rehabilitation services are not covered.

#### D. **HOME HEALTH SERVICES** means:

1. part-time or intermittent skilled nursing services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);

2. part-time or intermittent home health aide services provided by a certified home health aide in the home under the supervision of a registered nurse (R.N.) or a physical, speech, or occupational therapist;
3. physical, occupational, or speech therapy; and
4. medical supplies, drugs, medicines and related pharmaceutical and laboratory services that are prescribed by a Physician and provided in connection with covered Home Health Services. Drugs or nutrients taken by mouth or self-administered by injection are not covered.

The Plan covers up to 60 visits each Calendar Year, not to exceed 60 visits per spell of Illness, for all Home Health Services combined, including the services of social workers and dietitians when the Member is confined to home and requires skilled nursing services. If a Member is receiving Home Health Services at the end of the Calendar Year and continues to receive such services in the succeeding Calendar year, the maximum coverage provided for the entire spell of Illness is 60 visits total. All Home Health Services must be performed by a Plan Home Healthcare Agency. Benefits are only available for Members confined to their homes for conditions which, in the opinion of the Plan Physician, can be satisfactorily treated on such basis. A Home Healthcare treatment plan must be established in writing and approved by the Plan. No Home Health Services shall be provided under this Agreement beyond the date upon which, in the opinion of a Plan Physician and the Plan, continued Home Health Services are no longer Medically Necessary. For purposes of determining this benefit, all or part of one hour shall equal one Home Healthcare visit. Services or training for activities of daily living, domiciliary care, Custodial Care or care provided for the Member's convenience are not covered. Medical supplies, drugs, medicines and related pharmaceutical and laboratory services provided by the Plan Home Healthcare Agency will not be covered as Home Health Services after 60 visits. The Home Health Services benefit does not provide coverage for Home Infusion Services. This coverage is set forth in Article IV, Section E.

#### E. HOME INFUSION THERAPY

Home Infusion Therapy is the administration of drugs or nutrients using specialized delivery systems in Member's home by a Plan Home Care Provider which otherwise would have required the Member's hospitalization. Drugs, medical supplies and related pharmaceutical supplies for the home infusion are covered. Drugs or nutrients taken by mouth or self-administered injectables are not covered. The Plan covers up to 60 visits each Calendar Year for Home Infusion Therapy, not to exceed 60 visits per spell of Illness. If a Member is receiving Home Infusion Therapy at the end of a Calendar Year and continues to receive such services in the succeeding Calendar Year, the maximum coverage for the entire spell of Illness is 60 visits total. Drugs, medical supplies and related pharmaceutical supplies for home infusion will not be covered for Home Infusion Therapy after 60 visits.

#### F. HOSPICE CARE

The Plan covers lifetime maximum of 180 days of inpatient and/or outpatient Hospice Care for a Terminally Ill Member when requested by a Plan Physician. Hospice Care is palliative care (pain control and symptom relief), rather than curative care. Hospice Care must be provided by a Plan Provider.

#### G. MENTAL HEALTH AND NERVOUS DISORDERS

The Plan covers the treatment of Mental Health and Nervous Disorders as follows:

1. Inpatient hospitalization and partial hospitalization up to a combined total benefit of 30 days per Calendar Year. In any one (1) calendar year, if partial hospitalization services or a combination of inpatient and partial hospitalization services are rendered, the total benefits available are limited to the extent that all such services combined will not exceed the equivalent of thirty (30) days of inpatient hospitalization for psychiatric services. Partial hospitalization means treatment in which Member receives at least 8 hours of institutional care during a portion of a 24 hour period and returns home when treatments are not scheduled. For purposes of determining this benefit, two days of partial hospitalization will count as one inpatient hospital day.
2. Outpatient benefits for consultations with a Plan Physician or Plan Provider up to 20 visits per Calendar Year.

#### H. PHYSICAL REHABILITATION

The Plan covers a maximum of 60 days in a Calendar Year for a hospital stay, portion of a hospital stay, a Skilled Nursing Facility stay, or a portion of a Skilled Nursing Facility stay which is primarily for restorative physical therapy. Such services must be provided by a Plan Provider, unless otherwise approved in advance by Plan.

The services must be for restorative physical rehabilitation for a condition which is subject to significant clinical improvement through relatively short term therapy, as determined by Member's Plan Provider. More extensive specialized physical medicine and inpatient rehabilitation services, including physical therapy and physical rehabilitation, are not covered under this Agreement.

The 60 day time period for which this benefit is available is included in and part of the 120 day time period applicable to Skilled Nursing Facility Services set forth in Article IV, section I.

1. **SKILLED NURSING SERVICES** means services provided in a Skilled Nursing Facility that meet all of the following conditions: 1) ordered by and under the supervision of a Plan Physician; 2) sufficiently medically complex to require supervision, assessment, planning, or intervention by a Registered Nurse (R.N.); 3) required to be performed by, or

under the direct supervision, of a Registered Nurse for safe and effective performance; 4) required on a daily basis; 5) Medically Necessary to treat the Injury or Illness; and 6) consistent with the nature and severity of the Member's condition.

The Plan covers a maximum benefit of 120 days per Calendar Year, not to exceed 120 days per spell of Illness, in a semi-private room of a Skilled Nursing Facility when the Member's condition, Illness or Injury requires skilled nursing or rehabilitative care on a daily basis. If a Member is an inpatient in a Skilled Nursing Facility at the end of a Calendar Year and remains as an inpatient into the succeeding Calendar Year, the maximum coverage provided for the entire spell of Illness is 120 days total.

## J. TRANSPLANT SERVICES

For the purposes of this section, "Transplant Services", including Bone Marrow Transplants, means pre-transplant (i.e., evaluation), transplant and post-transplant services, and treatment of complications resulting from the transplantation. A Bone Marrow Transplant is the administration of human precursor cells to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

Transplant Services are Covered Services only if the Plan has separately approved the evaluation, transplant and post-transplant services. The Member or the Member's Primary Care Physician must notify the Plan in advance of the Member's initial evaluation for the transplant procedure. Such notice must be sufficient to allow the Plan a reasonable amount of time to determine if the transplant evaluation services are Covered Services under this Agreement. For approval of the transplant itself, the Plan must be given a reasonable period of time and the opportunity to review the clinical results of the evaluation. If approval is not given, coverage will not be provided for the transplant procedure. The Plan will not cover Transplant Services pursuant to this section if they are determined to be Experimental/Investigational by the American Medical Association DATA panel, HAYES, any department or agency of the federal government authorized to make such determinations, or otherwise deemed not Medically Necessary by the Plan. Post-transplant services and complications resulting from the transplantation are not covered if the transplant procedure was not a Covered Service.

If the transplant procedure is approved, the Plan will advise the Member's Physician of those facilities that are approved for the type of transplant procedure involved. A facility must meet criteria established by the National Institute of Heart, Blood and Lung or the National Institutes of Health to be approved

by the Plan. Coverage is available only if the pre-transplant services, the transplant procedure, and post transplant services are performed in approved facilities.

Subject to applicable Plan conditions, exclusions and limitations, only the following services are covered for approved transplant procedures and related complications in approved facilities:

1. Hospital Services and Physician Services under the same terms and conditions as provided for the care and treatment of any other covered Injury or Illness under this Agreement.
2. Medical costs associated with organ acquisition and donor cost. However: (1) medical donor costs are not covered if payable, in whole or in part, by any other group plan, insurance company, organization, or person other than the donor's family or estate; (2) Non-medical organ acquisition costs and donor costs are not covered under the Agreement, unless otherwise specified; and (3) the Plan will not cover any donor costs related to the removal of an organ from a Member for the purposes of transplantation into a recipient who is not a Member. Notwithstanding the above, donor costs associated with Bone Marrow Transplants are covered to the same extent as such services are covered for the Member receiving the Bone Marrow Transplant from the donor.
3. Transportation and lodging costs are only covered when the transplant procedure is performed in a facility which is outside the Service Area. Coverage for transportation and lodging costs are limited to an overall dollar maximum of \$5,000 per transplant. This includes any complications and follow-up visits related thereto. Transportation and lodging benefits only include: 1) round-trip coach class air fare for the Member receiving Transplant Services and one family member; and 2) lodging expenses for the Member who is the transplant recipient up to \$65 per day. In the event the Member is the recipient of a bone marrow transplant, transportation and lodging cost include: 1) round trip coach class air fare for the bone marrow donor and one family member, and 2) lodging expenses for a bone marrow donor, up to \$65 per day. The Member is required to provide detailed invoices and receipts documenting such expenses to the Plan in order to obtain reimbursement.
4. Bone Marrow Transplants that are specifically listed in Chapter 10D-127.001 of the Florida Administrative Code. This includes coverage for the bone marrow donor as described in items 1-3 above. Coverage for the costs for a bone marrow donor search is limited to costs associated with searches relating to immediate family members and the National Bone Marrow Donor Program.

K. **URGENT CARE SERVICES** when provided by a Plan Provider and when it is not reasonable or practical to wait to see the Primary Care Physician.

## ARTICLE V — MEDICAL, SURGICAL AND RELATED SERVICES

The following medical, surgical and related services, equipment and supplies are covered only if provided or arranged by the member's primary care physician and subject to prior authorization by the plan, except in the case of an emergency medical condition or as otherwise expressly provided below. All medical, surgical and related services, equipment and supplies must be medically necessary, except with regard to preventive and routine care, as expressly provided below. Any services, equipment and supplies which are not medically necessary, as determined by plan, are not covered services.

Coverage is subject to any applicable co-payment and all terms, conditions and exclusions under this agreement.

All benefits provided under this agreement are subject to article vii, exclusions and limitations

Every Member must select a Primary Care Physician who is a Plan Physician. Plan Physicians, including Primary Care Physicians, are listed in the Plan's Provider Directory which is updated from time to time by Plan. If the Member fails to select a Primary Care Physician, the Plan will assign one to the Member. Specialists must be selected from those Plan Specialists listed in the Plan's Provider Directory. A referral from the Primary Care Physician must be obtained before services are rendered by a Plan Specialist, except as set forth below.

Except when Emergency Services and Care are required, services of Non-Plan Providers are covered only when Prior Authorization is received from the Plan. *It is the Member's responsibility to determine if a provider is a Plan Provider and whether Plan Prior Authorization was obtained for use of a Non-Plan Provider. Non-Plan Provider services that do not receive Prior Authorization from the Plan and Plan Provider services which were not referred by the Member's Primary Care Physician shall be at the Member's own expense.* The Member may, however, receive services from a Plan Chiropractor, Plan Podiatrist, Plan Gynecologist (annual women exam and related follow-up care) and Plan Dermatologist (5 annual visits) without a PCP referral, subject to the terms and conditions stated in this Agreement.

On or after the Individual Effective Date, a Member is entitled to the following services and care for the diagnosis or treatment of an Illness or Injury:

### A. PHYSICIAN'S SERVICES

1. Consultation, examination and treatment by a Plan Physician at the Hospital or Skilled Nursing Facility where the Member is confined, or at the Plan Physician's Office.
2. Periodic health assessment, to include well-child care from birth, adult health examinations and immunizations, medical history, physical examination, laboratory, x-ray and other screening or diagnostic tests as indicated by

the age, sex, medical history or physical examination of the Member ordered by a Plan Physician in accordance with the Plan's Preventive Healthcare Guidelines (which are provided to Members by Plan). Travel vaccines and immunizations are not covered.

3. A female Member may choose to receive an annual gynecological exam including manual breast exam, pelvic exam and Pap smear ("well woman exam") from a Plan Gynecologist without a referral from the Primary Care Physician. Medically Necessary follow-up care for conditions detected during the well woman exam may be obtained from the same Plan Gynecologist without a referral from the Primary Care Physician. Care sought in excess of the well woman exam and follow-up visits must be Pre-Authorized by the Member's Primary Care Physician.
  4. Child Health Supervision Services from the moment of birth to age 16. Coverage is limited to the following services from the same provider during one visit: history; physical examination; developmental assessment; anticipatory guidance; immunizations; and lab tests. Services must be physician-delivered or physician-supervised, and provided in accordance with prevailing medical standards and consistent with the Plan's Preventive Health Guidelines.
  5. Immunizations for health maintenance in accordance with the Plan's Preventive Healthcare Guidelines and the injection of medicine in Plan Provider's office for preventive or therapeutic purposes. Medications which can be self-injected, as determined by Plan, whether or not they are administered by Plan Provider, are not covered.
  6. Complications of pregnancy will be treated the same as any other illness.
  7. Allergy testing and desensitization therapy to alleviate allergies, including the cost of hypersensitivity serum.
- B. **SURGICAL SERVICES.** Surgical services, including preoperative care, postoperative care and the administration of anesthesia. Services of physician operative assistants are covered according to Plan coverage criteria for surgical assistants.
- C. **AMBULANCE SERVICES.** Ambulance services required to transfer Member from a non-participating facility to the nearest Plan Hospital.
- D. **ANESTHESIA.** Administration of anesthesia in connection with surgery or maternity care covered under this Agreement, if in Plan's judgment, the nature of the procedure requires anesthesia.

- E. **BLOOD.** Blood and blood derivatives, including administration fees, excluding blood provided through a replacement program.
- F. **BRACES.** Special braces required to maintain the function of a disabled limb or Medically Necessary to support a functionally impaired body part.
- G. **CHIROPRACTIC SERVICES.** Chiropractic Services performed by a Plan Chiropractor for conditions that are medically recognized and accepted as being appropriately treated by such therapy. In addition, a Member may receive services from a Plan Chiropractor without a referral from a Primary Care Provider. Benefits are limited to a maximum of 12 chiropractic treatments per Calendar Year per Member.
- H. **CLEFT-LIP/CLEFT-PALATE.** Treatment and services for cleft-lip and cleft-palate for Members under the age of 18 years. Benefits for cleft-lip/cleft-palate are subject to the same terms, conditions, and limitations as all other Covered Services under this Agreement.
- I. **DERMATOLOGY.** A Member may receive up to 5 (five) visits per Calendar Year from a Plan Dermatologist for office visits and for the provision of minor procedures only, without a referral from the Primary Care Physician. All other services must be upon the referral of the Primary Care Physician and receive Prior Authorization from the Plan. Dermatological procedures which are primarily cosmetic in nature are not covered.
- J. **DIABETES.** Equipment, supplies, and services including outpatient self-management training and educational services used to treat diabetes obtained from a Plan Provider. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a Plan diabetes educator or Plan endocrinologist. Nutrition counseling must be provided by a licensed Plan dietician. Coverage for insulin pumps is limited to the most cost effective pump which meets the Member's medical needs, as determined by Plan. Equipment and supplies, including insulin pumps and pump supplies, are not subject to the DME lifetime maximum set forth in Subsection L.
- K. **DIALYSIS.** Treatment and services for renal disease, including equipment, training and supplies required for effective dialysis.
- L. **DURABLE MEDICAL EQUIPMENT (DME) and DISPOSABLE MEDICAL SUPPLIES.** Durable medical equipment is covered when provided in connection with or as the result of a Covered Service. Disposable medical supplies necessary for use in connection with covered DME are covered. All DME and disposable medical supplies must provide medical and therapeutic service and must be provided by a designated Plan Provider. Repair or replacement of damaged equipment and the purchase or rental of duplicate equipment is not covered under the Plan. DME is defined as equipment that meets all the following criteria:
  - 1. Can stand repeated use.

- 2. Primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.
- 3. Usually not useful to a person in the absence of sickness or Injury.
- 4. Appropriate for home use.
- 5. Related to the patient's physical disorder.
- 6. Certified in writing by a Plan Physician as Medically Necessary.

Benefits for DME and disposable medical supplies are subject to a aggregate lifetime maximum of \$2,500. The Plan may, at its option, authorize the purchase of DME if the rental price is projected to exceed the purchase price of the equipment.

- M. **EYE EXAMINATIONS.** Eye examinations for diseases of the eye. Eyeglasses and contact lenses are not covered benefits.
- N. **FAMILY PLANNING.** Family planning limited to voluntary surgical sterilization, prescription, fitting and insertion of implantable contraceptives and intrauterine birth control devices, including the device or appliance.
- O. **HEARING EXAMS.** One hearing exam per calendar year for children through age 17 is covered when performed by the Primary Care Physician for the primary purpose of determining the need for hearing correction.
- P. **HOSPITAL BASED PHYSICIANS.** Services provided by a Non-Plan Hospital based Physician or provider in a Plan Hospital or Non-Plan Hospital when Prior Authorized by Plan or when Emergency Care and Services are rendered are covered under this Agreement. Non-Plan Hospital based Physicians or providers include, but are not limited to, pathologists, radiologists, anesthesiologists and emergency room physicians.
- Q. **HOSPITALIZATION AND ANESTHESIA FOR DENTAL TREATMENT.** Hospitalization and general anesthesia in the delivery of Necessary dental treatment or surgery are covered only under the following conditions: 1) a Member under 8 years of age who is determined by a licensed dentist and the Member's Primary Care Provider to need Necessary dental treatment or surgery in a Hospital or ambulatory surgical center due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proved to be ineffective; or 2) any Member whose medical condition(s) would create significant or undue medical risks if Necessary dental treatment or surgery is not rendered in a Hospital or ambulatory surgical center. Dental care, treatment or surgery is excluded from coverage.

For purposes of this benefit, "Necessary" means the necessary dental surgery or treatment where the dental condition would likely result in a medical condition if left untreated.

R. **INFERTILITY.** Services relating to the diagnosis of infertility conditions limited to a lifetime maximum benefit of \$2,500 per Member.

S. **IMPLANTS.** Implants to restore routine function required as a result of acquired Illness, Injury or surgery such as cardiac defibrillators and pacemakers and cochlear implants, except as excluded in Article VII. Coverage for implants is limited to the most cost effective implant device which meets the Member's medical needs, as determined by Plan.

T. **MAMMOGRAPHY SCREENING.** Mammography screening performed on dedicated equipment for diagnostic purposes, as follows:

1. One baseline mammogram for women ages 35 through 39.
2. One mammogram for women ages 40 and over, every year.
3. One or more mammograms a year based upon a Plan Physician's recommendation for a woman who is at risk for breast cancer because: (i) there is a family history of breast cancer; (ii) there is a history of biopsy-proven benign breast disease; (iii) a mother, sister, or daughter has had breast cancer, or (iv) the woman has not given birth before the age of 30.

U. **MASTECTOMY SERVICES.** Mastectomy services for breast cancer treatment and outpatient post surgical follow up in accordance with prevailing medical standards. Mastectomy means the removal of all or part of the breast of a female Member for Medically Necessary reasons as determined by a Plan Physician. Breast reconstructive surgery following Mastectomy to establish contralateral symmetry between the breasts is covered. Breast reconstructive surgery does not include surgery on an otherwise healthy breast to change its size, shape, or appearance, except as stated in the preceding sentence.

V. **MATERNITY SERVICES.** Service and supplies for maternity related Covered Services are treated the same as any other Illness and/or Injury. Subject to applicable law, services may be provided by certified nurse-midwives, licensed midwives, and birth centers licensed pursuant to Florida law, who are also Plan Providers. Coverage includes services for a normal pregnancy, including routine office visits for prenatal and post-delivery care for a mother and her Newborn infant including a postpartum assessment and Newborn assessment and may be provided at the Hospital, at the attending Physician's office, at an outpatient maternity center, or in the home by a qualified licensed healthcare professional trained in mother and baby care. The services include physical assessment of the Newborn and mother, and any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards. Coverage for the length of a maternity and newborn stay in a Hospital or for follow-up care outside the Hospital will be for the period of time that such care is determined to be Medically Necessary. Medical Necessity will be determined by the Plan

in accordance with prevailing medical standards and consistent with guidelines for perinatal care of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the treating obstetrical care provider or pediatric care provider. Services received from lactation consultants are not covered. The Newborn Child must be enrolled under the Agreement in accordance with Article III. A.7, in order for benefits for the Newborn Child to be paid by the Plan.

W. **NEWBORN CHILDREN.** Services for Newborn Children consist of well baby care and diagnosis and treatment of Injury or Illness. This includes the care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and transportation costs of the Newborn to and from the nearest Plan facility with the appropriate staff and equipment necessary to protect the health and safety of the Newborn Child. The coverage of such transportation costs are limited to \$1,000 for each child born while coverage is in effect under this Agreement. The Newborn Child must be enrolled under the Agreement in accordance with Article III.A.7 in order for benefits for the Newborn Child to be paid by the Plan.

X. **ORAL SURGICAL AND DENTAL SERVICES.** Any diagnostic or surgical procedure involving bones or joints of the jaw or facial region necessary to treat conditions caused by a congenital or developmental deformity, disease, or Injury. Dental services rendered within twenty-four (24) hours of an accidental injury which damages sound natural teeth (not previously compromised by decay) when such services are for the treatment of such teeth are covered. All other dental services, including but not limited to, care or treatment of the teeth or gums, intraoral prosthetic devices, services or supplies whose primary purpose is to improve dental occlusion, and surgical procedures for cosmetic purposes are not covered under the Agreement.

Y. **OSTEOPOROSIS.** Diagnosis and treatment of osteoporosis for high-risk individuals is covered. High risk individuals include: (i) estrogen deficient individuals who are at clinical risk for osteoporosis; (ii) individuals who have vertebral abnormalities; (iii) individuals who are receiving long-term glucocorticoid (steroid) therapy; (iv) individuals who have primary hyperparathyroidism; and (v) individuals who have a family history of osteoporosis.

Z. **OUTPATIENT DIAGNOSTIC SERVICES.** Outpatient diagnostic service, including radiology, ultrasound, laboratory, pathology, and imaging.

AA. **OUTPATIENT RADIATION THERAPY** and **I.V. CHEMOTHERAPY.** Radiation therapy and Intravenous (I.V.), Intramuscular and Subcutaneous Chemotherapy is covered when prescribed by or with the concurrence of a Plan Physician.

BB. **OUTPATIENT REHABILITATION AND THERAPIES.** Outpatient physical, respiratory, speech, cardiac or occupational therapies for purposes of rehabilitation due to an acquired Illness or Injury that are expected to result in significant improvement within 2 months of the start of treatment are covered. In no

event will the maximum benefit exceed 60 visits per Calendar Year for all outpatient therapy services combined. Multiple therapies received on the same day will be counted as one visit for each therapy received.

**CC. PODIATRIC SERVICES.** Podiatric services performed by a Plan Podiatrist are covered without the need for a referral, except for services excluded in Article VII.

**DD. PROSTHETIC DEVICES.** Prosthetic devices to restore normal function required as a result of acquired illness, covered surgery or injury, including artificial limbs and eyes to replace natural limbs or eyes lost by a Member while covered under this Agreement and prosthetic devices incident to Mastectomy are covered. Prosthetic devices (except for prosthetic devices incident to Mastectomy) are limited to one permanent prosthesis (including a temporary prosthesis when Medically Necessary) prescribed for the Injury, Illness or surgery, except that replacement of prosthetic devices which are functionally necessary to respond to the needs of a growing child are covered. Replacement of damaged or lost prosthetic devices are excluded from coverage. Coverage for Prosthetic Devices is limited to the most cost effective prosthetic device which meets the Member's medical needs, as determined by Plan. Bionic devices are not covered.

**EE. RECONSTRUCTIVE SURGERY.** Reconstructive surgery required to correct a functional abnormality resulting from trauma, acquired disease or congenital deformity.

**FF. SECOND MEDICAL OPINION.** Each Member may request a second medical opinion whenever the Member disagrees with his or her Plan Physician's opinion regarding the reasonableness or necessity for surgery, or treatment for a serious Injury or Illness. If requested, the second opinion will be provided by a Physician chosen by the Member. The Member may select: 1) a Plan Physician; or 2) a Non-Plan Physician located in the Plan's

Service Area. Any tests that may be required by a Non-Plan Physician in connection with a second medical opinion must be Medically Necessary and performed at a Plan facility. A second opinion may be requested by contacting the Primary Care Physician or the Plan before the second opinion consultation.

The Member is responsible for payment of any applicable Co-payment for second opinions provided by Plan Physicians. Reimbursement for a second opinion by a Non-Plan Physician is limited to 60% of charges that the Plan determines are Usual, Customary and Reasonable in the Service Area. The Member shall be responsible for the difference. A Physician who renders a second opinion may not treat the condition for which the second opinion was sought, without the Plan's prior authorization. The Plan Physician's professional judgment concerning the treatment of a Member derived after review of a second opinion shall be controlling as to the treatment obligations of the Plan. The Member is financially responsible for treatments that are not Prior Authorized by the Plan. Any such treatments are not Covered Services under this Agreement.

The Plan may require a member to obtain a Second Medical Opinion when, in the Plan's judgment, it determines that a Plan Physician's opinion should be reviewed by a Second Medical Opinion.

The Plan may deny a Member access to Second Medical Opinions if the Plan determines that the Member has unreasonably overutilized the second opinion privilege. A Member denied coverage under this section shall have recourse through the Grievance procedures described herein.

**GG. VISION SCREENING.** One Vision screening per calendar year for children through age 17 when performed by the Primary Care Physician.

## ARTICLE VI — EMERGENCY MEDICAL CONDITIONS IN OR OUT OF THE SERVICE AREA

**A. EMERGENCY SERVICES AND CARE.** Emergency Services and Care in or out of the Service Area are covered under this Agreement subject to the applicable Co-payment. Emergency Services and Care provided to a Member in an emergency situation that does not permit treatment through Plan Providers are covered under the Agreement without prior notification to or approval of the Plan.

**B. NOTIFICATION UPON HOSPITALIZATION.** If a Member is hospitalized with an Emergency Medical Condition, the Member, or the Subscriber in the case of a minor Member, should notify the Plan within 48 hours of the Member's hospitalization. In the case of a Member who, by reason of

medical condition, is unable to communicate, notification is required as soon as reasonably possible once the Member regains the ability to communicate. If Members fails to notify Plan within 48 hours after the emergency occurred when it was reasonably possible to do so, coverage will be denied.

**C. HOSPITAL, MEDICAL AND SURGICAL SERVICES.** Treatment and services as defined in Article IV and Article V of this Agreement are covered for Emergency Medical Conditions.

**D. AMBULANCE SERVICES.** Ambulance service to the nearest Plan facility as a result of an Emergency Medical Condition is a Covered Service.



- E. **EMERGENCY ROOM.** Emergency room services for Emergency Medical Conditions are covered subject to applicable Co-payment amounts. The Co-payment is waived if the Member is admitted to the Hospital as a result of the Emergency Medical Condition.
- F. **NON-PLAN PROVIDERS.** Benefits for treatment and services of Emergency Medical Conditions received from Non-Plan Providers are limited to lesser of the Non-Plan Provider's charges or Usual, Customary and Reasonable charges. All claims and supporting documentation must be submitted to the Plan in English.

- G. **HOSPITAL TRANSFER.** The Plan may elect to transfer the Member to a Plan Hospital if the Member is hospitalized in a non-Plan Hospital as soon as the Member is medically stable after the Emergency Medical Condition. The Plan may further elect to transfer the Member between Plan Hospitals if the Plan determines such transfer to be medically appropriate under the circumstances. If a Member refuses transfer that is otherwise medically appropriate, then all charges incurred for provision of services to Member as of the requested transfer date shall be at the Member's own expense.
- H. **FOLLOW-UP CARE.** Care in follow-up to Emergency Services and Care must be received, prescribed, directed or Prior Authorized by the Member's Primary Care Physician.

## ARTICLE VII — EXCLUSIONS AND LIMITATIONS

No benefits or coverage are provided for the following:

### A. EXCLUSIONS

1. Services that are not provided, arranged or Prior Authorized by a Primary Care Physician and/or the Plan, except in the case of an Emergency Medical Condition, or for services set forth in Article V for which direct access to Participating Providers is expressly permitted;
2. Services that are not Medically Necessary;
3. Non-emergency health services received from Non-Plan Providers not Prior Authorized by the Plan;
4. Any expenses related to a Member staying in a Hospital, Skilled Nursing Facility or other facility past the discharge time or date set by the Plan or a Plan Physician, after notice to the Member of the same;
5. Any service or supply received in connection with a facility or program operated, or for which payment is made, by federal or state government or any agency or subdivision thereof and/or when a Member has no legal obligation for payment, or to the extent that payment has been made in accordance with Article VIII, Coordination of Benefits;
6. Services for personal comfort or convenience of the Member including, but not limited to television, newspaper, or telephone;
7. Private Hospital room unless Pre-Authorized by the Plan. In circumstances where the private room is not Pre-Authorized, the Plan shall not be responsible for the private room surcharge;
8. Corsets, shoes (including orthopedic shoes), splints, orthotics, and similar items are excluded from coverage;
9. Items or services that are primarily Custodial Care, training or supervision in personal hygiene, and other forms of self-care to a Member who does not require skilled medical or nursing services, including services provided in or by rest homes, companions, sitters, domestic maids, home mothers or respite care (except for Hospice Services);
10. Medication, supplies and equipment which Member takes home from the Hospital or other facility;
11. Any medical or surgical treatment or related services the primary purpose of which is to improve appearance, such as cosmetic surgery, including care and treatment of complication(s) resulting from or relating to such services;
12. Keloid removal;
13. Ambulance services, except as expressly authorized in Article V and VI;
14. Autopsy;
15. Dental evaluation and/or treatment, including any services or supplies involving repair, replacement or removal of teeth, the care of gums or other supporting structures of teeth, the preparation of the mouth for dentures, intraoral prosthetic devices, improvement of dental occlusion, or surgical procedures that are cosmetic in nature. This

exclusion does not apply to accidental injury to teeth set forth in Article V, Section Y or Cleft Lip or Cleft Palate Treatment Services set forth in Article V, Section H:

16. Counseling for family or marital problems;
17. Treatment or evaluation (including, without limitation, speech, physical and occupational therapy) of learning disabilities, mental retardation, and developmental disorders including, but not limited to, learning disorders, motor skills disorders, communication disorders, and autistic disorders;
18. Vision care, including examinations in connection with corrective lenses; or for the purchase of eye glasses, or contact lenses; or for services relating to radial keratotomy or other surgical procedure to correct myopia (nearsightedness), hyperopia (farsightedness) or stigmatic error; or training or orthoptics;
19. Items or services determined to be Investigational, Experimental or Obsolete;
20. Examinations for insurance, employment, flight physical, travel or school, unless the service is within the scope of, and coincides with, a periodic health assessment as provided in Article V; or services provided to evaluate scholastic and/or occupational ability, performance or potential;
21. Treatment, services or supplies related to a work related Illness or Injury are excluded to the extent the Member is covered or required to be covered by Workers' Compensation, except for Medically Necessary services (not otherwise excluded) for a Member who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by the Member;
22. Reversals of voluntary sterilizations;
23. Infertility treatment, including, but not limited to, artificial insemination; In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); embryo transport; surrogate parenting; donor semen; semen collection and preparation costs; or infertility medications and surgical procedures to correct infertility or other methods of assisted fertilization;
24. Termination of pregnancy unless Medically Necessary for the physical health of the mother or in the presence of documented fetal abnormalities;
25. Long term physical (including without limitation, chest physiotherapy), respiratory, occupational, cardiac or speech therapy (i.e., services in excess of 60 visits from the first date Member receives such services);
26. Any items or services ordered by a court of law, unless otherwise covered under this Agreement;
27. Items or services incurred as a result of voluntary participation in an assault, felony, insurrection or riot or arising during a period of detainment by law enforcement officers or incarceration;
28. Vision screening, except for children through age 17 when performed by the Primary Care Physician;
29. a) Purchase of any hearing aid regardless of age; and  
b) Hearing examinations, other than examinations for children aged 17 years and under when such examination is performed by the child's Primary Care Physician;
30. Complementary/Alternative healing methods, including but not limited to acupuncture, acupressure, massage, hypnosis, biofeedback, homeopathy, environmental medicine, thermography, mind-body interactions such as meditation, imagery, yoga, dance and art therapy, manual healing methods, herbal therapies or other alternative medicine as determined by Plan;
31. Any medical or surgical treatment whose primary purpose is to correct complications as a result of the Member's willful and knowing failure to follow the treatment plan of the Physician;
32. Services whose primary purpose is for routine foot care including, but not limited to, the trimming of corns, calluses, nails or bunions; flat feet; fallen arches; chronic foot strain; or supplies, including shoes, orthopedic shoes, arch supports, orthotics or similar supplies for the support of feet;
33. Services for cessation of smoking or educational programs to assist in health maintenance or improvement, unless such services are pre-approved by the Plan or are for diabetes outpatient self-management training or diabetes educational services;
34. Pre-natal or childbirth classes;
35. Services, including psychiatric services, whose primary purpose is the treatment of sexual dysfunction, gender change, sexual reassignment modifications or treatment for gender identity disorders; or medical or surgical treatment to improve or restore sexual function;
36. Care, treatment or services performed by a resident of the Member's household or from anyone related to the Member by blood or marriage;
37. Inpatient Hospital Services for substance abuse treatment unless for detoxification and treatment of acute withdrawal symptoms;

38. Private or special duty nursing care;
39. Emergency room and related medical services for Illness or Injury that are not for an Emergency Medical Condition;
40. Services or treatment provided by a person or facility that is not properly approved or licensed as required by applicable law;
41. Charges for out-of-network or out-of-Service Area services that exceed Usual, Customary and Reasonable charges;
42. The purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, whirlpools, jacuzzis, swimming pools, water beds, motorized transportation equipment, escalators, elevators, or other similar items or equipment or sports related devices;
43. Services for the treatment of obesity, including but not limited to, surgical operations and medical treatment;
44. Any services not specifically stated as a Covered Service in Article IV, V and VI, unless such services are specifically required to be covered by state or federal law;
45. Treatment and/or evaluation of complications arising from any non-covered services;
46. Travel or lodging expenses of any kind, unless related to organ transplant services that are approved in advance and in writing by the Plan;
47. Charges incurred prior to the Effective Date of coverage or on or after the date coverage is terminated, except as specifically stated under Extension of Benefits, Article III, Section I;
48. Service, treatments or supplies furnished in connection with a Pre-Existing Condition as set forth in Article VII, Section B(2);
49. Treatment of any Illness or Injury due to war or any act of war, declared or undeclared, and any Illness or Injury due to service in the armed forces;
50. Pre-conception or genetic testing or counseling, except for genetic testing and/or counseling performed during pregnancy for suspected fetal abnormality when Prior Authorized in advance by the Plan;
51. Confinement, treatment, service or supply for which a Member has no financial liability or that would be provided at no charge in the absence of insurance;
52. Prescription medications for outpatient treatment, over-the-counter drugs, medicines, supplies, vitamins, enteral formulas, nutritional supplies or food; or equipment, including but not limited to, heating pads, blood pressure cuffs and compression stockings, except as otherwise covered herein or by Endorsement or Rider attached hereto;
53. Illness or Injury resulting from participation in the following hazardous recreational activities, including but not limited to, bungee jumping, sky diving, scuba diving at depths below 60 feet or scuba diving without prior professional certification (such as PADI), hang-gliding, auto racing, mountain climbing, and rock climbing;
54. Drugs prescribed for uses other than approved by the United States Food and Drug Administration (FDA);
55. Weight control, weight loss, health and fitness programs, gastric stapling, gastric bypass, gastric banding, gastric bubbles, and other procedures for the treatment of obesity, morbid obesity, or any other diagnoses comorbid with obesity or morbid obesity;
56. Outpatient vestibular therapy, brain injury therapy, cognitive therapy, or visual therapy;
57. Nutritional consultants, except for Diabetes as set forth in Article V;
58. Circumcision, except for circumcisions performed within thirty (30) days of birth or when medically necessary;
59. Medical or surgical treatment for gynecomastia related to weight, hormonal, or growth development;
60. Replacement of damaged or lost prosthetic devices;
61. Bionic devices;
62. Costs associated with the surgical or medical care and treatment of erectile dysfunction, including penile implants/prosthesis and surgery to insert penile implant/prosthesis, regardless of cause of such erectile dysfunction;
63. Family planning, except as otherwise expressly covered herein;
64. Wigs or other cranial prosthetics;
65. Services received at military or government facilities;
66. Orthomolecular therapy, nutrients and food supplements;
67. Treatment of a condition or complications from a condition resulting, directly or indirectly, from a Member being under the influence of alcohol or due to illegal drug use;
68. Transplant services when: (a) Plan is not contacted for authorization within a reasonable time prior to referral for transplant evaluation for the procedure; (b) when the transplant procedure is performed in a facility that has

not been designated by the Plan as an approved transplant facility; (c) when expenses related to the transplant are eligible for reimbursement under any private or public research fund, government program or other funding program; or (d) when the transplant is for a non-human organ or tissue. Donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not a Member are not covered; and

69. Work or travel vaccines and immunizations.

## B. LIMITATIONS

The following limitations are in addition to any limitation or exclusion described in articles iv, v and vii.

### 1. Major Disasters

In the event of any major disaster, epidemic, war, riot or civil insurrections, the Plan Physicians shall render medical services and arrange for Hospital services insofar as practical according to their best judgment, within the limitation of such facilities and personnel as are then available. Neither the Plan nor its Physicians shall have any liability or obligation for delay or failure to provide medical services or arrange for hospitalization due to lack of available facilities or personnel if such lack is the result of conditions arising out of the social or environmental disturbances specified in this paragraph.

### 2. Pre-existing Conditions Limitations

A. **Pre-existing Conditions Limitation.** Pre-existing Conditions Limitations are limits, during some set period of time (a "Pre-existing Conditions Limitation Period"), on Covered Services due to Pre-existing Conditions. During any applicable Pre-existing Conditions Limitation Period (as described below), Covered Services do not include any services or supplies received in connection with a Pre-existing Condition or any services or supplies received in connection with a complication of a Pre-existing Condition.

B. **Large Employers.** Eligible Employees and Dependents of Large Employers are not subject to a Pre-existing Conditions Limitation Period.

C. **Small Employers Type A.** "Small Employers Type A" are: (i) Small Employers with 2 to 50 Eligible Employees and (ii) Small Employers with less than 2 Eligible Employees, who were covered under Creditable Coverage within 63 days prior to the Effective Date of coverage under the Plan.

1. Except as otherwise provided in this Paragraph C, Eligible Employees and Dependents of Small Employers Type A, other than Late Enrollees, shall be subject to a Pre-existing Conditions

Limitation Period of up to 12 months after the applicable Enrollment Date. Eligible Enrollees and Dependents of Small Employers Type A, who are Late Enrollees, are subject to a Pre-existing Conditions Limitation Period of up to 18 months.

2. Except as otherwise provided in this Paragraph C, Dependents of Eligible Employees of Small Employers Type A, who are added after such Eligible Employee's Effective Date, shall be subject to a Pre-existing Conditions Limitation Period of up to 12 months after the Dependent's Enrollment Date.

3. Eligible Employees and Dependents of Small Employers Type A shall be subject to a Pre-existing Conditions Limitation Period of 12 months with respect to any optional coverage added after the Effective Dates of such Eligible Employees and Dependents.

4. Eligible Employees and Dependents of Small Employers Type A, who: (i) within 30 days of birth are covered under Creditable Coverage and (ii) have not experienced a 63-day or longer period during which such individual was not covered by Creditable Coverage, shall not be subject to a Pre-existing Conditions Limitation Period.

5. Eligible Employees and Dependents of Small Employers Type A, who: (i) are adopted or placed for adoption prior to attaining 18 years of age, (ii) are covered under Creditable Coverage within 30 days of adoption or placement for adoption, and (iii) have not experienced a 63-day or longer period during which such individual was not covered by Creditable Coverage since the adoption or placement for adoption, shall not be subject to a Pre-existing Conditions Limitation Period. This provision shall not apply to coverage prior to the date of such adoption or placement for adoption.

6. Eligible Employees and Dependents of Small Employers Type A shall not be subject to a Pre-existing Conditions Limitation Period with respect to pregnancy.

7. Eligible Employees and Dependents of Small Employers Type A, who are subject to a Pre-existing Conditions Limitation Period, shall have such Pre-existing Conditions Limitation Period reduced by any applicable periods of Creditable Coverage and by any Waiting Period. Applicable periods of Creditable Coverage are all periods of Creditable Coverage, except periods of Creditable Coverage which occur prior to any 63-day or longer period during which the Eligible Employee or Dependent, as applicable, was not covered under Creditable Coverage. Applicable periods of Creditable Coverage must be established through the presentation of certificates of Creditable Coverage.

D. *Small Employers Type B*. "Small Employers Type B" are Small Employers with less than 2 Eligible Employees, who were not covered under Creditable Coverage within 63 days prior to the Effective Date of coverage under the Plan.

1. Eligible Employees and Dependents of Small Employers Type B, including Late Enrollees, shall be subject to a Pre-existing Conditions Limitation Period of 24 months after the Enrollment Date.
2. Dependents of Eligible Employees of Small Employers Type B, who are added after such

Eligible Employee's Effective Date, shall be subject to a Pre-existing Conditions Limitation Period of up to 24 months after the Dependent's Enrollment Date.

3. Eligible Employees and Dependents of Small Employers Type A shall be subject to a Pre-existing Conditions Limitation Period of 12 months with respect to any optional coverage added after the Effective Dates of such Eligible Employees and Dependents."

## ARTICLE VIII — COORDINATION OF BENEFITS AND SUBROGATION

### A. COORDINATION OF BENEFITS APPLICABILITY

If a Member is covered by more than one group health plan or insurance program (plan or program referred to herein collectively as "plan(s)"), then this Coordination of Benefits provision controls which plan or insurance carrier will be the primary payor and which will be secondary payor.

When coordinating benefits, one of the two or more plans involved is the primary plan which is required to pay its full benefit and the other plan is the secondary plan (or tertiary plan, as the case may be). Payments from secondary/tertiary plans are coordinated so that the total of the payments from all plans are not more than 100% of the amount owed by Plan for benefits under this Agreement (i.e., the amount the Plan would have paid if primary).

Any plan without a Coordination of Benefits provision is automatically designated as the primary plan. Where the applicable plans all have coordination of benefits provisions, the Plan will determine the order of benefits by using the first of the following rules that applies:

1. The benefits of the plan covering the person as an employee are determined before those of the plan covering the person as a Dependent.
2. For Employers with 20 or more employees, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as an active employee or Dependent, the order of benefit determination is:
  - a. First, benefits of a plan covering a person as an employee, member, or subscriber.
  - b. Second, benefits of a plan of an active worker covering a person as a Dependent.
  - c. Third, Medicare benefits.

3. Except as provided in paragraph 4., when more than one plan covers the same child as a Dependent of different parents, the following applies:

- a. The benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls earlier in the year are determined before the benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls later in that year; but
- b. if both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.
- c. However, if a policy or plan subject to the rule based on the birthdays of the parent coordinates with an out of state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a Dependent of a male are determined before those other policy or plan which covers the person as a Dependent of a female, and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan determine the order of benefits.

4. Where two or more plans cover a Dependent child of divorced or separated parents, the benefits for the child are determined in this order:
  - a. First, the plan of the parent with custody of the child;
  - b. Second, the plan of the spouse of the parent with the custody of the child; and
  - c. Finally, the plan of the parent who does not have custody of the child.

However, if the terms of a court decree stipulate that one of the parents is responsible for the child's healthcare expenses, and if the entity obliged to provide benefits under the plan of that parent has actual knowledge of the terms of such decree, the benefits of that plan are

determined first. This order of benefits does not apply to any claim determination period or plan year when benefits are actually paid or provided before the entity has actual knowledge of the terms of the court decree.

5. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's Dependent, are determined before those of a policy or plan which covers the person as a laid-off or retired employee or as the employee's Dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph does not apply.
6. If rules 1-5 do not determine the order of benefits, the benefits of a plan covering an employee, Dependent, member, or subscriber for a longer period of time are determined before those of the plan covering the shorter time.
7. If a person is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 99-272), and also under another group plan, the following order of benefits applies:
  - a. First, the plan covering the person as an employee, or as the employee's Dependent;
  - b. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent pursuant to the provisions of COBRA.
8. Plan may coordinate benefits under the following types of contracts:
  - a. any group or group-type insurance or HMO;
  - b. any plan or insurance policy, including automobile insurance policy, provided that such plans contain coordination of benefit provisions;
  - c. Medicare, as allowed by law.
9. Plan shall not coordinate benefits against indemnity-type policy (regardless of whether such indemnity-type policy is an individual policy, group blanket policy, or group franchise policy), an excess insurance policy as defined in Florida Statutes, Chapter 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.
10. The Coordination of Benefit rules set forth above apply whether or not the Member files a claim under the plans.

The Covered Services rendered pursuant to this Agreement are primary to any services for which a Member may be eligible to receive under the Medicaid program.

**B. THE PLAN IS ENTITLED TO RECOVER FROM THE MEMBER AMOUNTS THAT ARE OVERPAID TO HIM OR FOR HIM FOR MEDICAL SERVICES PROVIDED BY THE PLAN.**

**C. TIME LIMIT FOR PAYMENT**

Payment of benefits due under any plan subject to this Article VIII, will be made in accordance with the time frames listed in Section 641.3155, Florida Statutes, unless the Plan provides the claimant a clear and concise statement of a valid reason for further delay which is in no way caused by the existence of a COB provision nor otherwise attributable to the Plan claiming delay.

**D. FACILITY OF PAYMENT AND RECOVERY**

1. Whenever payments that should have been made under this Agreement have been made under any other plans, the Plan shall have the right to pay that amount to the organization that made such payments. That amount will then be treated as though it was a benefit paid under this Agreement. The Plan will not have to pay that amount again. The term "payment" includes providing benefits in the form of services, in which case "payment" means reasonable cash value of the benefits provided in the form of services.
2. If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under this Agreement, it may recover the excess payments from among one or more of the following, as this Plan shall determine: 1) any persons to or for or with respect to whom such payments were made; and 2) any other insurers, service plans or any other organizations.

**E. SUBROGATION AND REIMBURSEMENT**

1. **Subrogation and Reimbursement.** Generally, in the event that the Member recovers damages from a third party or first party insurer (i.e., uninsured motorist coverage) due to any negligent act or omission of the third party, Plan shall, to the extent of medical benefits or payments provided to or on behalf of the Member, retain a right of reimbursement or be subrogated to the Member's rights of recovery arising out of any claim or cause of action related to such third party's negligent act or omission, including the proceeds of first party coverage.
2. **Filing a Claim Against a Third Party and Other Action.** In the event that a Member files a claim, lawsuit or otherwise seeks to recover damages from a any party arising from the negligent act or omission of a third party, the Member will include in such lawsuit a claim for the medical benefits or payments provided to or on behalf of the Member by Plan. A Member will take such action, furnish such information and assistance and execute and deliver all instruments to Plan or such other party as Plan may require to enforce its reimbursement and/or subrogation rights under this Agreement.
3. **Allocation of Proceeds.** To the extent that a Member which Plan has provided medical benefits or payments to, or on

behalf of, due to injury, disease, or illness by virtue of the intentional or negligent act or omission of a third party, recovers any monies as a result of judgment, settlement or otherwise from any party, including first party insurer, Plan shall be entitled to reimbursement or subrogation in accordance with Florida law and the applicable allocation of proceeds that appear below, or such other allocation as the Member may adopt, whichever is greater. For purposes of this Agreement, any settlement or judgment received by a Member is deemed full and complete compensation for any injury, disease, or illness suffered by virtue of the negligent act or omission of a third party.

(a) If the total amount recovered from all such third party recoveries is less than or equal to one hundred fifty percent (150%) of the amount of medical benefits or payments provided by Plan to or on behalf of the Member, the Member will designate a portion of any such settlement, judgment or other third party recovery among such medical benefits or payments and other reasonable damages sustained by the Member according to the proportion that medical benefits or payments provided by Plan to, or on behalf of, the Member bears to the total amount of the Member's recovery for purposes of determining Plan's entitlement to reimbursement or subrogation.

(b) If the total amount recovered from all recoveries is greater than one hundred fifty percent (150%) of the amount of medical benefits or payments provided by Plan to or on behalf of the Member, the Member specifically agrees to designate a portion of any such recovery sufficient to fully reimburse Plan for the amount of medical benefits or payments provided by Plan to or on behalf of the Member for purposes of determining Plan's entitlement to reimbursement or subrogation under Florida law.

4. **Attorneys' Fees and Other Costs.** In the event that Plan engages an attorney or other agent for purposes of enforcing its subrogation or reimbursement rights as stated in this provision against a Member's failure to cooperate with Plan, the prevailing party in any legal action or other proceeding brought to enforce such rights shall be entitled to an award of its costs, including, without limitation, reasonable attorneys' fees associated with enforcement of its subrogation or reimbursement rights.

5. **Survival of Rights.** In the event that any or all of Plan's subrogation or reimbursement rights as set forth in this Agreement are found by a court to be unenforceable for any reason, such a finding shall not affect the validity or enforceability of any provision of this Agreement not specifically addressed by such Court, nor shall such a finding affect Plan's rights to reimbursement or subrogation under Florida law.

6. **Notice; Right of Intervention.** The Subscriber shall provide Plan with timely written notification in the event that the Subscriber or any Member related to the Subscriber suffers injury, disease, or illness by virtue of the negligent act or omission of a third party. Such a notice must inform Plan: (i) of the nature of the injury, disease, or illness; (ii) of the name(s) and addresses (if available) of the third party(ies); (iii) of the names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Member; (iv) a description of the accident or occurrence that the Member reasonably believes was responsible for the injury, disease, or illness at issue and the approximate date(s) upon which such accident or occurrence occurred; and (v) the name of any legal counsel retained by a Member in connection with any such accident or occurrence. In the event that a Member brings a lawsuit, counterclaim, cross-claim or any other action in connection with any such accident or occurrence, Member or Member's counsel is required to notify Plan if the Member intends to claim damages from the third party for the injuries or illness. Plan shall be provided with copies of all pleadings, notices and other documents and papers that relate to Plan's rights of reimbursement or Subrogation under this Agreement. Plan reserves the right to intervene in any proceeding in which a Member is a party to the extent that such intervention is reasonably necessary to protect Plan's rights of reimbursement or subrogation under this Agreement.

F. Members shall fully cooperate with Plan regarding the Plan's exercise of its rights to Coordination of Benefits and Subrogation, and will cooperate with Plan's actions to administer benefits. Member shall execute and submit such consents, releases, assignments and other documents as may be requested by Plan. Failure to provide such documents shall be a basis for termination of this Agreement.

## ARTICLE IX — COMPLAINTS AND GRIEVANCES, PRIOR APPROVALS AND CLAIMS

There are situations when Members have questions about their coverage or are dissatisfied with Plan services. Such questions and Complaints will be handled by the Plan in a timely manner.

Questions relating to this Agreement should be addressed by Members to the Customer Service Department of the Plan.

Complaints/Grievances shall be addressed to the Grievance Coordinator who is the person responsible for the maintenance of records and for the supervision of the Complaint/Grievance process for the Plan. A specific set of records will be maintained to document Complaints/Grievances filed. Records will include the reason for Complaints/Grievance, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Coordinator.

### Complaint Procedures

The Plan encourages Members to resolve individual inquiries and problems without the initiation of a formal Grievance. Any Member who has an inquiry or Complaint regarding a matter arising under the Agreement should contact the Customer Service Department of the Plan for verbal resolution. A Customer Service Representative will respond to the Member's inquiry or complaint promptly.

### Formal Grievance Procedure

In the event the Member's problem has not been settled at the informal level and the Member is still dissatisfied, he/she will be advised to file a formal written grievance. This is called a Level I Grievance. Grievances must be submitted within one year of occurrence (i.e., the date when the issue which is the subject of the Grievance is known to Member). Grievance forms are available from the Plan by writing to the address below. Additional information or assistance in preparing the written Grievance may be obtained by contacting the Customer Service Department of the Plan.

The Grievance must contain the following information:

1. The Member's name, address and identification number;
2. A summary of the Grievances, any previous contact made with the Plan, and a description of relief sought;
3. The Member's signature; and
4. The date the Grievance is signed.

The written Grievance must be mailed to the following address:

NEIGHBORHOOD HEALTH PARTNERSHIP  
P.O. Box 526646  
Miami, FL 33152  
Attn: Grievance Coordinator

The Grievance Coordinator will acknowledge receipt of the Grievance by the Plan, and will investigate the Grievance. In the case of a medical or quality-of-care Grievance, the investigation will include a review by a Physician or Physicians, including a Physician other than the Primary Care Physician. The Member will receive a decision, in writing, regarding the Level I Grievance within 30 days of the date the written Grievance is received by the Plan, unless the decision regards care or a service which has not yet been received, in which case the Member will receive a decision, in writing, regarding the Level I Grievance within 15 days.

If the Member is not satisfied with the decision in the Level I Grievance, the Member may request within 30 days of the date of the decision a hearing and review by the Plan's Grievance Committee. This is called a Level II Grievance. The Grievance Committee will investigate the case and conduct a hearing. The Member and/or an authorized designee may be present at the hearing. If the Member cannot appear in person at the hearing, he/she will be provided the opportunity to communicate with the committee by conference call or other appropriate technology. The decision of the Grievance Committee will be mailed to the Member within five (5) working days of the date of the disposition of the Level II Grievance. The decision of the Grievance Committee will be final.

The Plan will process all Level II Grievances within an additional 15 days for pre-service denials or an additional 30 days for post-service denials from the date of receipt.

The review process may be accelerated for an Urgent Grievance and will occur within three (3) calendar days or more expeditiously as required by the medical condition. The Member or the provider acting on behalf of the Member may submit a request for an expedited review orally or in writing. All requests for expedited review must meet the criteria of an Urgent Grievance as set forth in the definition of Urgent Grievance. The Plan Medical Director or designee shall exercise professional discretion in determining cases eligible for accelerated review. The Plan shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of such decision, if the initial notification was not in writing.

If the Member is still not satisfied after completion of the Level I and Level II Grievance process, he/she has the right to appeal to the Agency for Health Care Administration Statewide Provider and Subscriber Assistance Program. The Member may contact the Agency for Health Care Administration Statewide Provider and Subscriber Assistance Program at:

Statewide Provider and Subscriber Assistance Program  
2727 Mahan Drive  
Tallahassee, FL 32308  
(850) 921-5458

Additionally, the Member has the right contact the Agency for Health Care Administration Hot Line at (800) 419-3456 or the Statewide Provider and Subscriber Assistance Program at any time to inform it of an unresolved Grievance.



## ARTICLE X — GENERAL PROVISIONS

A. Covered Services provided by the Plan Provider shall be paid directly to the Plan Provider of service. If Member has already paid Plan Provider, Member must seek reimbursement from such Provider for Covered Services paid to Plan Provider by Plan. Benefits will not be paid directly to any Members except reimbursement for payments made by the Member to a Non-Plan Provider for which the Plan was liable at the time of payment. As soon as practical, the person making claim for cash reimbursement for benefits provided under provisions of Articles IV, V or VI shall give to the Plan written proof of claim including full particulars of the nature and extent of the Illness, Injury or condition and treatment received, and any other information that may assist the Plan in determining the amount due and payable.

B. Plan may use and disclose certain General Patient Information for routine purposes in accordance with the Plan's confidentiality policy and pursuant to the Member's routine consent for the use and disclosure of General Patient Information which is provided when the Member signs the Enrollment Form. Such routine purposes shall include, but are not limited to, application of the coordination of benefits rules and determination of payment obligations under such rules; payment of claims; coordination of care; risk management; peer review procedures; quality assessment, measurement and improvement; utilization management and case management.

The Member or Subscriber shall provide the Plan with all information needed to determine the Plan's payment obligations under the coordination of benefits rules within a reasonable time frame from the Plan's request. The Plan may also obtain the necessary information from other organizations or persons. Further, the Plan may disclose this information to any other organization or person as necessary to apply the coordination of benefit rules, without obtaining additional consent from the Member, Subscriber or any other person.

Each Member claiming benefits under this Agreement must also give the Plan any other information it needs to pay claims or to administer benefits under this Agreement. The Plan reserves the right to decline coverage for any claim for which it has requested and not received such necessary information.

C. Member must complete the Plan Grievance process before Member may bring an action at law or in equity. Such action shall not be brought prior to the expiration of sixty (60) days following a final appeal in accordance with requirements of this Agreement. No such action may be brought after the expiration of the applicable statute of limitations. The statute of limitations applicable to any action relative to this appeal shall commence from the date services or supplies are rendered giving rise to the action.

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

E. No person other than a Member is entitled to any benefit under this Agreement.

F. When applying for benefits or services under this Agreement, the Member shall present the Identification Card provided by the Plan.

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

1. If to the Plan, mailed to the address printed on the Application.

2. If to a Member, mailed to the most recent address provided by the Member or to the Subscriber's most recent address on file with the Plan.

3. If to Group, mailed to the most recent address provided by the Group to Plan.

H. Unless federal law is applicable, this Agreement shall be governed by and construed in accordance with the laws of the State of Florida and the exclusive and sole venue for any action arising hereunder shall be in Miami-Dade County, Florida.

I. This Agreement in writing, together with the Application and any endorsement hereto, constitute the entire Agreement between the Plan and the Group. No agent of the Plan other than a corporate officer of the Plan is authorized to establish, change or waive any of the provisions of this Agreement. No change or amendments to this Agreement shall be valid unless evidenced by an endorsement, rider or amendment to the Agreement and is signed by an authorized representative of the Plan.

J. Time Limit on Certain Defenses: Relative to a misstatement in the Application, after two years from the date of issue, only fraudulent misstatements in the Application may be used to void the policy or deny any claim for loss incurred or disability starting after the two year period.

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

L. The Plan is not responsible for the judgement or conduct of any Plan Provider who treats or provides a professional service or supply, but rather each Plan Provider is an independent contractor who is not the agent, servant, or employee of the Plan. Under this Agreement, Plan makes benefit determinations only relating to Covered Services hereunder and does not provide healthcare services or make medical decisions on behalf of Members. Plan Providers exercise independent medical judgment on Members' behalf.

M. Members will participate in the development of alternative treatment plans and cooperate with Plan's case management of services they are receiving. In addition to the benefits specified in this Agreement, Plan may provide benefits for services furnished not otherwise covered under this Agreement pursuant to an alternative treatment plan as part of the Plan's case management of Member's care. Plan may provide alternative benefit(s) when, in the Plan's judgment, alternative services are Medically Necessary, cost effective and feasible and that the total benefits paid for such alternative services do not exceed the total benefits to which Member would otherwise be entitled under this Agreement in the absence of alternative benefits. If Plan elects to provide alternative benefits for a member in one instance, it will not obligate Plan to provide the same or similar

benefits for another Member in any other instance, nor shall it be construed as a waiver of Plan's right to administer this Agreement thereafter as to the Member receiving alternative benefits in strict compliance with its expressive terms. If benefits under an alternative treatment plan are to be terminated, Plan will provide at least ten (10) days written notice of the termination to Member.

N. Plan may develop or adopt standards which describe in more detail when Plan will make or will not provide coverage or make payments under this Agreement and administrative rules pertaining to enrollment and other administrative matters. Plan shall have all the powers necessary or appropriate to enable Plan to carry out its duties in connection with the administration of this Agreement, including without limitation thereto, the power to conduct utilization review, quality review and case management; the power to construe this Agreement; to determine all questions arising under this Agreement; and to make and establish (and therefore change) rules and regulations and procedures with respect to this Agreement. If a Member has a question about the standards which apply to a particular benefit or the administrative rules, Member may contact Plan and Plan will explain the standards or rules.

**MUTUAL OF OMAHA**

MUTUAL OF OMAHA INSURANCE COMPANY  
 UNITED OF OMAHA LIFE INSURANCE COMPANY  
 Mutual of Omaha Plaza  
 Omaha, NE 68175



Home Office Use Only  
 Policy Number(s):

Group Insurance Application

Applicant (Full Legal Name) TOWN OF SUNNYSIDE (the Policyholder)

Address 9293 HAWKING AVE City SUNNYSIDE State FL Zip 33154

Requested Effective Date: 10/1/10 subject to our acceptance of this application and payment of premium on or before such date.

Coverage(s) being applied for:	GROUP (Contributory / Non-Contributory)	VOLUNTARY (100% Employee Paid)
[Life]	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
[AD&D]	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
[Short Term Disability]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
[Long Term Disability]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
[Dental]	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Active at work requirement:** An employee must meet an Active at Work requirement to become insured. Will all proposed insureds meet the Active at Work requirement?  Yes  No If "No," please provide the name of the individual, date of birth, date of disability or confinement and nature of disability or confinement on a separate page.

Certain states have enacted legislation that requires insurers to provide specific coverage for people residing in their states. Do you have employees residing in or working in other states?  Yes  No

If "Yes," which states: \_\_\_\_\_

**Financial Risk** (If "Yes," to any part, please explain below)

- Has the applicant ever filed for bankruptcy?  Yes  No
- Does the applicant anticipate ceasing or materially reducing active business operations?  Yes  No

Explanation: \_\_\_\_\_

Application is made on the basis of the proposal, any available experience data and the information contained in this application.

The applicant signing below agrees to accept the terms and provisions of the Master Policy for the coverages applied for above. Insurance will become effective on the requested effective date shown above, unless we send written notice of a different effective date. If this application is not approved by an officer at the Home Office of the underwriting company, no insurance is in effect at any time and any advance payment received will be returned.

The applicant signing below understands that the statements made in this application are representations and not warranties.

This application is submitted with the following advance payment \$ \_\_\_\_\_

**Fraud Warning:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Applicant

By [Signature]  
 (Signature)

TOWN MANAGER  
 (Title)

9/1/10  
 (Date)

Name of broker, agent and/or insurance agency soliciting this coverage:

STAN BERSHAD C.L.U.

A020748  
 Florida License Number

# POLICY ADMINISTRATION



## ACCEPTANCE OF TERMS AND CONDITIONS

I confirm that I have reviewed and completed all appropriate sections of the Group Insurance Application and the Policy Administration document included in this Guide.

I agree to and accept the terms and conditions of the Group Insurance Proposal, the Group Insurance Application, and eligibility, benefit, cost details and other information provided in this Guide.

Company Name: TOWN OF SUNBESIDE

Printed name of Authorized Company Representative: GARY WOOD

Signature of Authorized Company Representative: [Handwritten Signature]

Title: TOWN MANAGER Date: 9/1/10

An implementation call will take place during the setup of your new coverage. Who should be contacted in this call?

Primary Contact  Producer  other: \_\_\_\_\_

Name: STAN BERSHAD C.L.U.

Phone: 305-868-7300

**PARTICIPATION AND COST SUMMARY (CONT'D)**

**COST SUMMARY**

	Number of Lives	Weekly Benefit Volume	Monthly Rate	Total Monthly Premium	Total Annual Premium
STD	78	\$42,910	\$0.300 (Per \$10 of Weekly Benefit)	\$1,287.29	\$15,447.48

**RATE GUARANTEE** 2 Years

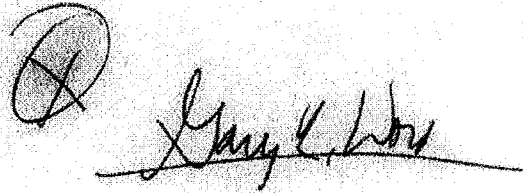
**RATE GUARANTEE DATE** 10/01/2012

**ADDITIONAL BENEFITS**

**VOC REHAB INCENTIVE** 5%

**FICA PAYMENT** Without reimbursement

**W-2 PREPARATION** Included



**PARTICIPATION AND COST SUMMARY (CONT'D)**

**COST SUMMARY**

	Number of Lives	Covered Monthly Payroll	Monthly Rate	Total Monthly Premium	Total Annual Premium
LTD	78	\$315,087	\$0.380 (Per \$100 of Monthly Covered Payroll)	\$1,197.33	\$14,367.96

**RATE GUARANTEE** 2 Years

**RATE GUARANTEE DATE** 10/01/2012

**ADDITIONAL BENEFITS**

**VOC REHAB INCENTIVE** Mandatory, 5%

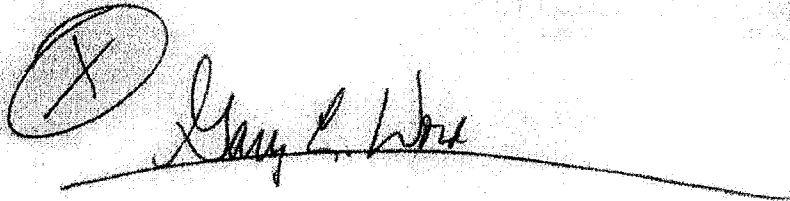
**RECURRENT DISABILITY** 6 months

**SURVIVOR BENEFIT** 3 months

**EMPLOYEE ASSISTANCE PROGRAM (EAP)** Basic; 3 face to face visits

**WAIVER OF PREMIUM** Included

**W-2 PREPARATION/  
FICA PAYMENT** Included/Without reimbursement



## PARTICIPATION AND COST SUMMARY

**PARTICIPATION ASSUMPTIONS**

Minimum Participation	Number of Eligible Employees	Employer Contribution Percentage
95%	78	64%

**COST SUMMARY**

**CLASS 1**

Employee Only  
Employee + Spouse  
Employee + Child(ren)  
Employee + Family

Assumed Lives	Monthly Rates*	Monthly Premium	Annual Premium Sub-Total
48	\$33.05	\$1,586.40	\$19,036.80
11	\$75.69	\$832.59	\$9,991.08
5	\$65.17	\$325.85	\$3,910.20
10	\$109.19	\$1,091.90	\$13,102.80

\*The rates quoted include the cost of state mandated benefits as of the date of this proposal.

**RATE GUARANTEE**      2 Years

**RATE GUARANTEE DATE**    10/01/2012

**POLICY YEAR**            Calendar Year

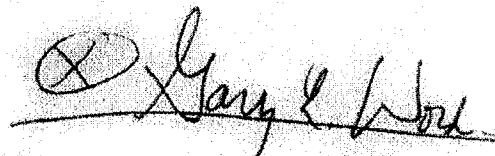
## ADDITIONAL BENEFITS

**NETWORK**

The network quoted is DenteMax.

- Participating provider allowances are based on DenteMax Participating provider fee schedules.
- Non-participating provider maximum allowances are based on the 90th Percentile of Reasonable and Customary data.

Charges that exceed the maximum allowance for any covered dental service are not considered.



Dental Insurance Proposal Option 1 (continued)





# BASIC TERM LIFE AND AD&D INSURANCE

Proposal for: Town of Surfside

The following Basic Term Life and AD&D plan is being proposed on a fully-insured basis effective 10/01/10. This proposal assumes this coverage is underwritten by United of Omaha Life Insurance Company. For additional information about Mutual of Omaha's products and services, visit [mutualofomaha.com](http://mutualofomaha.com).

## ELIGIBILITY

**CLASS DEFINITION(S)**  
 Class 1: Employer Class 01  
 Class 2: Employer Class 02

**EMPLOYEE ELIGIBILITY REQUIREMENT**  
 This proposal provides coverage for all actively at work employees on the policy effective date working a minimum of 30 hours per week in the United States, unless otherwise approved by Mutual of Omaha. Certain requirements apply.

## BENEFIT SUMMARY

EMPLOYEE TERM LIFE BENEFIT AMOUNTS	Benefit	Maximum Benefit	Guarantee Issue Amount	Minimum Benefit
Class 1	1X Annual Salary	\$50,000	\$50,000	\$0
Class 2	\$2,500	\$2,500	\$50,000	\$2,500

EMPLOYEE BENEFIT REDUCTION SCHEDULE* CLASS 2, 1	At Age	Benefits Reduce to:
	65	65%
	70+	50%

\* All benefit reductions are a percentage of the original benefit amount. Coverage terminates at retirement. The Guarantee Issue Amount is reduced according to the reduction schedule.

**EMPLOYEE AD&D BENEFIT AMOUNT**  
 The AD&D Principal Sum amount is equal to the amount of basic term life insurance.

## PARTICIPATION AND COST SUMMARY

PARTICIPATION ASSUMPTIONS	Minimum Participation	Number of Eligible Employees	Contribution Structure
Class 2, 1	100%	83	Non-Contributory

COST SUMMARY	Number of Lives	Total Monthly Volume	Monthly Rate	Total Monthly Premium	Total Annual Premium
<b>CLASS 1</b>					
Employee Term Life	78	\$3,160,000	\$0.21/\$1,000	\$863.60	\$7,963.20
Employee AD&D	78	\$3,160,000	\$0.03/\$1,000	\$94.80	\$1,137.60
<b>CLASS 2</b>					
Employee Term Life	5	\$6,250	\$0.21/\$1,000	\$1.31	\$15.72
<b>Total</b>	--	--	--	\$759.71	\$9,116.52

**RATE GUARANTEE** 2 Years

Basic Term Life and AD&D Insurance - Proposal Option 1

**PARTICIPATION AND COST SUMMARY (CONT'D)**

**COST SUMMARY\***  
Voluntary Term Life

Number of Lives	Employee Rate per \$1,000
28	\$0.39

Voluntary AD&D

Employee Rate per \$1,000
\$0.03

**RATE GUARANTEE** 2 Years

**RATE GUARANTEE DATE** 10/01/2012

**ADDITIONAL BENEFITS - CLASS 1**

**WAIVER OF PREMIUM - DISABILITY**

- Definition of Disability - Any Occupation
- Elimination Period - 9 months
- Termination - Age 65

**LIVING CARE BENEFIT** 50% to \$100,000

**PORTABILITY** Included

**AD&D** 24 hour coverage for employees

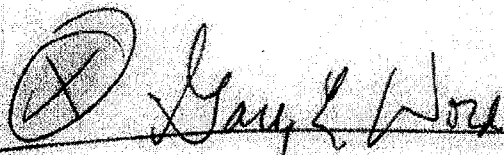
**AD&D BENEFITS** - Seat Belt - Paralysis - Common Carrier  
- Child Education - Airbag

**CONVERSION** Included

**ADDITIONAL BENEFITS - CLASS 2**

**LIVING CARE BENEFIT** 50% to \$100,000

**CONVERSION** Included



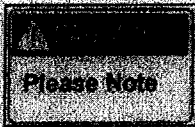
# POLICY ADMINISTRATION



## CONTACT INFORMATION

### Applicant Information

Legal Name of Company	TOWNSHIP ASSOCIATION		
Doing Business As (DBA)			
Legal Address of Company	9293 HADDING AVE		
Address 2			
City, State, Zip	SUNGRISS	FL	33154
Employer Identification Number (Tax ID Number)	59-6000434		
Company Phone & Fax	305-861-4863		
Company Email			
Corporate Structure	<input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Other		



Please identify the controlling owners/partners on the census/enrollment:

- If you are applying for Short Term or Long Term Disability and
- If your corporate structure is an S-Corp, a Partnership or a LLC and
- The premium is fully paid for by the employer

### Primary Contact

- Contact For:
- Premium/Billing
  - Claims
  - Administration

Contact Name	MAYTE GAMIOTEA		
Address (if different than above)			
Address 2			
City, State, Zip			
Contact Phone & Fax	305-861-4836		
Contact Email	MGAMIOTEA@TOWNSHIPASSOCIATION.FL.GOV		
Should this contact have access to:	Online Billing and Reporting <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Online Eligibility Maintenance (List Billed customers only) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

### Additional Contact:

- Contact For:
- Premium/Billing
  - Claims
  - Administration

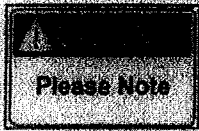
Contact Name	MAMILETH SLATE-McCLOUD		
Address (if different than above)			
City, State, Zip			
Contact Phone & Fax	305-861-4863		
Contact Email	MSLATE-McCLOUD@TOWNSHIPASSOCIATION.FL.GOV		
Should this contact have access to:	Online Billing and Reporting <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Online Eligibility Maintenance (List Billed customers only) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

# POLICY ADMINISTRATION



## BILLING INFORMATION

- Billing Assumptions:** All bills will be sent to the primary contact indicated in the Contact Information section above. Unless otherwise agreed to, or stated in the Group Insurance Proposal, billing statements will be issued on a monthly basis. Premium is due on the first day of the month. The group policy will include a premium grace period provision.
- Billing Type:** Select the type of bill you prefer:
  - List Bill *(mandatory for Dental and Groups under 50 covered employees)*
  - Are confirmation statements of Voluntary Term Life coverage necessary for each employee?  Yes  No
  - Self-Administration Bill



We recommend that all groups under 200 covered employees be set up with the List Bill option that provides you with a monthly-itemized bill. This option provides you online access to the following:

- Enrollment Data Administration- Adds, Terminations and Changes
- Management Reports- Standard and On Demand formats
- Real-Time reporting access to Evidence of Insurability member status
- Administrative Invoice Verification Tool

- Enrollment Method** *(required for List Billing only)*: Indicate what method your billing should be based on:
  - Excel census  Enrollment forms  Both
  - Specify which method takes precedence in the event of conflicting information:
    - Excel census  Enrollment forms
- Payroll Deduction Frequency:** Indicate payroll deduction frequency for any voluntary and/or contributory coverages. Select one option.
 

Monthly <i>(Standard)</i>	Weekly <i>(52/yr)</i>	Bi-Weekly <i>(26/Yr)</i>	Semi-Monthly <i>(24/Yr)</i>	9thly	10thly	13thly
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify first payroll date following the effective date (mm/dd/yyyy): \_\_\_\_\_
- Billing Format:** If you have multiple locations, we can include a location name and number on your billing statement or send a separate bill to each location. Select the billing format your prefer:
  - One bill for all locations/divisions sent to Primary Contact (Standard)
  - One bill itemized by location/division codes sent to Primary Contact *(available for List Billed customers only)*
  - One bill for each location/division sent to the applicable location contacts.

Additional Billing Location *1/18*

Location Name & Number			
Contact Name			
Billing Address			
City, State, Zip			
Contact Phone & Fax			
Contact Email			
Should this contact have access to:			
Online Billing and Reporting <input type="checkbox"/> Yes <input type="checkbox"/> No			
Online Eligibility Maintenance <i>(List Billed customers only)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No			

For additional locations, provide information on a separate sheet of paper.

# POLICY ADMINISTRATION



## EARNINGS DEFINITION

**Insurable earnings:** All employees' insurable earnings must be clearly defined so that premiums and claim payments are correctly calculated. Specify Class Description and Definition of Earnings for each class of employees.

Check this box if the Earnings Definition applies to all Class Descriptions and only complete Section 1.

	Section 1	Section 2	Section 3
Class Description			
Current Base Salary <sup>1</sup>	<input checked="" type="checkbox"/> <i>Match Current Plan</i>	<input type="checkbox"/>	<input type="checkbox"/>
Overtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commissions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bonuses <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 36	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 36	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 36
Prior Year W-2 <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior Year K-1, W-2 or S-Corp <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup>Earnings will be determined on the last day worked. Salary shall not exceed payroll records or premium paid.

<sup>2</sup>Additional approval may be necessary

<sup>3</sup>Bonuses, Commissions and Overtime are included

## PREMIUM CONTRIBUTIONS

1. For Contributory coverages, indicate the percentage of premium paid by both the employer and employee.

	Life	Dep. Life	LTD	STD	Dental
Employer %	100%	—	100%	100%	7.5
Employee %	0	—	0	0	Balance

Note: Voluntary coverages are 100% employee paid

## POLICY INFORMATION

1. **Master Policy and Booklets:** Electronic copies of the Master Policy and Certificate booklets will be issued.

2. **ERISA:** Your ERISA information can be included in any Certificate booklet, to form a combined Certificate/Summary Plan Description (SPD)?

Would you like your ERISA information included in your Certificate booklet(s)?  Yes  No

If yes, provide the three digit plan number beginning with a 5 and the Plan Year Beginning (mm/dd) \_\_\_\_\_

Plan Number	5	5	5
Coverage			

Note: Your plan number can be found on your welfare benefit plan 5500.

Is the ERISA Plan Administrator the same as the primary contact?  Yes  No

If no, indicate the ERISA Plan Administrator below:

Contact Name	
Address	
City, State, Zip	
Phone & Fax	

3. **Section 125/Cafeteria Plan:** Is your policy covered under Section 125?  Yes  No

If yes, indicate your subsequent enrollment period (mm/dd): \_\_\_\_\_

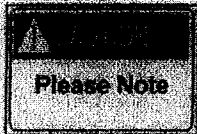
# POLICY ADMINISTRATION



## ADDITIONAL INFORMATION FOR DISABILITY COVERAGE

1. **Funding Information:** How are your Disability premiums paid?  Fully by employer  Fully/Partially by employee  
 How are premiums deducted?  Post-Tax  Pre-Tax  Employee Chooses  
 Are the employees' wages 'grossed up' to fund the premium?  Yes  No

2. **Federal Insurance Contribution ACT (FICA):**



Your FICA Payment method is shown in the 'BENEFIT PROVISIONS' section of the Group Insurance Proposal. For a detailed description of your FICA Payment method, refer to the following:

**FICA With Reimbursement-** We will pay your share of employer FICA tax to the IRS, create form W-2 and bill you monthly for your share of FICA tax. We will initiate Automated Clearing House (ACH) for reimbursement of your share of FICA taxes that we have paid. A monthly report will be provided reflecting gross benefits paid and taxes withheld for each beneficiary. *(Standard)*

**Do Not Pay FICA -** It is your responsibility to pay your share of employer FICA tax to the IRS and create form W-2. We will provide you with daily and monthly reports reflecting gross benefits paid and taxes withheld for each beneficiary.

**FICA Without Reimbursement-** We will pay your share of employer FICA tax to the IRS and create form W-2. Your share of the FICA tax has been included in your premium rate and you will not be billed separately. A monthly report will be provided reflecting gross benefits paid and taxes withheld for each beneficiary. *(Additional cost may apply)*

3. **FICA Contact Information:** If Premium Billing Primary Contact is also your FICA contact, check this box   
 Otherwise, please specify your FICA Contact:

Contact Name			
Address			
City, State, Zip			
Phone & Fax			
Email			

List any additional locations to which FICA information should be sent:

Location Name & Number			
Contact Name			
Address			
City, State, Zip			
Phone & Fax			
Email			

Provide the above information for any additional contacts or locations on a separate attachment.

# POLICY ADMINISTRATION



## ELIGIBILITY INFORMATION

- Eligibility Assumptions:** Unless otherwise noted in the Group Insurance Proposal, the policy will be issued with the following provisions:
  - Rehire Provision:** Former employees rehired within 90 days of termination will not be required to satisfy the eligibility waiting period.
  - Layoff/Leave of Absence:** Employee's coverage will terminate on the last day worked in the event of a layoff or approved leave of absence.
  - Reinstatement for Basic Life/AD&D, STD, LTD, Dental:** If the insurance of an employee is terminated by reason of temporary layoff or leave of absence and the employee subsequently returns to work, the employee must satisfy the waiting period upon return to full-time active employment, unless returning from a military leave immediately after discharge from active duty or upon return to full-time active employment when the disability ends. *Basic Life and Voluntary Term Life* policies include specific language allowing for reinstatement of coverage after an employee has lost coverage due to non-payment of premium, involuntary work-hour reduction in hours, or is rehired.
- Eligibility Rules:** A clear definition of eligibility rules by class is necessary to properly administer your plan. Complete the table below to clarify whether or not any classes have varying eligibility criteria by product (*include all variations*). If eligibility does not vary by class or product, only complete the first row of the below chart.
  - Class Description:** How the employees class should be described in the policy
  - Minimum Hours:** Minimum number of hours an employee must work each week to be eligible for coverage
  - Waiting Period:** Days, months, years an employee must be employed full-time before becoming eligible for coverage
  - Effective Date:** Day on which coverage begins after employees satisfy the waiting period
  - Termination Date:** Day on which coverage terminates once an employee is no longer eligible

CLASS DESCRIPTION	WEEKLY MINIMUM HOURS	COVERAGE WAITING PERIOD	COVERAGE EFFECTIVE DATE	COVERAGE TERMINATION DATE	APPLIES TO WHICH PRODUCTS
<i>more coming PLAN</i>		___ Days ___ Months ___ Years	<input type="checkbox"/> on the day <input type="checkbox"/> first day of the month following or coinciding	<input type="checkbox"/> on the day- (Required for disability) <input type="checkbox"/> last day of month	<input type="checkbox"/> Life <input type="checkbox"/> Vol. Life <input type="checkbox"/> STD <input type="checkbox"/> Vol. STD <input type="checkbox"/> LTD <input type="checkbox"/> Vol. LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vol. Dental
_____	_____	___ Days ___ Months ___ Years	<input type="checkbox"/> on the day <input type="checkbox"/> first day of the month following or coinciding	<input type="checkbox"/> on the day- (Required for disability) <input type="checkbox"/> last day of month	<input type="checkbox"/> Life <input type="checkbox"/> Vol. Life <input type="checkbox"/> STD <input type="checkbox"/> Vol. STD <input type="checkbox"/> LTD <input type="checkbox"/> Vol. LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vol. Dental
_____	_____	___ Days ___ Months ___ Years	<input type="checkbox"/> on the day <input type="checkbox"/> first day of the month following or coinciding	<input type="checkbox"/> on the day- (Required for disability) <input type="checkbox"/> last day of month	<input type="checkbox"/> Life <input type="checkbox"/> Vol. Life <input type="checkbox"/> STD <input type="checkbox"/> Vol. STD <input type="checkbox"/> LTD <input type="checkbox"/> Vol. LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vol. Dental
_____	_____	___ Days ___ Months ___ Years	<input type="checkbox"/> on the day <input type="checkbox"/> first day of the month following or coinciding	<input type="checkbox"/> on the day- (Required for disability) <input type="checkbox"/> last day of month	<input type="checkbox"/> Life <input type="checkbox"/> Vol. Life <input type="checkbox"/> STD <input type="checkbox"/> Vol. STD <input type="checkbox"/> LTD <input type="checkbox"/> Vol. LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vol. Dental
_____	_____	___ Days ___ Months ___ Years	<input type="checkbox"/> on the day <input type="checkbox"/> first day of the month following or coinciding	<input type="checkbox"/> on the day- (Required for disability) <input type="checkbox"/> last day of month	<input type="checkbox"/> Life <input type="checkbox"/> Vol. Life <input type="checkbox"/> STD <input type="checkbox"/> Vol. STD <input type="checkbox"/> LTD <input type="checkbox"/> Vol. LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vol. Dental

- Waiting Period:** Should the waiting period be waived for all employees actively at work on the effective date?  Yes  No
  - Domestic Partner:** Are Domestic Partners covered?  Yes  No  
 If yes, does Domestic Partners include opposite sex partners?  Yes  No
- more coming  
PLAN*

# MUTUAL OF OMAHA

## PRIVACY NOTICE – PERSONAL INFORMATION

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This Privacy Notice applies to the Personal Information of customers of the Mutual of Omaha companies. The companies include:

- Mutual of Omaha Insurance Company
- Mutual of Omaha Investor Services, Inc.
- Mutual of Omaha Marketing Corporation
- United of Omaha Life Insurance Company
- United World Life Insurance Company
- Companion Life Insurance Company
- Omaha Property and Casualty Insurance Company

The Notice applies to our current as well as former customers.

### Why You Are Receiving This Notice

The federal Financial Services Modernization Act and state privacy laws require us to send you an annual Notice. This Notice describes how we collect, use, and protect the Personal Information you entrust to us.

If you have a policy that is covered by the HIPAA Privacy regulations, you received a privacy notice that relates to the privacy of your medical information. To obtain an additional copy of the privacy notice related to your medical information you can log onto our company's website.

[www.mutualofomaha.com/hipaa.html](http://www.mutualofomaha.com/hipaa.html)

or you can contact us at:

Mutual of Omaha Insurance Company  
Attn: Privacy Office  
Mutual of Omaha Plaza  
Omaha, NE 68175-1029

### Personal Information

**Personal Information** means information that we collect about you, such as name, address, Social Security number, income, marital status, employment and similar personal information.

### Information We Collect

In the normal course of business we may collect Personal Information about you from:

- Applications or other forms we receive from you
- Your transactions with us, such as your payment history
- Your transactions with other companies
- Other sources (such as motor vehicle reports, government agencies and medical information bureaus)
- Consumer-reporting agencies

### Information We Share

In the normal course of business we may share your Personal Information among the Mutual of Omaha companies. Depending on the products you have with us, the type of information we share could include:

- Your name
- Your income
- Your Social Security number
- Other identifying information you give us
- Your transactions with us, such as your payment history

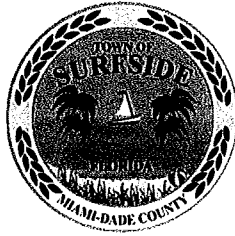
We do not share Personal Information with third parties outside of the Mutual of Omaha companies except as required or permitted by law.

### How We Protect Your Information

We restrict access to your Personal Information. It is given only to the employees of Mutual of Omaha and others who need to know the information to provide our insurance or financial services to you.

We have physical, electronic and procedural safeguards in place to make sure your Personal Information is protected. These safeguards follow legal standards and established security standards and procedures.





# Town of Surfside Commission Communication

**Agenda Item #**

**Agenda Date:** September 22, 2010

**Subject:** Town Manager Separation Agreement - Fiscal Year ended September 30, 2010

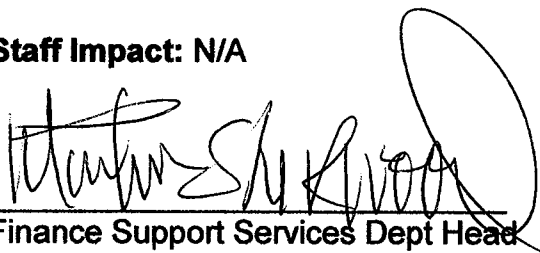
**Background:** The Town Commission entered into an employment agreement on April 8, 2008 via resolution number 1828 and now desires to enter into a separation agreement effective September 30, 2010.

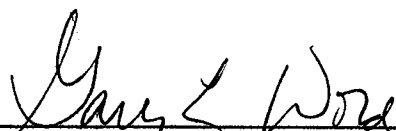
**Recommendation:** It is recommended that the Town Commission adopt the proposed fiscal year 2009-2010 amended budget resolution attached in accordance with sound budgeting principles.

**Analysis:** The employment agreement dictates a payment in the amount of \$89,508.90 covering base salary and accrued vacation/sick leave only. Employer payroll taxes amount to \$6,713.17 (7.5%) and is in accordance with internal revenue service regulations.

**Budget Impact:** A total reappropriation and therefore a net reduction in General Fund - fund balance (reserves), for current budget year 2009-2010, in the amount of \$96,222.07 is anticipated.

**Staff Impact:** N/A

  
Finance Support Services Dept Head

  
Town Manager

**RESOLUTION NO. \_\_\_\_\_**

**A RESOLUTION OF THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, AMENDING THE ANNUAL APPROPRIATIONS RESOLUTIONS ADOPTED FOR THE FISCAL YEAR OCTOBER 1, 2009 TO SEPTEMBER 30, 2010; FOR THE PURPOSE OF AMENDING THE CURRENT YEAR'S BUDGET UPWARD; AND OTHER BUDGETARY ADJUSTMENTS REQUIRED TO THE FISCAL YEAR ENDED SEPTEMBER 30, 2010 BUDGET; PROVIDING FOR AN EFFECTIVE DATE.**

**WHEREAS,** the Town of Surfside adopted Resolution Nos. 1902 and 1903 on September 22, 2009 establishing revenues and appropriations for the Town of Surfside, Florida for the fiscal year ended September 30, 2010; and

**WHEREAS,** the Town's Commission desires to enter into a separation agreement with the Town Manager and the General Fund does not anticipate an underage in expenditures to cover this agreement; and

**WHEREAS,** and as a result of State statutes as well as the Town's commitment to sound budgeting practices, budgeted expenses need to be increased. Accordingly, the budget resolution proposes to amend the current year's budget; and

**WHEREAS,** it is in the best interest of the Town of Surfside to adopt the proposed FY 2009-2010 amendatory General Fund budget resolution as submitted.

**NOW, THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA;**

**Section 1. Recitals.** That the above and foregoing recitals are true and correct and are incorporated herein by reference.

**Section 2. Authorization.** The Town Commission hereby approves and authorizes the proposed budget 2009/10 amendment where the net effect would be a .74% (less than 1%) increase in the General Fund, respectively of both projected revenues and expenditures for the current, 2009-2010 fiscal year as follows:

001-2000-512-1210 Salaries	\$89,508.90
001-2000-512-2110 Payroll Taxes	<u>\$ 6,713.17</u>
001-0000-392-0000 Reappropriated Fund Balance	\$96,222.07

**Section 3. Implementation.** The Town Manager is hereby authorized to take any and all action necessary to implement this Resolution.

**Section 4. Effective Date.** This Resolution shall become effective immediately upon its adoption.

**PASSED and ADOPTED** on this \_\_\_\_\_ day of \_\_\_\_\_, 2010

Motion by Commissioner \_\_\_\_\_, second by Commissioner \_\_\_\_\_.

FINAL VOTE ON ADOPTION

Commissioner Michael Karukin	_____
Commissioner Edward Kopelman	_____
Commissioner Marta Olchyk	_____
Vice Mayor Joseph Graubart	_____
Mayor Daniel Dietch	_____

\_\_\_\_\_  
Daniel Dietch, Mayor


Resolution No. \_\_\_\_\_

**ATTEST:**

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Debra E. Eastman, MMC  
Town Clerk

**APPROVED AND TO FORM AND  
LEGAL SUFFICIENCY FOR THE TOWN OF SURFSIDE ONLY:**



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Lynn M. Dannheisser  
Town Attorney

Resolution No. \_\_\_\_\_