Capital Health Plan

Non-Federally Qualified for Large Groups

MASTER POLICY

John Hogan
Executive Director

Blue Cross Blue Shield of Florida

2140 Centerville Place • Tallahassee, Florida • (850) 383-3311
An affiliate of Blue Cross and Blue Shield of Florida Since 1982
(Independent licensee of the Blue Cross and Blue Shield Association)

State Qualified
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GROUP ADMINISTRATIVE PROVISIONS

Introduction

Thank you for choosing Capital Health Plan ("CHP"), an affiliate of Blue Cross and Blue Shield of Florida, Inc., a leader in health care financing solutions for over 50 years. CHP is a Florida-based Health Maintenance Organization ("HMO") providing comprehensive HMO-type coverage for groups. By purchasing coverage for your employees, and their covered dependents, you have established an employee welfare benefit plan ("Group Plan"). This document ("Master Policy") will evidence the existence of the Group Plan and describe the rights and obligations which you and CHP have with respect to the coverage and/or benefits to be provided by CHP.

In exchange for your payment of Premium, CHP agrees to provide the coverage and/or benefits specified in the Member Handbook, a copy of which is made part of this Master Policy. The comprehensive health care coverage to be provided by CHP under the Group Plan which you have established is subject to all the requirements set forth in this Master Policy including the Member Handbook and any amendments or endorsements issued by CHP.

The Master Policy is divided into two parts. The first part generally contains various administrative and other provisions relating to your agreement with CHP. You should make sure that you read and understand these provisions as they describe important obligations applicable to you and CHP. The second part of the Master Policy is the Member Handbook which describes the coverage and benefits which you have purchased for enrollees of the Group Plan. Any attachments or endorsements issued by CHP to the Member Handbook or the first part of the Master Policy are also part of the Master Policy.

Additional Definitions

Certain terms used throughout the Group Administrative Provisions, Group Payment Provisions, General Group Provisions, and Group Medicare Secondary Payer Provisions of this Master Policy are defined in the Member Handbook. Such terms shall have the same meaning given to those terms in the Member Handbook unless stated otherwise. In addition to the definitions set forth in the Member Handbook, the following terms shall apply to this Master Policy:

Anniversary Date means the date one (1) year after the Effective Date stated on the Group Application, and subsequent annual anniversaries of that date.

Master Policy means the written document which is evidence of the entire agreement between the Group and CHP whereby comprehensive HMO-type coverage and/or benefits will be provided under the Group Plan to Members. The Master Policy includes the Member Handbook, the Group Application, the Individual Application for Group Insurance/

Membership, and any attachments, amendments or endorsements to the Member Handbook or the Master Policy.

Grace Period means the ten-day period beginning on the date the Premium is due.

Group means the employer, labor union, association, partnership, corporation or other entity which has entered into this Master Policy with CHP for provision of comprehensive health care coverage and/or benefits. References to "you" or "your" throughout the Group Administrative Provisions, Group Payment Provisions, General Group Provisions, and Group Medicare Secondary Payer Provisions of this Master Policy also refer to the Group.

Premium means the amount required to be paid by the Group in order for there to be coverage under this Master Policy.

Term of Master Policy

This Master Policy shall become effective as of the Effective Date provided that (1) CHP accepts your Group Application, and (2) that you pay the required initial Premium specified by CHP. This Master Policy shall continue in effect until the first Anniversary Date following the Effective Date unless terminated earlier as permitted by its terms. After the initial term, this Master Policy shall automatically renew each succeeding year on the Anniversary Date for an additional one-year period unless, at least 45 days prior to such Anniversary Date, you notify us that you do not want the Master Policy to automatically renew.

If this Master Policy renews as specified above, the terms and provisions of this Master Policy (including the Premium due) shall govern coverage under the Group Plan, as of the Anniversary Date, unless written notice of a modification or revision is given by CHP to you at least 30 days prior to the Anniversary Date. In the event that CHP gives such written notification, you may elect not to renew this Master Policy effective as of the Anniversary Date by giving CHP written notice prior to the Anniversary Date. If you fail to give CHP written notice as required, this Master Policy shall renew on the Anniversary Date with the modified or revised terms. Nothing in this subsection shall prohibit CHP from amending, at any time, the coverage and/or benefits to be provided by CHP.

You can terminate this Master Policy at any time provided you do so in accordance with the terms specified herein. The Premium may be modified by CHP at any time in accordance with the applicable provisions of this Master Policy.

Commencement of Coverage

CHP's coverage in accordance with the terms of this Master Policy begins on the Member's Effective Date, which will be the first of the month after the receipt and approval of the Group Application by CHP, unless this Master Policy specifies a date other than the first of the month (See Enrollment and Effective Date). You agree that CHP is not required by this

Master Policy to pay for expenses incurred prior to a Member's Effective Date. CHP hereby disclaims any obligation to provide coverage or benefits under this Master Policy for expenses incurred prior to a Member's Effective Date.

Voluntary Termination by the Group

The Group may terminate this Master Policy at any time by giving CHP at least 45 days prior written notice. Coverage will not be provided on or after such termination date.

Termination by CHP for Non-payment of Premium

This Master Policy will automatically terminate as of the applicable Premium due date if CHP does not receive the Premium payment prior to the end of the Grace Period. In no event will such termination relieve you of the obligations to either pay CHP the prorated portion of the Premium due for coverage provided by CHP prior to termination, the amount of any payments made by CHP for health care provided to persons who were Members as of the termination date, or for any amounts otherwise due CHP.

CHP will mail to you a written notification prior to 45 days after the date the Premium is due that this Master Policy has terminated. This notification will tell you the reasons for termination. It is your obligation to immediately notify each Subscriber of any such termination.

Termination and Conditions of Renewal

This Master Policy is conditionally renewable. This means that it automatically renews each year on your Anniversary Date unless terminated earlier in accordance with the terms of this Master Policy. CHP may terminate this Master Policy or refuse to renew it if:

1. You fail to pay Premiums or contributions in accordance with the terms of this Master Policy or CHP has not received timely Premium payments.

2. You perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact with respect to the Group Plan.

3. You fail to comply with a material provision of the Master Policy which relates to rules for Group contributions or Subscriber participation.

4. There is no longer any Member who lives, resides, or works in the Service Area.

If CHP determines that the Master Policy should not be renewed, based on one or more of circumstances 2, 3 and 4 mentioned above, CHP will give you at least 45 days advance written notice.

Discontinuation of Form

CHP may decide to discontinue this form, but may do so only if:

1. CHP ceases to offer this form in the large-group market in accordance with §641.31074 *Florida Statutes*;

2. CHP provides notice to all groups and each subscriber having coverage under this form of the discontinuation of this form at least 90 days prior to the date of non-renewal; and

3. CHP offers to all groups having coverage under this form type the option to purchase any other health maintenance form currently being offered by CHP in the large-group market.

Termination Based on Discontinuation in Large-Group Market

CHP may terminate this Master Policy if it elects to terminate all of the policies it has issued in the large-group market in this state. In that case, CHP will provide notice, at least 180 days prior to the date of non-renewal, to the Florida Department of Insurance and to all large groups and each Subscriber.

Representations Made By, and Obligations of, the Group

In agreeing to provide coverage under the Group Plan in accordance with the terms of this Master Policy, CHP relies on the representations which you made when you applied for coverage with CHP and your representation that you have authority to act on behalf of all Subscribers and Dependents with respect to the Group Plan. Consequently, every act by, agreement with, or notice given to, you will be binding on all Subscribers and Dependents. You agree that you shall offer to all Eligible Employees the opportunity to become a Subscriber under the Group Plan. You must notify persons considering enrollment with CHP under the Group Plan that CHP is an HMO and that, in order to obtain HMO-type coverage under the Group Plan, certain coverage access rules must be followed. (See the Coverage Access Rules Section of the Member Handbook). While you may require a Subscriber to pay a portion of the Premium due CHP, you agree that you shall contribute toward the cost of coverage which you purchased.

You agree that, if requested by CHP, you will distribute to Members the Member Handbooks (and any amendments or endorsements to it) and other coverage materials.

Eligibility For Employees

Subject to any eligibility requirements set forth in the Member Handbook (and any amendments or endorsements to it), an employee becomes eligible for coverage on the next Premium due date following any Waiting Period established by you. The Waiting Period which you designated is shown on the Group Application which you submitted to CHP.

GROUP PAYMENT PROVISIONS

Monthly Invoice

CHP will prepare a monthly invoice of the Premium due on or before the due date. This monthly invoice will also reflect any pro-rated charges and credits resulting from changes in the number of Members and changes in the types of coverage that took place in the previous or current month.

If a Member becomes ineligible for coverage under the Group Plan for any reason, you are required to provide CHP with written notice of such ineligibility. Written notice of such ineligibility shall be provided to CHP on or before the Effective Date of the change.

Do not add names to a Group invoice or pay for an employee whose name does not appear on the invoice. No changes can be made to a Group invoice unless a signed application form is on file and submitted to CHP. Payment shall be for the total amount of the Group invoice, minus any employee deletions for the current month only.

Payment Due Date

The first Premium payment is due before the Effective Date of the Master Policy. Each following payment is due monthly unless you and CHP agree on some other method and/or frequency of payment. The Premium is due and payable on or before the first day of each succeeding calendar month to which such payments apply, unless you and CHP agree to have the 15th day of each month as the payment due date.

Grace Period

This Master Policy has a ten-day Grace Period. If any required payment is not received by CHP on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If payments are not received by the end of the Grace Period, coverage automatically terminates effective as of the end of the applicable due date.

Changes in Premium

The amount of Premium may be modified by CHP at any time.

CHP shall provide at least 30 days prior written notice to you of any such change. Payments submitted to CHP following receipt of any such written notice of change constitutes your acceptance of any such change. You shall immediately notify each Subscriber of any such change which affects the Subscriber's financial contribution requirement.

If an increase in Premium takes place on a date other than the payment due date, a pro-rated increase will be applied from the date of the increase to the next payment due date. If a decrease in Premium takes place on a date other than the payment due date, a pro-rated credit will be granted. The pro-rated credit will apply for the decrease from the date of the decrease to the next payment due date.

Administration

You must provide CHP with any information it needs to administer the coverage and/or benefits to be provided and to compute the Premium due. While this coverage is in force, CHP has the right, at any reasonable time, to examine your records on any issues necessary to verify information provided by you.

Assignment and Delegation

You may not assign, delegate or otherwise transfer this Master Policy and the obligations hereunder without the written consent of CHP. Any assignment, delegation, or transfer made in violation of this provision shall be void. CHP may assign, delegate or otherwise transfer this Master Policy to its successor in interest or an affiliated entity without your consent at any time.

Authorization

Where this Master Policy requires that an act involving the administration of coverage and/or benefits be authorized or approved by CHP, such authorization or approval shall be considered given when provided in writing by a duly authorized officer of CHP or his/her designee.

Complaint and Grievance Process

CHP has established and will maintain a process for hearing and resolving complaints and grievances raised by Members. Details regarding the complaint and grievance resolution process are provided in the Member Handbook provided to each enrolled Subscriber.

Changes To The Master Policy

No changes to this Master Policy will be effective unless made by an amendment or endorsement that has been signed by a duly authorized officer of CHP. No agent may change the written terms of this Master Policy or any of its provisions or waive any of its provisions unless such agent has been expressly authorized in writing by CHP to make such change or waive any provision.

Enrollment Records

1. Furnishing and Maintaining Enrollment Records

   You and each Eligible Employee must submit accurate and complete enrollment forms on a timely basis. You are responsible for collecting the enrollment forms, reviewing them for accuracy and completeness, and forwarding them to CHP, along with the applicable Premium payment. You shall furnish to CHP all information that CHP may reasonably require for the purpose of enrolling individuals, processing terminations, and recording changes in family status and any other information regarding any individual which will assist CHP in maintaining accurate enrollment files ("Enrollment Records"). All records which are relevant to the eligibility or coverage status of any individual shall be made available to CHP for inspection and copying upon reasonable notice.

2. Errors or Delays

   Clerical errors or delays by CHP in maintaining Enrollment Records regarding Members will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise be validly terminated, provided you have furnished CHP with timely and accurate enrollment information. Errors or delays by you in furnishing accurate enrollment information to CHP will not affect CHP's right to strictly enforce any and all eligibility requirements. You agree that you shall be liable to CHP for any claims payments made by CHP on behalf of any individual who was not eligible for coverage at the time the service or supply was rendered.

Entire Agreement

This Master Policy sets forth the entire understanding and agreement between the parties and shall be binding upon the Members, the parties, and any of their subsidiaries, affiliates, successors, heirs, and permitted assigns. All prior negotiations, agreements, and understandings are superseded hereby.

Financial Responsibilities Of The Group

CHP reserves the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Recovery efforts will relate to benefit payments made for services or supplies rendered subsequent to the Member's termination date and prior to the date notice of coverage termination is required to be made by you. You shall cooperate with and support such recovery efforts.

In the event that you do not comply with the notice requirements set forth in the Monthly Invoice subsection, you shall be solely liable to CHP, to the extent of any payment made on behalf of such individual, for services or supplies rendered subsequent to the date notice of a Member's termination was due.

Indemnification

You shall hold harmless and indemnify CHP against all claims, demands, liabilities, or expenses (including reasonable attorney's fees and court costs), which are related to, arise out of, or are in connection with any of your acts or omissions, or any of your employees or agents, in the performance of your obligations under this Master Policy.

Member Handbook

CHP will issue a Member Handbook and Membership Card to each Subscriber. The Member Handbooks will describe the coverage and/or benefits to be provided by CHP.

Representations on the Group Application and the Enrollment Forms

CHP relies on the information which you and your Eligible Employees provide: to determine whether to issue coverage; to determine the appropriate rate and financing method; and, to determine eligibility for coverage under the Group Plan. All such information must be accurate, truthful, and complete. Statements made on the Group Application and the enrollment forms are representations and not warranties.

CHP may cancel, terminate, or void this Master Policy if the information which you provide is fraudulent, or if you make an intentional misrepresentation.

Reservation of Right to Contract

CHP reserves the right to contract with any individuals, corporations, associations, partnerships, or other entities for the delivery of any of the coverage and/or benefits to be provided by CHP.

Service Mark

You, on behalf of the Group and its Subscribers, hereby expressly acknowledge your understanding that the Master Policy constitutes a contract solely between you and CHP, that CHP is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting CHP to use the Blue Cross and Blue Shield Service Mark in the State of Florida and that CHP is not contracting as the agent of the Association. You further

acknowledge and agree that you have not entered into the Master Policy based upon representations by any person other than CHP and that no person, entity, or organization other than CHP shall be held accountable or liable to you for any of CHP's obligations to you created under the Master Policy. This paragraph shall not create any additional obligations whatsoever on the part of CHP other than those obligations created under other provisions of the Master Policy.

GROUP MEDICARE SECONDARY PAYER PROVISIONS

In order to ensure compliance with the applicable Medicare laws, you are required to advise CHP, without delay, of any Member who will be, or is, covered under Medicare prior to or immediately following the date such Member becomes so covered (e.g., prior to the Member's 65th birthday). Additionally, you are required to advise CHP, without delay, of the Medicare status of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date. **You shall indemnify and hold CHP harmless to the extent of any liability, including attorneys' fees and costs, that results directly or indirectly from your failure to so advise CHP.**

In any circumstances under which the Medicare statute requires that the Covered Services under the Master Policy be primary for any Member, you MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such Member. Also, you MAY NOT induce such Member to decline or terminate his or her group health coverage and elect Medicare as primary payer.

Working Elderly

If you employ 20 or more persons for 20 or more weeks of the current or preceding Calendar Year, or if you are a member of a multi-employer group health plan that includes at least one employer with 20 or more employees, the Master Policy provides primary coverage for employees and/or their spouses, age 65 or older, who are covered under the Master Policy, pursuant to the following terms:

1. You shall provide CHP, without delay, the names of employees, age 65 or older:

    a. who are covered under the Master Policy;
    b. who are employed (not retired);
    c. who have not elected Medicare as primary payer of their health insurance claims; and
    d. who are not eligible for Medicare due to end stage renal disease (ESRD).

2. You shall provide CHP, without delay, the names of spouses, age 65 or older, of current employees of any age:

    a. who are covered under the Master Policy;
    b. who have not elected Medicare as primary payer of their health insurance claims; and
    c. who are not eligible for Medicare due to ESRD.

The names required to be provided as set forth above, along with any other identifying information requested by CHP, shall be provided to CHP on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls with CHP.

3. For an enrolled individual who meets one of the descriptions set out in paragraph 1 or 2 above, CHP will provide group health coverage, as set forth in the Member Handbook, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is 65 or over at the time of enrollment.

4. Individual entitlement to primary coverage under this subsection will terminate automatically:

   a. for a current employee, age 65 or older, when he or she elects Medicare as the primary payer or when he or she becomes eligible for Medicare due to ESRD;
   b. for the spouse, age 65 or older, of a current employee of any age, when the spouse elects Medicare as the primary payer or when the spouse becomes eligible for Medicare due to ESRD.

   You are required to provide CHP, without delay, the names of any current employees or spouses of such employees, age 65 or older, who choose Medicare as primary payer of their health insurance claims or who become eligible for Medicare due to ESRD.

   Under Medicare, you MAY NOT offer, subsidize, procure or provide a Medicare supplement insurance policy to such individual. Also, you MAY NOT induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

5. Entitlement of the employee and/or spouse to primary coverage under this subsection will terminate automatically when:

   a. the employee retires; or
   b. the employee no longer meets the employer eligibility requirements.

   You are required to notify CHP, without delay, of the retirement or reduction to a part-time schedule of any employee who has received primary coverage pursuant to this subsection or whose spouse has received primary coverage pursuant to this Working Elderly subsection.

6. The primary coverage described in this subsection will not be provided in the case of a group who is a member of a multi-employer group health plan where that group has fewer than 20 employees and the plan has elected treatment of that group's employees under the exception for small employers described at 42 U.S.C. §1395y(b)(1) (A)(iii).

NOTE: You must immediately report to CHP changes in the number of employees to fewer than 20 employees or from fewer than 20 employees to 20 or more employees, including pertinent changes in multi-employer group health plans.

Individuals With End Stage Renal Disease

Primary coverage is provided for your current and former employees and/or their Dependents who are covered under this Master Policy and who are entitled to Medicare coverage because of end stage renal disease (ESRD), pursuant to the following terms:

1. You are required to provide CHP, without delay, information, including, but not limited to, the following:

   - the names of any individuals who are or will be undergoing a regular course of renal dialysis;
   - the names of any individuals who will receive or already have received a kidney transplant;
   - the beginning date of such dialysis or the date of such transplant;
   - the individual's date of birth, sex, and social security number;
   - Health Insurance Claim Number;
   - relationship of each individual covered to the employee (i.c., employee, employee's spouse, or employee's dependent child);
   - reason for Medicare entitlement;
   - Medicare Part A effective date;
   - employee's social security number;
   - employee's Member number;
   - current employment status;
   - coverage effective date;
   - coverage termination date;
   - group number;
   - benefits provided (i.e., hospital benefits only, medical benefits only, or all other); and,
   - type of coverage provided (i.e., self, family, etc.).

2. For an enrolled individual who is entitled to Medicare coverage because of ESRD, CHP will provide group health coverage, as set forth in the Member Handbook, on a primary basis for 30 months beginning with the earlier of:

   a. the month in which the individual became entitled to Medicare Part A ESRD benefits; or
   b. the first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, CHP will provide group health coverage, as set forth in the Member Handbook, on a primary basis for 30 months.

Under Medicare, you MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

Disabled Active Individuals

CHP provides primary coverage to Members who are covered under this Master Policy if:

- You are a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year; and

- The Members are entitled to Medicare coverage because of disability (unless they have ESRD).

Primary coverage under this Master Policy is pursuant to the following terms:

1. You are required to provide CHP, without delay, with the names of any Members covered under this Master Policy, who are entitled to Medicare coverage because of disability (other than those with ESRD), and who have not elected Medicare as primary payer of their health insurance claims, along with any other identifying information requested.

2. For a Member, CHP will provide group health coverage, as set forth in the Member Handbook, on a primary basis during any month in which that individual meets the description set out in paragraph 1 above.

3. Individual entitlement to primary coverage under this subsection will terminate automatically when:

   a. the individual turns 65 years of age; or
   b. the individual no longer qualifies for Medicare coverage because of disability; or
   c. the individual elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

Under Medicare, you MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

You are required to notify CHP, without delay, of the occurrence of any of the above events.

4. Entitlement of the Member to primary coverage under this subsection will terminate automatically if the Subscriber no longer qualifies as such under applicable Medicare regulations and instructions. You are required to notify CHP, without delay, of any such change in status.

NOTE: You must immediately report to CHP changes in the number of employees to fewer than 100 employees or from fewer than 100 employees to 100 or more employees.

Miscellaneous

1. The Group Medicare Secondary Payer Provisions section shall be subject to, modified if necessary to conform to or comply with, and interpreted with reference to, the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Master Policy.

2. CHP shall not be liable to you or to any individual covered under this Master Policy due to any nonpayment of primary benefits resulting from any failure of performance of your obligations as set forth in this section.

3. If CHP should elect to make primary payments covering services rendered to Member described in this section in a period prior to receipt of the information required by the terms of this section, CHP may require you to reimburse CHP for such payments. Alternatively, CHP may require you to pay the rate differential that resulted from your failure to provide CHP with the required information in a timely manner.

4. You shall indemnify and hold CHP harmless to the extent of any liability that CHP may be charged with on account of improper primary Medicare payments that were made as a result of any failure of performance of your obligations as set forth in this section.

NOTE: You are subject to the federal laws described in this section. Individuals with questions regarding their rights under those laws should direct their questions to you.

MEMBER HANDBOOK PROVISIONS

The remainder of this Master Policy consists of the Member Handbook and any attachments, amendments, or endorsements issued to Subscribers under this Master Policy. These provisions are made a part of the Master Policy. Attachments, amendments and endorsements, if any, changing the provisions of the Member Handbook are also made a part of this Master Policy.

Capital Health
PLAN

An Independent Licensee of the
Blue Cross and Blue Shield Association

LARGE EMPLOYER

MEMBER HANDBOOK

Non-Federally Qualified for Large Groups

This Member Handbook Does Not Contain a Pre-existing Condition Limitation

2012.01.LgMbrHB

Effective Date: 2/6/2012
Retirement Date:

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If the Group Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the plan administrator is solely responsible for complying with ERISA. While the benefit determination timeliness standards set forth in this section are generally consistent with ERISA, Capital Health Plan is not legally responsible for notifying the covered person of any rights he or she may have under ERISA. If the covered person is not sure of his or her rights under ERISA, the covered person should contact the plan administrator or an attorney of his or her choice. Capital Health Plan will follow the claim determination procedures and notice requirements set forth in this section even if the Group Plan is not subject to ERISA.

Under no circumstances will Capital Health Plan be held responsible for, nor will it accept liability relating to, the failure of the Group Plan's sponsor or plan administrator to: (1) comply with ERISA's disclosure requirements; (2) provide the covered person with a Summary Plan Description (SPD) as that term is defined by ERISA; or (3) comply with any other legal requirements. The covered person should contact the plan sponsor or administrator if he or she has questions relating to the Group Plan's SPD. Capital Health Plan is not the Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

SECTION 1: ELIGIBILITY FOR MEMBERSHIP

Each employee or other individual who is eligible to participate in the Employer Sponsored Plan, and who meets and continues to meet Capital Health Plan's eligibility requirements described in the Employer Plan, shall be entitled to apply to become a Member of Capital Health Plan. Such eligibility requirements shall be binding upon the Employer Plan Sponsor and the Member and no change in such requirements shall be permitted unless Capital Health Plan has been notified of, and has agreed, in writing, to any such change in advance.

Eligibility Requirements for Subscribers

To be an Eligible Employee, a person must be a bona fide employee of the Employer and must meet each of the following requirements:

1. the employee's job must fall within a job classification set forth on the Employer Plan Sponsor Application;

2. the employee must maintain his/her primary residence in the Service Area or be regularly employed in the Service Area;

3. the employee must have completed any applicable Waiting Period set forth on the Employer Plan Sponsor Application; and

4. the employee must meet any other applicable eligibility requirement(s) set forth on the Employer Plan Sponsor Application or in the Employer Sponsored Plan.

This Subscriber eligibility class may be modified, and may be expanded to include:

1. Retired employees;

2. Additional job classifications;

3. Employees of affiliated or subsidiary companies of the Employer Plan Sponsor, provided such companies and the Employer Plan Sponsor are under common control; and

4. Other individuals as determined by Capital Health Plan and the Employer Plan Sponsor (e.g. members of associations or labor unions).

Any expansion of the Subscriber eligibility class must be approved by Capital Health Plan and the Employer Plan Sponsor, in writing, prior to such expansion.

Eligibility Requirements for Dependent(s)

To be an Eligible Dependent, a person must:

1. be the present, lawful spouse of a Subscriber (under a legally valid existing marriage); or

2. be a member's natural child (including a newborn child), step-child, foster child, adopted child (including a newborn child who is required to be eligible for membership hereunder as an adopted child in conformity with applicable law), or a child for whom the Subscriber has been appointed legal guardian, pursuant to a valid court order, and who is:

    a. under 26 years of age (eligibility automatically terminates at the end of the Calendar Year in which the Dependent has his/her 26th birthday); or

    b. for an additional individual monthly premium, an eligible dependent between the Calendar Year in which he/she becomes 26, but has not reached the end of the Calendar Year in which he/she becomes 30 and who:

        i. is unmarried and does not have a dependent;

        ii. is a Florida resident or a full-time or part-time student;

        iii. is not enrolled in any other health coverage policy or plan; and

        iv. is not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.

    a. Age 26 until the end of the Calendar Year in which the child turns age 30 if the child is enrolled in a post-secondary educational institution taking a medically necessary leave of absence for whom continued coverage:

        i. Is available for up to one year after the first day of the medically necessary leave of absence but ending earlier if coverage under the plan would otherwise terminate; and

        ii. Stays the same as if the dependent child had continued to be a covered student and had not taken a medically necessary leave of absence.

    Written certification must be provided by a treating physician of the Dependent child certifying that such individual is suffering from a serious illness or injury that would require a medically necessary leave of absence.

Length of continued coverage is based on the date that is determined by the Dependent child's treating physician to be medically necessary. The coverage continues until the earlier of: (1) one year from the start of the medically necessary leave of absence, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

Note: If a Covered Dependent child who has reached the end of the Calendar Year in which he/she becomes age 26, but has not reached the end of the Calendar Year in which he/she becomes age 30, obtains a dependent of his/her own (e.g. through birth or adoption), such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage. It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

b. A Dependent child, who maintains his/her primary residence in the Service Area, is 26 years of age or older, and in the opinion of Capital Health Plan, is incapable of self-sustaining employment as a result of mental retardation or physical handicap which commenced prior to the time such Dependent reached his/her 26th birthday. If a child attains the limiting age for a Covered Dependent, coverage will not terminate while that person is, and continues to be, both:

    i. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

    ii. chiefly dependent on the Covered Employee for support and maintenance.

If a claim is denied for the stated reason that the child has reached the limiting age for dependent coverage, the Covered Employee has the burden of establishing that the child is, and has continued to be, handicapped as defined above.

The coverage of the handicapped child may be continued, but not beyond the termination date of such incapacity of the dependent. This provision shall in no event limit the application of any other provision of this Employer Sponsored Plan terminating such child's coverage for any reason other than the attainment of the applicable limiting age.

Other Requirements/Rules Regarding Eligibility

1. No individual whose Membership in Capital Health Plan has been terminated for cause (see the *Termination of Individual Membership for Cause* subsection), shall be eligible to re-enroll in Capital Health Plan.

2. No person shall be refused enrollment or re-enrollment in Capital Health Plan because of race, color, creed, marital status, sex, or age (except as provided in the *Eligibility Requirements for Dependents* subsection above).

3. The Subscriber must notify Capital Health Plan as soon as possible when a Dependent Member is no longer eligible for Membership. If a Dependent fails to continue to meet each of Capital Health Plan's eligibility requirements, and such proper notification is not timely provided by the Subscriber to Capital Health Plan, Capital Health Plan shall have the right to retroactively terminate Membership of such Dependent to the date any such eligibility requirement was not met, and to recover an amount equal to the Allowance for services and/or supplies provided, following such date less any Premium received by Capital Health Plan for such Dependent for coverage after such date. Upon Capital Health Plan's request, the Subscriber shall provide proof, which is acceptable to Capital Health Plan, of a Dependent's continuing eligibility for Membership.

4. If the Employer Plan Sponsor offers an alternative health benefit plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for Membership.

SECTION 2: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Any individual who is not properly enrolled will not be eligible for Covered Services hereunder and Capital Health Plan shall have no obligation whatsoever with respect to such individual.

Eligible Employees and Eligible Dependents may apply for Membership according to the provisions set forth below.

General Rules for Enrollment

1. All factual representations on the enrollment forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) Capital Health Plan may have, in disqualification for, or termination of coverage. Capital Health Plan will rescind coverage only due to fraud or an intentional misrepresentation of material fact.

2. Capital Health Plan shall not be required to provide coverage and/or benefits to any individual, who would not have otherwise been entitled to Membership in Capital Health Plan, had accurate and complete information been provided on a timely basis on the enrollment forms. In such cases, Capital Health Plan may require such individual, or an individual legally responsible for that individual, to reimburse Capital Health Plan for any such Covered Services provided or payments made by Capital Health Plan on behalf of such individual.

3. If the Employer Plan Sponsor requires an individual to make a periodic financial contribution in order to be a Member, such individual shall have agreed in writing to make, and actually shall make, all required financial contributions.

Enrollment Forms/Electing Coverage

To apply for Membership, the Eligible Employee must:

1. Complete and submit, through his or her employer, a Capital Health Plan Member Enrollment Application for Employer Plan Sponsor Coverage/Membership form to Capital Health Plan;

2. Provide any additional information needed to determine eligibility, if requested by Capital Health Plan;

3. Agree to pay his or her portion of the required Premium; and

4. Complete and submit, through his or her employer, a Member Status Change Request form to add or delete Dependents.

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Employer Plan Sponsor's program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.

2. Employee/Spouse Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's present, lawful, spouse only.

3. Employee/Child(ren) Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's eligible child(ren) only.

4. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

There may be additional Premium for each Dependent based on the coverage selected by the Employer Plan Sponsor.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is an annual 30-day period occurring no less than 30 days prior to the Anniversary Date, during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the Employer Plan Sponsor's health benefit program.

Special Enrollment Period is the 30-day period immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for Membership. Special circumstances are described in the Special Enrollment subsection.

Employee Enrollment

1. An individual who is an Eligible Employee on the Employer Plan Sponsor's Effective Date may choose to enroll during the Initial Enrollment Period. The Eligible Employee shall become a Subscriber as of the Effective Date of the Employer Plan Sponsor. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) shall be the same as the Subscriber's Effective Date.

2. An individual who becomes an Eligible Employee after the Effective Date of the Employer Plan Sponsor (for example, newly-hired employees) may choose to enroll before, or within, the Initial Enrollment Period. The Effective Date of coverage for such individual shall be the first Capital Health Plan billing date (1st of each month) following the date the individual first became enrolled.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Subscriber.

1. Newborn Child -- To enroll a newborn child who is an Eligible Dependent, submit a Member Status Change Request form to Capital Health Plan prior to or during the 60-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

   If the newborn child is enrolled within 30 days of the date of birth, Premium will not be charged for the first 30 days of coverage. If the newborn child is enrolled after this 30-day period, Premium will be charged from the moment of birth. Coverage will be denied if notice is not given within 60 days of the date of birth of the newborn child; however, such newborn child may be enrolled during the next Annual Open Enrollment Period.

   NOTE: Coverage for a newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes age 26, will automatically terminate 18 months after the birth of the newborn child, provided the Dependent child, parent of the newborn, remains enrolled under the Subscriber policy.

   For a Covered Dependent child who has reached the end of the Calendar Year in which he/she becomes age 26, but not reached the end of the Calendar Year in which he/she becomes age 30, if the Covered Dependent child obtains a dependent on their own (e.g. through birth or adoption), such newborn child will not be

eligible for this coverage and cannot enroll. Further, the Covered Dependent child will also lose his or her eligibility for this coverage.

2. Adopted Newborn Child -- To enroll an adopted newborn child, the Subscriber must submit a Member Status Change Request form to Capital Health Plan prior to or during the 60-day period immediately following the date of adoption and pay the additional Premium, if any. The Effective Date of coverage for an adopted newborn child eligible for Membership shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Member prior to the birth of such child, whether or not such agreement is enforceable; or,

   If the adopted newborn child is enrolled within this 30-day period, Premium will not be charged for the first 30 days of coverage. If the adopted newborn child is enrolled after this 30-day period, Premium will be charged from the moment of birth. Coverage will be denied if notice is not given within 60 days of the date of birth of the adopted newborn child; however, such adopted newborn child may be enrolled during the next Annual Open Enrollment Period.

   If the adopted newborn child is not ultimately placed in the residence of the Subscriber, there shall be no coverage for the adopted newborn child under the Employer Sponsored Plan. It is the responsibility of the Subscriber to notify Capital Health Plan within ten (10) calendar days if the adopted newborn child is not placed in the residence of the Subscriber.

3. Adopted Child -- To enroll an adopted child, the Subscriber must submit a Member Status Change Request form to Capital Health Plan prior to or during the 30-day period immediately following the date of placement and pay the additional Premium, if any. The Effective Date for an adopted child (other than an adopted newborn child) shall be the date such adopted child is placed in the residence of the Member in compliance with Florida law; provided that the adopted child is so placed in the residence of the Member. If the adopted child is enrolled within this 30-day period, Premium will not be charged for the first 30 days of coverage.

   For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child under the Employer Sponsored Plan. Proof of final adoption must be submitted to Capital Health Plan. It is the responsibility of the Subscriber to notify Capital Health Plan if the adoption does not take place. Upon receipt of this notification, Capital Health Plan will terminate the coverage of the child on the first billing date following our receipt of your written notice.

4. Marriage -- A Subscriber may apply for coverage of an Eligible Dependent due to marriage. To apply for coverage, the Subscriber must complete the Member

Status Change Request form and forward it to Capital Health Plan. The Subscriber must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

5. Court Order -- A Subscriber may apply for coverage for an Eligible Dependent under the Employer Sponsored Plan outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Subscriber's plan. To apply for coverage, the Subscriber must complete the Member Status Change Request form and forward it to Capital Health Plan. The Subscriber must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court order.

Annual Open Enrollment

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by submitting the Capital Health Plan Member Enrollment Application for Employer Plan Sponsor Coverage/Membership form during the Annual Open Enrollment Period.

The Effective Date of Coverage for an Eligible Employee and any Eligible Dependent(s) will coincide with the effective date of the Employer Plan Sponsor's Annual Renewal Date.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period must wait until the next Annual Open Enrollment Period, unless the Eligible Employee is enrolled due to a special circumstance as outlined in the Special Enrollment subsection.

Special Enrollment

An Eligible Employee who declined coverage in writing at the time of his/her Initial Enrollment Period may apply for coverage due to certain Special Enrollment circumstances as outlined below. The request for enrollment must be received by Capital Health Plan within the timeframes specified below or the request may be denied:

1. Loss of Coverage -- An Eligible Employee and/or Eligible Dependent(s) may request enrollment outside of the Initial Enrollment Period and Annual Open Enrollment Period if the individual:

a. was covered under another Employer Sponsored health benefit plan as an employee or dependent, or, was covered under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Plan [CHIP] or Medicaid, see #3 below), or was covered under COBRA, at the time he or she was initially eligible to enroll with Capital Health Plan provided that:

    i. when offered coverage by Capital Health Plan at the time of initial eligibility, states, in writing, that coverage under another employer-provided health plan was the reason for declining enrollment; and

    ii. demonstrates that he or she has lost coverage under another health benefit plan (except in the case of loss of coverage under a Children's Health Insurance Plan [CHIP] or Medicaid, see #3 below) within the past 30 days as a result of legal separation, divorce, death, or, for an employer-provided health benefit plan, termination of employment, termination of employer contributions, exhaustion of COBRA, or reduction in the number of hours of employment; and

    iii. requests enrollment within 30 days after the termination of coverage or employer contributions under another health benefit plan (except in the case of loss of coverage under a Children's Health Insurance Plan [CHIP] or Medicaid, see #3 below).

Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the Enrollment Application and forward it to Capital Health Plan. The Eligible Employee must make application for enrollment within 30 days of the loss of coverage (except in the case of loss of coverage under a Children's Health Insurance Plan (CHIP) or Medicaid, see #3 below).

2. Birth of a Child, Placement for Adoption, or Marriage -- An Eligible Employee may apply for coverage due to the following special circumstances: birth of a child or placement for adoption, or marriage. Newly Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the Enrollment Application and forward it to Capital Health Plan within 60 days in the instance of the birth of a natural or adopted child and 30 days in the instance of placement for adoption or marriage.

3. Loss of Coverage under a Children's Health Insurance Program [CHIP], Medicaid, or Obtaining Eligibility under a State Premium Assistance Program -- An Eligible Employee and/or Eligible Dependent(s) may request enrollment outside of the Initial Enrollment Period and Annual Open Enrollment Period if the individual lose(s) coverage under a Children's Health Insurance Program [CHIP] or Medicaid

due to loss of eligibility for such coverage or becomes eligible for the optional State Premium Assistance Program. To apply for coverage, the Eligible Employee must complete the Enrollment Application and forward it to Capital Health Plan. The Eligible Employee must make application for enrollment within 60 days of the date such coverage was terminated or the date the Eligible Employee and/or Eligible Dependent(s) become eligible for the optional State Premium Assistance Program.

The Effective Date of coverage for an Eligible Employee and any other Dependent(s) who are enrolled as a result of a special enrollment event is the date of the special enrollment event. Eligible employees who do not enroll or change their coverage selection during the Special Enrollment period must wait until the next Annual Open Enrollment Period. (See the *Dependent Enrollment* subsection of the Member Handbook for the rules relating to the enrollment of Eligible Dependents of a Covered Employee.)

Note: Loss of coverage for failure to pay your portion of the required Premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

Other Requirements/Rules Regarding Enrollment

All of the following additional requirements must be met in order for an individual to be enrolled.

1. Capital Health Plan must be properly notified on a timely basis by the Employer Plan Sponsor of any changes in the Member's status (see the *Records* subsection). Additionally, the Employer Plan Sponsor shall immediately forward any enrollment form submitted by a Subscriber to Capital Health Plan.

2. Entitlement to Covered Services is subject to the timely receipt by Capital Health Plan from the Employer Plan Sponsor of the monthly Premium on behalf of Eligible Employees and their Dependents enrolled as Members of Capital Health Plan. Capital Health Plan is not obligated to provide any Covered Services to any individual for whom Capital Health Plan has not received such fees and charges in advance.

3. Subscribers are responsible for adding and deleting Dependents in accordance with Capital Health Plan’s requirements and on a timely basis. Subscribers must advise the Employer Plan Sponsor immediately in the event a Dependent no longer meets the eligibility requirements by submitting a Member Status Change Request form to the Employer Plan Sponsor. Capital Health Plan is not responsible for providing Covered Services for any individual who should not have been added or who should have been deleted. The Employer Plan Sponsor and the Subscriber are liable

to Capital Health Plan for any such Covered Services provided by Capital Health Plan.

SECTION 3: TERMINATION OF INDIVIDUAL MEMBERSHIP

Termination Forms/Terminating Coverage

To Terminate Membership, the covered Employee must:

1. Complete and submit, through his or her Employer Plan Sponsor, an accurate Member Status Change Form to Capital Health Plan within 30 days of the qualifying event;

2. Provide any additional information needed to determine ineligibility, if requested by Capital Health Plan;

3. Agree to pay his or her portion of the Premium, as required by Capital Health Plan, to honor coverage through the last date of enrollment as determined by Capital Health Plan.

Termination of Subscriber Membership

A Subscriber's Membership will automatically terminate at 12:01 a.m. on the last day of the month that:

1. the Employer Sponsored Plan terminates;

2. the Subscriber becomes covered under an alternative health benefits plan which is offered through or in connection with the Employer Plan Sponsor;

3. the Subscriber otherwise fails to continue to meet each of the eligibility requirements specified by Capital Health Plan or the Employer Plan Sponsor; or

4. the Subscriber's Membership is terminated for cause (see the *Termination of Individual Membership for Cause* subsection).

Termination of Dependent Membership

A Dependent's Membership will automatically terminate at 12:01 a.m. on the last day of the month that:

1. the Employer Sponsored Plan terminates;

2. his or her Subscriber's Membership terminates for any reason;

3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Employer Plan Sponsor;

4. the Dependent otherwise fails to continue to meet each of the eligibility requirements; or

5. the Dependent's Membership is terminated for cause (see the *Termination of Individual Membership for Cause* subsection).

Note: As further clarification for purposes of this subsection, a covered dependent child who has reached the end of the calendar year in which he or she becomes age 26, but who has not reached the end of the calendar year in which the covered dependent child becomes age 30, will lose coverage if the covered dependent child incurs any of the following:

a. Marriage;
b. No longer resides in Florida or is no longer a full-time or part-time student;
c. Obtains a dependent (e.g. through birth or adoption); or
d. Obtains other health coverage or becomes entitled to benefits under Title XVIII of the Social Security Act.

Termination of Individual Membership for Cause

1. If, in Capital Health Plan's opinion, any of the following events occur, Capital Health Plan may terminate an individual's Membership for cause:

    a. disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Member's continued Membership in Capital Health Plan impairs Capital Health Plan's ability to provide coverage and/or benefits or to arrange for the delivery of health care services to such member or to other Members. Prior to dis-enrolling a Member for any of the above reasons, Capital Health Plan will:

        i. make a reasonable effort to resolve the problem presented by the member, including the use or attempted use of Capital Health Plan’s Complaint and Grievance Process (refer to the Complaint and Grievance Process Section of this member Handbook); and

        ii. ascertain, to the extent possible, that the Member’s behavior is not related to the use of medical services or mental illness; and

iii. document the problems encountered, efforts made to resolve the problems, and any of the Member's medical conditions involved.

b. the knowing misrepresentation, omission, or the giving of false information on the Capital Health Plan Member Enrollment Application for Employer Sponsored Insurance/Membership, Member Status Change Request form, or other forms completed for Capital Health Plan, by or on behalf of the Member;

c. fraud, material misrepresentation, or omission in applying for Membership or in requesting the receipt of Covered Services;

d. misuse of the Membership Card;

e. no longer resides or works in the Service Area; or

f. a Dependent reaches the limiting age as specified in the *Eligibility for Membership*, and *Enrollment and Effective Date of Coverage* sections.

2. Any termination made under the provisions stated above is subject to review in accordance with the Complaint and Grievance Process described herein.

Notice of Member Termination

Notice by Capital Health Plan -- If an individual's Membership terminates for reasons other than the termination of the Employer Sponsored Plan, or for nonpayment of Premium, or as a result of termination of eligibility, Capital Health Plan shall notify such Member and the Employer Plan Sponsor, in writing, at the respective addresses on file with Capital Health Plan, at least 45 days prior to the date of termination. Such notice to Members who are Dependents may be made through such Dependent's Subscriber. This notice shall state the reason(s) and effective date of termination of Membership.

Responsibilities of Capital Health Plan Upon Termination of an Individual's Membership

Upon termination of an individual's Membership for any reason, Capital Health Plan shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Member Handbook.

SECTION 4: FINANCIAL OBLIGATIONS OF THE MEMBER

Copayments

Each Member is obligated to pay the Copayment amounts set forth in the Schedule of Copayments. The Subscriber shall also be responsible for the payment of all Copayments for Covered Services with respect to every individual enrolled as his or her Dependent. There is no Copayment for an enrolled newborn child or adopted newborn child in connection with the initial newborn well baby hospital nursery stay following birth. All such payment obligations are due and payable as they are incurred, and are paid directly to the health care provider.

Non-Covered Services

Members are responsible for the payment of charges for non-Covered Services and for the payment of charges in excess of any maximum benefit limitation set forth in the Schedule of Copayments.

Contributions

The Subscriber is responsible for any Premium contribution amount required by the Employer Plan Sponsor.

Maximum out-of-pocket

Total Copayments in any Calendar Year, excluding prescription drug Copayments, shall not exceed the amount indicated in the Schedule of Copayments, which in no event shall exceed twice the total annual Premium costs which a Subscriber (or, if there are Dependents, the Subscriber and his or her Dependents) would be required to pay if such individual(s) were enrolled under an option with no Copayments. Thereafter, Covered Services will be provided for that Member with no Copayment charge for the remainder of the Calendar Year. Subscribers enrolled with single coverage (no dependents) will have to meet the single out of pocket Copayment maximum before any subsequent Copayments will be waived for the remainder of that year. Members, including the Subscriber enrolled through a Subscriber contract that includes coverage for additional family members, will have to meet the family out of pocket Copayment maximum before any subsequent Copayments will be waived for the remainder of that year. The family out of pocket Copayment maximum can be met by any individual member on the dependent coverage/ family plan or by combining Copayments from each member enrolled on the dependent coverage/

family plan. It is the Member's responsibility to retain receipts and to notify and document to the satisfaction of Capital Health Plan when either of these Copayment limits has been reached.

SECTION 5: EXTENSION OF BENEFITS/CERTIFICATION OF CREDITABLE COVERAGE

Extension of Benefits
Florida Statute 641.3111

1. Every group health maintenance contract shall provide that termination of the contract shall be without prejudice to any continuous loss which commenced while the contract was in force, but any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member. Such extension of benefits may be limited to the occurrence of the earliest of the following events:

    a. The expiration of 12 months.
    b. Such time as the member is no longer totally disabled.
    c. A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.
    d. The maximum benefits payable under the contract have been paid.

2. For the purposes of this section, an individual is totally disabled if the individual has a condition resulting from an illness or injury which prevents an individual from engaging in any employment, training , or experience, and the individual is under the regular care of a physician.

3. In the case of maternity coverage, when not covered by the succeeding carrier, a reasonable extension of benefits in connection with maternity expenses for a pregnancy that commenced while the policy was in effect. The extension shall be for the period of that pregnancy and shall not be based upon total disability.

4. Except as provided in subsection (1), no subscriber is entitled to an extension of benefits if the termination of the contract by the health maintenance organization is based upon any event referred to in s. 641.3922(7)(a), (b), or (e).

Certification of Creditable Coverage

In the event Membership terminates for any reason, Capital Health Plan will issue a written Certification of Creditable Coverage to the Member.

The Certification of Creditable Coverage will indicate the period of time the Member was enrolled with Capital Health Plan. Creditable Coverage may reduce the length of any pre-existing condition exclusion period by the length of time the Member had prior Creditable Coverage.

Members may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if the Capital Health Plan coverage meets the qualifying creditable coverage guidelines (e.g., no more than a 63-day break in coverage).

SECTION 6: THE EFFECT OF MEDICARE COVERAGE/ MEDICARE SECONDARY PAYER PROVISIONS

When a Member becomes covered under Medicare and continues to be eligible and covered under the Employer Sponsored Plan, Capital Health Plan's coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, Capital Health Plan's coverage hereunder shall be secondary to any Medicare benefits. To the extent Capital Health Plan is primary payer, claims for Covered Services should be filed with Capital Health Plan first.

Under Medicare, the Employer Plan Sponsor MAY NOT offer, subsidize, procure or provide a Medicare supplement insurance policy to such individual. Also, the Employer Plan Sponsor MAY NOT induce such individual to decline or terminate his or her Employer Sponsored health coverage and elect Medicare as his or her primary payer.

Working Elderly

A Member who becomes 65, or who becomes eligible for Medicare due to End Stage Renal Disease (ESRD), or any other reason, should notify the Employer Plan Sponsor.

Individuals with End Stage Renal Disease

For a Member who is entitled to Medicare coverage because of ESRD, Capital Health Plan will provide Employer Sponsored health coverage on a primary basis for 30 months beginning with the earlier of:

1. the month in which the individual became entitled to Medicare Part A ESRD benefits; or

2. the first month in which the individual would have been entitled to Medicare Part A, ESRD benefits, if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if Employer Sponsored Plan coverage was primary prior to ESRD entitlement, then the Employer Sponsored Plan will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, Capital Health Plan will provide Employer Sponsored health coverage, as set forth herein, on a primary basis for 30 months.

Disabled Active Individuals

Capital Health Plan will provide primary coverage to Members if:

1. The Employer Plan Sponsor is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year; and

2. The Members are entitled to Medicare coverage because of disability (unless they have ESRD).

Primary coverage under the Employer Sponsored Plan is pursuant to the following terms:

1. For a Member, Capital Health Plan will provide Employer Sponsored health coverage, as set forth in the Employer Sponsored Plan, on a primary basis during any month in which that individual is entitled to Medicare coverage because of disability.

2. Individual entitlement to primary coverage under this subsection will terminate automatically when:

    a. The individual turns 65 years of age; or

    b. The individual no longer qualifies for Medicare coverage because of disability; or

    c. The individual elects Medicare as the primary payer. Coverage will terminate as of the last day of the month in which the individual made such election.

Under Medicare, the Employer Plan Sponsor MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her Employer Sponsored health coverage and elect Medicare as his or her primary payer.

3. Entitlement of the Member to primary coverage under this subsection will terminate automatically if the member no longer qualifies as such under applicable Medicare regulations and instructions. The Employer Plan Sponsor shall notify Capital Health Plan, without delay, of any such change in status.

Miscellaneous

1. This section shall be subject to, and modified if necessary to conform to, or comply with, and interpreted with reference to the requirements of Federal statutory

and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Employer Sponsored Plan.

2. Capital Health Plan shall not be liable to the Employer Plan Sponsor or to any individual covered under the Employer Sponsored Plan due to any nonpayment of primary benefits resulting from any failure of performance of the Employer Plan Sponsor's obligations as set forth in this handbook.

3. If Capital Health Plan should elect to make primary payments covering services rendered to a Member described in this section in a period prior to receipt of the information required by the terms of this section, Capital Health Plan may require the Employer Plan Sponsor to reimburse Capital Health Plan for such payments. Alternatively, Capital Health Plan may require the Employer Plan Sponsor to pay the rate differential that resulted from the Employer Plan Sponsor's failure to provide Capital Health Plan with the required information in a timely manner.

4. If the Employer Plan Sponsor offers Retiree Advantage coverage to its Retirees, once the Retiree is eligible for Medicare parts A & B, the Retiree must elect to convert to the Employer Plan Sponsors Retiree Advantage coverage or the Retiree will become ineligible for Capital Health Plan coverage under the Employer Plan Sponsor.

SECTION 7: CONTINUATION OF COVERAGE UNDER COBRA

Federal Continuation Provisions (Generally for employers with 20 or more employees. Please refer to State and Federal statutes for eligibility.)

Federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, also known as Section 4980B of the Internal Revenue Code of 1986, may apply to the Employer Plan Sponsor. If COBRA applies to the Employer Plan Sponsor, a Member may be entitled to continue his or her Employer Sponsored health coverage for a limited period of time. The Member must meet the applicable requirements, make a timely election, and pay the proper Premium.

A Member must contact the Employer Plan Sponsor to determine if he/she is entitled to COBRA continuation of coverage. The Employer Plan Sponsor is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Subscribers and Dependents of their rights under COBRA. If the Employer Plan Sponsor or the Member fails to meet its obligations under COBRA and the Employer Sponsored Plan, Capital Health Plan shall not be liable for any claims incurred by the Member after his/her termination of coverage.

Solely for the convenience of the Employer Plan Sponsor and Members, a summary of a Member's COBRA rights and the general conditions for a Member's qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Employer Plan Sponsor are met by establishing the Employer Sponsored Plan; the duty to meet such obligations remains solely with the Employer Plan Sponsor.

If COBRA applies to the Employer Plan Sponsor and the Member is eligible for such coverage, Members may elect to continue their Employer Sponsored health coverage if they qualify under one of the following circumstances:

1. If coverage would otherwise be lost due to the death of a Subscriber, the surviving Dependent(s) may qualify to elect to continue Employer Sponsored health coverage for a period of time not to exceed 36 months from the date coverage is lost due to the death.

2. A Dependent who would otherwise lose coverage due to a divorce or legal separation from a Subscriber, may qualify to elect to continue Employer Sponsored health coverage for a period of time not to exceed 36 months from the date coverage is lost due to divorce or legal separation.

3. A Dependent of a Subscriber who would otherwise lose coverage due to the Subscriber's entitlements to Medicare, may qualify to elect to continue Employer Sponsored health coverage for a period not to exceed 36 months from the date coverage is lost due to the Subscriber's first entitlement to Medicare.

4. Children who are Dependents of a Subscriber, who would otherwise lose coverage due to a failure to meet Capital Health Plan's eligibility requirements (e.g. exceeding the limiting age), may qualify to elect to continue Employer Sponsored health coverage for a period not to exceed 36 months from the date the child lost coverage because he/ she ceased to meet such eligibility requirements.

5. Subscribers and Dependents may qualify to elect to continue Employer Sponsored health coverage if coverage would otherwise be lost due to termination of employment with the Employer Plan Sponsor (other than for reasons of gross misconduct). This continuation of coverage may continue for a period not to exceed 18 months from the date coverage was lost due to the termination or reduction in hours.

   If the Member is totally disabled (as defined by the Social Security Administration) at the time of the Subscriber's termination, reduction in hours, or within the first 60 days of COBRA continuation of coverage, an extension of coverage of up to 11 additional months may be available (29 months total) if all notification and eligibility requirements have been met. Extension of coverage for 11 additional months will not be provided if the Member fails to provide the Employer Plan Sponsor with a copy of the "Determination of Disability" letter from the Social Security Administration within 60 days of the date of the determination of disability. The "Determination of Disability" letter must be provided to the Employer Plan Sponsor prior to the end of the 18-month COBRA continuation period. If the extension of coverage for 11 additional months is granted, the extension is also applicable to all non-disabled family members who were entitled to COBRA coverage during the 18 months of coverage.

6. If a Member is receiving continuation of coverage under paragraph 5 above, such coverage may continue for a period longer than the time stipulated in that paragraph if an event that would otherwise have entitled the Member to COBRA continuation of coverage (for example, divorce, legal separation, or death) later occurs. In no case will the Member receive coverage beyond 36 months from the event that originally made him or her eligible for coverage.

7. If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to the Employer Plan Sponsor, continuation rights shall be provided to the Member to the extent required under COBRA.

In order for the Employer Sponsored health coverage to continue pursuant to COBRA, the following conditions must be met:

1.a. If coverage would be lost due to a reduction in hours or termination of employment (for reasons other than gross misconduct), the Employer Plan Sponsor must notify the Subscriber and Dependents of their continuation of coverage rights under COBRA within 14 days of the loss of coverage due to the termination of

employment or reduction in hours causing a loss of coverage.

b. If coverage would be lost due to Medicare entitlement, divorce, legal separation, or the failure of a Dependent child to meet the eligibility requirements, the Subscriber or Dependent must notify the Employer Plan Sponsor, in writing, within 60 days of any of these events. The Employer Plan Sponsor must notify the Dependents of their continuation of coverage rights within 14 days of receipt of notice from the Subscriber or Dependent.

2. The qualified Member must elect to continue the Employer Sponsored health coverage within 60 days of the date that the coverage terminates or the date the notification of continuation of coverage rights is sent by the Employer Plan Sponsor, whichever is the later.

3. The qualified Member who elects continuation of coverage must not become covered under any other Employer Sponsored health coverage plan. However, COBRA coverage may continue if the new Employer Sponsored health coverage plan contains exclusions or limitations due to a pre-existing condition that would affect the continuant's coverage.

4. The qualified Member must not become entitled to Medicare after electing continuation of coverage.

5. A totally disabled Member who is eligible to extend and who elects to extend his or her continuation of coverage after 18 months may not continue such coverage more than 30 days after a determination by the Social Security Administration that the Member is no longer disabled. The Member must inform the Employer Plan Sponsor of the Social Security determination within 30 days of such determination.

6. The qualified Member electing continuation of coverage must meet all Premium payment requirements, and all other requirements, and all other eligibility requirements set forth in COBRA and, to the extent not inconsistent with COBRA, in this Member Handbook.

7. The Employer Plan Sponsor must continue to provide Employer Sponsored health coverage to its employees through Capital Health Plan unless the member no longer resides in the Capital Health Plan service area and the Employer Plan Sponsor offers alternate coverage through an alternate carrier for the area in which the member resides.

An election by an employee or spouse shall be deemed to be an election for any other qualified beneficiary related to that employee or spouse, unless otherwise specified in the election form.

The Member does not need to show insurability to receive COBRA continuation of coverage. However, the Member must pay the applicable Premium charged by the

Employer Plan Sponsor.

In the case of a qualified Member whose maximum period of continuation of coverage expires, the Employer Plan Sponsor must, during the 180-day period prior to such expiration date, provide the qualified Member the option of enrolling in a conversion health plan made available to the Members of the Employer Plan Sponsor by Capital Health Plan. Additionally, Capital Health Plan shall allow such Member to apply for a conversion policy during the 63-day period immediately following the date such Member's maximum period of continuation of coverage expires.

NOTE: This section shall not be interpreted to grant any Member any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Employer Sponsored Plan shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Employer Plan Sponsor.

SECTION 8: CONVERSION PRIVILEGE

An individual whose Membership has terminated may apply for conversion to non-group membership. Capital Health Plan and the Employer Plan Sponsor have no obligation to notify any such individual of the conversion privilege. **It is the sole responsibility of the Member to exercise this conversion privilege subject to the provisions set forth below**.

Eligibility Criteria for Conversion

A Member is entitled to apply for either a Conversion Option contract for non-group membership if:

1. The Member has been continuously covered under this Employer Sponsored Plan for 3 months;

2. The Member was covered for at least 3 months under any Employer Sponsored Plan providing similar benefits that this Employer Sponsored Plan immediately replaced;

3. The Member's coverage has been terminated for any reason, including discontinuance of this Employer Sponsored Plan in its entirety and termination of continued coverage under COBRA; and

4. The Member maintains his/her primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for health care services. **Capital Health Plan must receive the completed conversion application and the applicable Premium payment within the 63-day period beginning on the date coverage under this Employer Sponsored Plan terminated.**

In the event Capital Health Plan does not receive the conversion application and the initial Premium payment within such 63-day period, the Member's conversion application will be denied. Furthermore, the Member will not be entitled to a conversion policy.

Conversion is not available if termination occurred for any of the following reasons:

1. Failure to pay any required Premium unless such nonpayment was due to acts of an employer or person other than the individual;

2. Any Member contribution(s) required by Capital Health Plan are not paid by the member when due;

3. Replacement of coverage by similar group coverage within 31 days of termination;

4. Fraud or intentional misrepresentation in applying for Membership or for any Covered Services;

5. Termination for cause as set forth in the Termination of Individual Membership for Cause subsection;

6. The individual has left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or

7. The individual is eligible for, or covered under Medicare, Title XVIII of the Social Security Act of 1965

Additionally, conversion is not available:

1. If the individual is eligible for similar benefits, whether or not covered under any arrangement of coverage for individuals in a Employer Sponsored Plan, whether on a Member or non-Member basis;

2. If the individual is covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service insured contract or medical practice or other prepayment plan, or by any other plan or program;

3. If similar benefits are provided for or are available to the individual pursuant to or in accordance with the requirements of any State or Federal law (e.g. COBRA);

4. If the benefits provided or available to the individual, together with the benefits provided by Capital Health Plan, would result in excess of coverage, as determined by Capital Health Plan's standards;

Conversion Coverage

The conversion contract issued to each individual who converts to non-group membership shall include a level of benefits for "minimum services" which is similar to the level of benefits for the services included in this Member Handbook. For purposes of this section, the term "minimum services" shall mean services which include any of the following: emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services. Conversion coverage is not a continuation of the Employer Sponsored Plan. In addition, an alternative standard health

benefit conversion plan shall be offered. Benefits under such conversion coverage may differ from benefits under the Employer Sponsored Plan and any riders or endorsements attached thereto. Conversion coverage may continue in effect as long as each individual: (1) continues to meet all applicable eligibility requirements; (2) pays all applicable fees and charges; and (3) otherwise complies with all requirements under the conversion contract.

Effective Date of Conversion; Reimbursement

The effective date of conversion coverage shall be the day following the termination of Membership. However, until such time as coverage under the conversion contract becomes effective, the individual shall pay the Allowance for any services or supplies rendered during the 63-day period immediately following such termination of Membership. In the event such conversion coverage becomes effective, an individual may request reimbursement from Capital Health Plan for any payment for Covered Services, minus the Member's applicable copayments. The individual must submit proof of payment to Capital Health Plan in order to obtain reimbursement.

SECTION 9: DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided by Capital Health Plan. It is designed to avoid the costly duplication of payment for health care services and/or supplies. Capital Health Plan shall coordinate payment of Covered Services to the maximum extent allowed by law provided Members follow the Coverage Access Rules set forth in the Coverage Access Rules Section. Contracts which may be subject to Coordination of Benefits include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. Any Employer Plan Sponsored insurance, Employer Plan Sponsored-type self-insurance, or HMO plan;
2. Any Employer Plan Sponsored contract issued by a Blue Cross and/or Blue Shield Plan(s);
3. Any plan, program or insurance policy including an automobile insurance policy, provided that any such non- Employer Plan Sponsored policy contains a coordination of benefits provision;
4. Medicare, as described in the Effect of Medicare Coverage/Medicare Secondary Payer Provisions Section;
5. Any other insurance providing medical expense coverage.

The amount of payment by Capital Health Plan, if any, is based on whether or not Capital Health Plan is the primary payer. When Capital Health Plan is primary, Capital Health Plan will provide Covered Services without regard to the Member's coverage under other plans. When Capital Health Plan is other than primary, Covered Services may be reduced, so that total benefits under all such plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services. In the event the Covered Services were rendered by a Contracting Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount Capital Health Plan is obligated to pay such Contracting Provider pursuant to the applicable provider contract.

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. When Capital Health Plan covers the Member as a Dependent and the other plan covers the Member as other than a Dependent, Capital Health Plan will be secondary.

2. When Capital Health Plan covers a Dependent child whose parents are not separated or divorced:
    a. The plan of the parent whose birthday, excluding year of birth, falls earlier

in the year will be primary;
   b. If both parents have the same birthday, excluding the year of birth, and the other plan has covered one of the parents longer than Capital Health Plan, Capital Health Plan will be secondary.

3. When Capital Health Plan covers a Dependent child whose parents are separated or divorced:
   a. If the parent with custody is not remarried, the plan of the parent with custody is primary;
   b. If the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;
   c. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.

4. When Capital Health Plan covers the Member as a Dependent child and the other plan covers the Member as a Dependent child:
   a. The plan of the parent who is neither laid off nor retired will be primary;
   b. If the other plan is not subject to this rule, and if as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the Member the longest shall be primary.

Capital Health Plan will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare Supplement policy.

Subrogation

If a Member is injured or becomes ill as a result of another party's intentional act or negligence, the Member must notify Capital Health Plan concerning the circumstances under which the Member was injured. Under §768.76, *Florida Statutes* the Member or the Member's lawyer must notify Capital Health Plan, by certified or registered mail, if the Member intends to claim damages from someone for injuries or illness. If the Member recovers money to compensate for the cost/expense of health care services to treat the Member's illness or injury, Capital Health Plan is legally entitled to be reimbursed for payments made on the Member's behalf to the doctors, hospitals, or other providers who treated the Member. Capital Health Plan's legal right to be reimbursed in such cases is called "subrogation." Normally, Capital Health Plan may recover the amount of any payments it made on the Member's behalf, minus its pro rata share, for any costs and attorney fees incurred by the Member in pursuing and recovering damages.

Capital Health Plan may "subrogate" against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage.

Right to Receive and Release Necessary Information

In order to administer coverage and/or benefits, Capital Health Plan may, without the consent of or notice to any person, plan, or organization, release to or obtain from any person, plan, or organization any information with respect to any Member or applicant for enrollment which Capital Health Plan deems to be necessary.

Facility of Payment

Whenever payments which should have been made by Capital Health Plan are made by any other person, plan, or organization, Capital Health Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts Capital Health Plan shall determine to be required in order to satisfy its coverage obligations hereunder. Amounts so paid shall be deemed to be paid under the Employer Sponsored Plan and, to the extent of such payments, Capital Health Plan shall be fully discharged from liability.

Right of Recovery

Whenever Capital Health Plan has made payments in excess of the maximum provided, Capital Health Plan shall have the right to recover any such payments, to the extent of such excess, from any Member, person, plan, or other organization that received such payments.

Non-Duplication of Government Programs

The coverage and/or benefits provided by Capital Health Plan hereunder shall not duplicate any benefits to which Members are entitled, or for which they are eligible, under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Act, to the extent that such Member has been paid under any such programs. In the event Capital Health Plan has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to Capital Health Plan to the extent of such duplication.

Cooperation Required of Members

Each Member shall cooperate with Capital Health Plan, and shall execute and submit to Capital Health Plan such consents, releases, assignments, and other documents as may be requested by Capital Health Plan in order to administer and exercise its rights. Failure to do so shall constitute grounds for termination for cause by Capital Health Plan under the *Termination of Individual Membership* subsection.

SECTION 10: CLAIMS REVIEW

This section is intended to:

- help the Member understand what his or her treating providers must do, under the terms of this Certificate of Coverage, in order to obtain payment for expenses for Covered Services that have been rendered or will be rendered to the Member; and,

- provide the Member with a general description of the applicable procedures Capital Health Plan will use for making Adverse Benefit Determinations, Concurrent Care Decisions, and for notifying the Member when Capital Health Plan denies benefits.

If the Employer Sponsored Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the plan administrator is solely responsible for complying with ERISA. While the benefit determination timeliness standards set forth in this section are generally consistent with ERISA, Capital Health Plan is not legally responsible for notifying the Member of any rights he or she may have under ERISA. If the Member is not sure of his or her rights under ERISA, the Member should contact the plan administrator or an attorney of his or her choice. Capital Health Plan will follow the claim determination procedures and notice requirements set forth in this section even if the Employer Sponsored Plan is not subject to ERISA.

Under no circumstances will Capital Health Plan be held responsible for, nor will it accept liability relating to, the failure of the Employer Plan Sponsor or plan administrator to: (1) comply with ERISA's disclosure requirements; (2) provide the Member with a Summary Plan Description (SPD) as that term is defined by ERISA; or (3) comply with any other legal requirements. The Member should contact the plan sponsor or administrator if he or she has questions relating to the Employer Sponsored Plan's SPD. Capital Health Plan is not the Employer Plan Sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

For purposes of this Certificate of Coverage, there are three types of claims: (1) Pre-Service Claims; (2) Post-Service Claims; and (3) Claims Involving Urgent Care. It is important that Members become familiar with the types of claims that can be submitted to Capital Health Plan and the timeframes and other requirements that apply.

Definitions

The following terms, as used in this section, are defined as follows:

Adverse Benefit Determination means:

- a denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit;

- any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay or other health care service does not meet Capital Health Plan's requirements for medical necessity, appropriateness, health care setting, or level or care or effectiveness;

- based in whole or in part on medical judgment, including the failure to cover services because they are determined to be experimental, investigational, cosmetic, not medically necessary or inappropriate;

- a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required premiums or contributions toward cost of coverage.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to the Member with respect to which the application of time periods for making non-urgent care determinations: (1) could seriously jeopardize the Member's life or health or his or her ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Member's Condition, would subject the Member to severe pain that cannot be adequately managed without the proposed Services being rendered.

Concurrent Care Decision means a decision by Capital Health Plan with respect to an extension of an ongoing course of treatment over a period of time or number of treatments, if Capital Health Plan had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the *Case Management* subsection as described in the Coverage Access Rules section of this Certificate of Coverage.

Health Care Service(s) or Service(s) means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other services rendered or supplied, by or at the direction of Capital Health Plan contracted providers.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to the Member (not just proposed or recommended) that is received by Capital Health Plan in a format acceptable to Capital

Health Plan in accordance with the provisions of this section.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to the Member (in whole or in part). A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by Capital Health Plan regarding coverage, benefits, or payment for a Service that has not actually been rendered to the Member if the terms of this Certificate of Coverage do not require approval by Capital Health Plan of coverage or benefits (or condition payment) for the Service before it is received.

Post-Service Claims

How to File a Post-Service Claim

This section defines and describes the three types of claims that may be submitted to Capital Health Plan. Experience shows that the most common type of claim Capital Health Plan will receive from the Member, or his or her treating providers, will likely be Post-Service Claims.

Contracting Providers have agreed to file Post-Service Claims for Services rendered to the Member. If the Member receives a bill from a Contracting Provider, it should be forwarded to Capital Health Plan. If the Member requires Emergency Services and Care from a Non-Contracting Provider while inside or outside the Service Area, or if Capital Health Plan refers the Member to a Non-Contracting Provider, Capital Health Plan will pay for Covered Services provided to the Member. If the Member receives a bill from a Non-Contracting Provider for such Services, it should be forwarded to Capital Health Plan. Capital Health Plan relies on the information the Member provides when processing a claim.

Capital Health Plan must receive a Post-Service Claim within 90 days of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if Capital Health Plan does not receive it at the address indicated on the Membership Card within one year of the date the Service was rendered unless the Member is legally incapacitated.

For Post-Service Claims, Capital Health Plan must receive an itemized statement containing the following information:

- the date the Service was provided;
- a description of the Service including any applicable procedure code(s);
- the amount actually charged by the provider;
- the diagnosis including any applicable diagnosis code(s);
- the provider's name and address;
- the name of the individual who received the Service; and

- the Member's name and contract number as they appear on the Membership Card.

The Processing of Post-Service Claims

Capital Health Plan will use its best efforts to pay, contest, or deny all Post-Service Claims for which Capital Health Plan has all of the necessary information, as determined by Capital Health Plan. Post-Service Claims will be paid, contested, or denied within the timeframes described below:

1. **Payment for Post-Service Claims**

When payment is due under the terms of this Certificate of Coverage, Capital Health Plan will use its best efforts to pay (in whole or in part) electronically submitted Post-Service Claims within 20 days of receipt. Likewise, Capital Health Plan will use its best efforts to pay (in whole or in part) paper Post-Service Claims within 40 days of receipt. The Member may receive notice of payment for paper claims within 30 days of receipt. If Capital Health Plan is unable to determine whether the claim or a portion of the claim is payable because Capital Health Plan needs more or additional information, Capital Health Plan may contest or deny the claim within the timeframes set forth below.

2. **Contested Post-Service Claims**

In the event Capital Health Plan contests an electronically submitted Post-Service Claim, or a portion of such a claim, Capital Health Plan will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event Capital Health Plan contests a paper Post-Service Claim, or a portion of such a claim, Capital Health Plan will use its best efforts to provide notice, within 30 days of receipt that the claim, or a portion of the claim, is contested. The notice may identify: (1) the contested portion or portions of the claim; (2) the reason(s) for contesting the claim or a portion of the claim; and (3) the date that Capital Health Plan reasonably expects to notify the Member of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If Capital Health Plan requests additional information, Capital Health Plan must receive it within 45 days of the request for information. **If Capital Health Plan does not receive the requested information, the claim or a portion of the claim, will be adjudicated based on the information in Capital Health Plan's possession at the time and may be denied.** Upon receipt of the requested information, Capital Health Plan will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

3. **Denial of Post-Service Claims**

In the event Capital Health Plan denies a Post-Service Claim submitted electronically, Capital Health Plan will use its best efforts to provide notice, within 20 days of receipt that the claim, or a portion of the claim, is denied. In the event Capital Health Plan denies a paper Post-Service Claim, Capital Health Plan will use its best efforts to provide notice, within 30 days of receipt of the claim, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Member's responsibility to ensure that Capital Health Plan receives all information that Capital Health Plan determines is necessary to adjudicate a Post-Service Claim. **If Capital Health Plan does not receive the necessary information, the claim or a portion of the claim may be denied.**

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the *Adverse Benefit Determination* standards in this section, and the appeal procedures described in the *Complaint and Grievance Process* section.

4. **Additional Processing Information for Post Service Claims**

In any event, Capital Health Plan will use its best efforts to pay or deny all (1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and (2) paper Post-Service Claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by Capital Health Plan or otherwise electronically transmitted. Any claims payment relating to a Post-Service claim that is not made by Capital Health Plan within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

Pre-Service Claims

How to file a Pre-Service Claim

This Certificate of Coverage may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by Capital Health Plan of a Pre-Service Claim as that term is defined herein. In order to determine whether Capital Health Plan must receive a Pre-Service Claim for a particular Covered Service, please refer to the *Coverage Access Rules* section, the *Covered Services* section and other applicable sections of this Certificate of Coverage. The Member may also call the Member Services number on the Membership Card for assistance.

Capital Health Plan is not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to the Member unless the terms of this Certificate of Coverage require approval by Capital Health Plan (or condition payment) for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, Capital Health Plan will use its best efforts to provide notice of the determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, Capital Health Plan will use its best efforts to provide notice within 24 hours of: (1) the need for additional information; (2) the specific information that the Member or the provider may need to provide; and (3) the date that Capital Health Plan reasonably expects to provide notice of the decision. If Capital Health Plan requests additional information, Capital Health Plan must receive it within 48 hours of the request. Capital Health Plan will use its best efforts to provide notice of the decision on the Pre-Service Claim within 48 hours after the earlier of: (1) receipt of the requested information; or (2) the end of the period the Member was afforded to provide the specified additional information as described above.

Benefit Determinations on Pre-Service Claims that Do Not Involve Urgent Care

Capital Health Plan will use its best efforts to provide notice of a decision of a Pre-Service Claim not involving urgent care within 15 days of receipt, provided additional information is not required for a coverage decision. This 15-day determination period may be extended by Capital Health Plan one time for up to an additional 15 days. If such an extension is necessary, Capital Health Plan will use its best efforts to provide notice of the extension and reasons for it. Capital Health Plan will use its best efforts to provide notification of the decision on the Member's Pre-Service Claim within a total of 30 days of the initial receipt of the claim if an extension of time was taken by Capital Health Plan.

If additional information is necessary to make a determination, Capital Health Plan will use its best efforts to: (1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; (2) identify the specific information that the Member or the provider may need to provide; and (3) inform the Member of the date that Capital Health Plan reasonably expects to notify him or her of the decision. If Capital Health Plan requests additional information, Capital Health Plan must receive it within 45 days of the request for the information. Capital Health Plan will use its best efforts to provide notice of the decision on the Pre-Service Claim within 15 days of receipt of the requested information. A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the *Adverse Benefit Determination* standards in this section, and the appeal procedures described in the *Complaint and Grievance Process* section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

A reduction or termination of coverage or benefits for Services will be considered an

Adverse Benefit Determination when:

- Capital Health Plan has approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and

- the reduction of termination occurs before the end of such previously approved time or number of Service(s); and

- the reduction or termination of coverage or benefits by Capital Health Plan was not due to an amendment to the Certificate of Coverage or termination of the Member's coverage as provided by this Certificate of Coverage.

Capital Health Plan will use its best efforts to notify the Member of such reduction or termination in advance so that he or she will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Complaint and Grievance Process described in this Certificate of Coverage. In no event shall Capital Health Plan be required to provide more than a reasonable period of time within which the Member may develop his or her appeal before Capital Health Plan actually terminates or reduces coverage for the Services.

Requests for Extension of Services

The Member's provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, Capital Health Plan will use its best efforts to notify the Member of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number of visits or length of coverage for such Services. Capital Health Plan will use its best efforts to notify the Member within 24 hours if: (1) Capital Health Plan needs additional information; or (2) the Member, or the Member's representative failed to follow proper procedures in the request for an extension. If Capital Health Plan requests additional information, the Member will have 48 hours to provide the requested information. Capital Health Plan may notify the Member orally or in writing, unless the Member or the Member's representative specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Certificate of Coverage.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

Capital Health Plan will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include

(or will be made available to the Member free of charge upon request):

- the specific reason or reasons for the Adverse Benefit Determination;
- a reference to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and,
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Member how to obtain the specific explanation of the scientific or clinical judgment for the determination.

Capital Health Plan will determine whether the Member seeking to file an Appeal is entitled to receive notices in an appropriate non-English language. In the event the Member is so entitled, Capital Health Plan shall provide all notices to the Member in the appropriate non-English language if the Member has made a request to Capital Health Plan. If the Member has not already made such a request, Capital Health Plan must provide all notices to the Member in the appropriate non-English language only upon the request of the Member or the Member's authorized representative.

If the claim is a Claim Involving Urgent Care, Capital Health Plan may notify the Member orally within the proper timeframes, provided Capital Health Plan follows up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims, Capital Health Plan may need certain information, including information regarding other health care coverage the Member may have. The Member must cooperate with Capital Health Plan in its effort to obtain such information by, among other ways, signing any release of information form at Capital Health Plan's request. Failure by the Member to fully cooperate with Capital Health Plan may result in a denial of the pending claim and Capital Health Plan will have no liability for such claim.

Physical Examination

In order to make coverage and benefit decisions, Capital Health Plan may, at its expense, require the Member to be examined by a health care provider of Capital Health Plan's choice as often as is reasonably necessary while a claim is pending. Failure by the Member to fully cooperate with such examination shall result in a denial of the pending claim and Capital Health Plan shall have no liability for such claim.

Legal Actions

No legal action arising out of or in connection with coverage under this Certificate of Coverage may be brought against Capital Health Plan within the 60-day period following Capital Health Plan's receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

Fraud, Misrepresentation or Omission in Applying for Benefits

Capital Health Plan relies on the information provided on the itemized statement when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy Capital Health Plan may have, in denial of the claim or cancellation or rescission of the Member's coverage.

Communication of Claims Decisions

All claims decisions, including denial and claims review decisions, will be communicated to you.

Explanation of Payments will be posted through the Member's Portal of Capital Health Plan Connect for all Claims Payments. Should you not have access to the Member's Portal of Capital Health Plan Connect, a written explanation of Payment can be obtained by contacting our Member Services Department at 850-383-3311 or you may request in writing at:

Capital Health Plan, Inc.
PO Box 15349
Tallahassee, Fl. 32317-5349

Claim denial and claims review decisions will be communicated to you in writing. This written correspondence may indicate:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline,

protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

- A description of any additional information that would change the initial determination and why that information is necessary;
- A description of the applicable Adverse Benefit Determination review procedures and time limits applicable to such procedures; and
- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Member how they can obtain the specific explanation of the scientific or clinical judgment for the determination.

Capital Health Plan will determine whether the Member seeking to file an Appeal is entitled to receive notices in an appropriate non-English language. In the event the Member is so entitled, Capital Health Plan shall provide all notices to the Member in the appropriate non-English language if the Member has made a request to Capital Health Plan. If the Member has not already made such a request, Capital Health Plan must provide all notices to the Member in the appropriate non-English language only upon the request of the Member or the Member's authorized representative.

Circumstances Beyond the Control of Capital Health Plan

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of Capital Health Plan, results in facilities, personnel, or financial resources of Capital Health Plan being unable to process claims for Covered Services, Capital Health Plan will have no liability or obligation for any delay in the payment of claims for Covered Services, except that Capital Health Plan will make a good faith effort to make payment for such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of Capital Health Plan if Capital Health Plan cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

SECTION 11: COVERAGE ACCESS RULES

It is important that Members become familiar with the rules for accessing health care coverage through Capital Health Plan. The following sections explain the roles of Capital Health Plan and the Primary Care Physician (PCP), how to access specialty care coverage through Capital Health Plan and the Primary Care Physician, and what to do if Emergency Services and Care is needed. It is also important for the Member to review all Service Area-specific Coverage Access Rules for particular types of services and Contracting Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the Directory of Physicians & Service Providers and may vary based on negotiated provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician

The first and most important decision each Member must make when joining a health maintenance organization is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of Specialists, are obtained. The Member is free to choose any Primary Care Physician listed in Capital Health Plan's published list of Primary Care Physicians whose practice is open to additional Members. This choice should be made when the Member enrolls. The Subscriber is responsible for choosing a Primary Care Physician for all minor Dependents including a newborn child or an adopted newborn child. Some important rules apply to the Member's Primary Care Physician relationship:

1. The Primary Care Physician selected by the Member will maintain a Physician-patient relationship with the Member, and will be, except as specified by the Coverage Access Rules set forth in the Directory of Physicians & Service Providers, if any, responsible for providing, authorizing, and coordinating all medical services for the Member.

2. Except as specified in the Coverage Access Rules set forth in the Directory of Physicians & Service Providers, if any, the Member must look to the Primary Care Physician to provide or coordinate his/her care.

3. Except for Emergency Services and Care, all services must be received from the Member's Primary Care Physician, from Contracting Providers on referral from, or authorization of, the Primary Care Physician, or through another health care provider designated by the Member's Primary Care Physician or Capital Health Plan. See the *Access to Other Contracting Providers* subsection of this section for exceptions to this rule.

4. Capital Health Plan wants the Member and the Primary Care Physician to have a good relationship. To be certain this relationship is conducive to effective health care, both the Member and the Primary Care Physician may request a change in the Primary Care Physician assignment:

   a. The Member may request a transfer to another Primary Care Physician whose practice is open to enrollment of additional Members. The transfer of care to the newly selected Primary Care Physician shall be effective the first day of the following calendar month.

   b. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with the Member. In such a circumstance, the Primary Care Physician may request that Capital Health Plan assist the Member in the selection of another Primary Care Physician.

5. If the Primary Care Physician selected by the Member terminates his or her contract with Capital Health Plan, is unable to perform his or her duties, or is on a leave of absence, Capital Health Plan may assist the Member in selecting, or Capital Health Plan may assign, another Primary Care Physician to the Member.

Referrals and Authorizations

It is important to understand the difference between a referral and an authorization, and how to obtain each one.

Referral is the process of sending a patient to another practitioner (ex. specialist) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Your primary care physician will refer you to a participating specialist or a health care service provider if he or she cannot personally provide the care you need. Many referrals do not require an authorization number.

Authorization, also known as precertification, is a process of reviewing certain medical, surgical or behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered. The review also includes a determination of whether the service being requested is a covered benefit under your benefit plan. Authorizations are only required for certain services. Your physician will submit authorization/precertification requests electronically, by telephone, or in writing by fax or mail. If approved, an authorization number is then generated by Capital Health Plan and is available to you via CHP*Connect.* If the requested service is not authorized, the member and provider are notified in writing with the specific reasons for the denial.

Refer to Capital Health Plan's web site, www.capitalhealth.com, or contact Member Services, for the list of services requiring an authorization.

Specialist Care

Except as specified in the Coverage Access Rules set forth in this handbook, if any, the Primary Care Physician selected by the Member is responsible for referring the Member to Specialists when Medically Necessary, using the referral procedure authorized by Capital Health Plan. The referral will identify a course of treatment or specify the number of recommended visits for the diagnosis or treatment of the Member's Condition. Once the referral has been obtained by the Member, the Member may make an appointment with the Specialist.

When additional services are suggested by the Specialist, Members should consult with their Primary Care Physician to coordinate any necessary authorizations that may be required.

The Member's Primary Care Physician may consult with Capital Health Plan and with the Specialist regarding coverage or benefits, in order to coordinate the Member's care. This procedure provides the Member with continuity of treatment by the Physician who is most familiar with the Member's medical history and who understands the Member's total health profile.

The Primary Care Physician may refer the Member to a Non-Contracting Provider, but payment for such services will only be made if coverage is authorized by Capital Health Plan. An agreed-upon treatment plan will then be implemented.

Emergency Services and Care

If necessary, the Member should seek Emergency Services and Care and then contact his/her Primary Care Physician as soon as possible. Prior authorization is not required for Emergency Services and Care. It is the Member's responsibility to notify Capital Health Plan as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. **Follow-up care must be received, prescribed, directed, or authorized by the Member's Primary Care Physician.** If the follow-up care is provided by a physician other than the Member's Primary Care Physician, coverage may be denied. If a determination is made that an Emergency Medical Condition does not exist, payment for other than Emergency Services and Care will be the responsibility of the Member.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges or the charge mutually agreed to by Capital Health Plan and the provider within 60 days of the submittal of the claim for such Emergency

Services and Care. It is the responsibility of the Member to furnish Capital Health Plan written proof of loss in accordance with the Claim Processing Section.

Non-emergency services rendered outside of the Service Area must be authorized in advance by Capital Health Plan in order to be Covered Services.

Verifying Provider Participation

The Member is responsible for verifying the participation status of the Physician, Hospital, or other provider prior to receiving the health care service. To determine if a particular health care provider is in the Capital Health Plan provider network, review the most recent Directory of Physicians & Service Providers listing those Primary Care Physicians and Contracting Providers under the Employer Sponsored Plan and verify a specific health care provider's participation status by contacting the local Capital Health Plan office. Coverage may be denied for non-compliance with Capital Health Plan procedures if the Member fails to verify participation status or show the Membership Card at the time services are rendered.

Case Management

Capital Health Plan reserves the right (but, in no event shall it be required) to offer its case management program to its Members. If the Member and the Member's Physician agree, Capital Health Plan may use its case management program policies and procedures then in effect. Capital Health Plan's use of case management program policies and/or procedures with respect to any Member shall not restrict or otherwise modify Capital Health Plan's right to administer coverage and/or benefits in strict accordance with the terms of this Member Handbook with respect to said Member, or with respect to any other Member or other individual under any other policy or contract. Further, when the cost of providing alternative or equivalent services varies, depending upon whether or not a particular provider or supplier is used to provide such service, Capital Health Plan may (but shall not be required to) take such variations into consideration when authorizing or approving payment, coverage, or benefits for such services under the case management program.

Access to Osteopathic Hospitals

At the option of the Member, inpatient and outpatient services, similar to inpatient and outpatient services by allopathic hospitals, may be obtained from a Hospital accredited by the American Osteopathic Association when such services are available in the Service Area and when such Hospital has entered into a written agreement with Capital Health

Plan with regard to such services. The Hospital providing such services may not charge rates that exceed the Hospital's usual and customary rates less the average discount that Capital Health Plan has with allopathic Hospitals within the Service Area. It is the Member's responsibility to contact Capital Health Plan to obtain the documents necessary to comply with this provision.

Access to Other Contracting Providers

Chiropractors and Podiatrists: Upon request by a Member, a Doctor of Chiropractic or a Doctor of Podiatry who is a Contracting Provider shall be assigned to the Member for the purpose of providing covered chiropractic services and covered podiatric services, respectively. Members shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need of referrals from the Primary Care Physician who is licensed as a Doctor of Medicine or Doctor of Osteopathy.

Dermatologists: Members have access to dermatologists who are Contracting Providers without an authorization or referral from the Member's Primary Care Physician.

Obstetricians and Gynecologists: Members have access to obstetricians/ gynecologists who are Contracting Providers for routine care without authorization or referral from the Member's Primary Care Physician. Medically necessary follow-up care requires that the Obstetrician/Gynecologist coordinate care through the Member's Primary Care Physician.

Physician Assistant: Members have access to surgical assistant services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other services covered hereunder may be rendered by licensed physician assistants, nurse practitioners, or other individuals who are not Physicians.

Certified Registered Nurse Anesthetist: Members have access to anesthesia services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if the Member requests such services, provided such services are available, as determined by Capital Health Plan, and are Covered Services under the Employer Sponsored Plan.

Continuity of Coverage and Care upon Termination of a Provider's Contract

If the member is actively receiving treatment for a Condition when our agreement with a Contracting Provider (including a PCP) is terminated without cause, the member may continue to be covered (for treatment of that Condition) after the date of the Contracting Provider's termination. Coverage for that Condition will continue only until:

1. the completion of treatment for the Condition;
2. the member selects another Contracting Provider; or

3. the next Open Enrollment Period.

We are not required to provide coverage under this provision for longer than six months after termination of our agreement with the provider. If a shorter period of coverage is permitted under applicable Florida law, we are not required to provide coverage beyond that period.

We will continue to provide maternity benefits under the Employer Sponsored Plan's Master Policy, regardless of the trimester in which care was initiated, until completion of postpartum care for a pregnant Member who has initiated a course of prenatal care prior to the termination of the Contracting Provider's contract.

We are not required to cover or pay for any Services under this subsection for an individual whose coverage under this Employer Sponsored Plan's Master Policy is not in effect at the time that Services are rendered. Further, this subsection does not apply if the Contracting Provider is terminated "for cause."

Services Not Available from Contracting Providers

Except as provided in the Covered Services sections, if a Covered Service is unavailable through Contracting Providers, the Medical Director will authorize coverage for such services to be rendered by a Non-Contracting Provider. Covered Services provided by a Non-Contracting Provider under this provision must be authorized by the Medical Director.

BLUECARD® Program

Introduction

Members who are traveling outside of Capital Health Plan's service area may obtain Emergency Care Services from a provider participating with an on-site Blue Cross and/or Blue Shield Plan ("Host Blue"), where available.

Emergency Care Services: If you experience a Medical Emergency while traveling outside Capital Health Plan's service area, go to the nearest urgent care center or Emergency facility. If the provider is contracting with a Host Blue, the provider will automatically file a claim for the services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copay Amount for Emergency Care Services, as stated in your Schedule of Copayments.

Please Note: Services that are not Emergency Care Services are not covered through the BlueCard® Program. Such services must be provided or authorized by your Primary Care Physician. Follow-up care (suture removal, changing casts, etc.) is not considered Emergency Care Services. Urgent Care Services, Follow-up Care, and any other services that Capital Health Plan offers must be provided or authorized by your Primary Care Physician.

When amounts are paid or payable by Capital Health Plan, Inc. (Capital Health Plan) under this Certificate to a provider outside the State of Florida who is not in Capital Health Plan's network, payment to the out-of-state provider may be determined based on the provider arrangements, if any, that the Blue Cross and/or Blue Shield Plan has with the provider in the area where services are provided. In those instances the Blue Cross and/or Blue Shield Plan in that area is called a "Host Blue." Capital Health Plan will coordinate with the appropriate Host Blue when payment and financial responsibilities are to be so handled. This is done by use of a special national program of the Blue Cross and Blue Shield Association called the BlueCard® Program.

Program

When the Member obtains Covered Services through the BlueCard® Program outside of the State of Florida, the terms and conditions of the Member Handbook will still apply. Capital Health Plan will reimburse the Host Blue for Covered Services calculated on the lower of:

- the billed charges for the Member's Covered Services; or
- the negotiated price that the on-site Host Blue passes on to us, Capital Health Plan.

The amount of reimbursement to the Host Blue does not include any amount the Member is required to pay under the Member Handbook.

Often the negotiated price will consist of a simple discount that reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Member's health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the Member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than the estimated price. The negotiated price will also be prospectively adjusted in the future to correct for over- or underestimation of past prices. However, the amount the Member pays for Covered Services is considered a final payment. For information on the BlueCard® participation status of providers, call the BlueCard® access number on the Membership Card when listed or call the Member Services number on the Membership Card for further assistance.

Under the BlueCard® Program, the Member's financial responsibility may include:

1. The payment of any applicable Copayment requirements;
2. The payment of expenses that are limited, excluded, or not covered;
3. The payment of any expenses in excess of any benefit maximum limitations; and
4. The payment of any expenses for services where coverage authorization from Capital Health Plan was required and not obtained.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard® Program method noted above or require a surcharge, Capital Health Plan would then calculate the Member's liability for any Covered Services in accordance with the applicable state statute in effect at the time the Member received his or her care.

Contracting Provider Financial Incentive Disclosure

Health care decisions are the shared responsibility of Members, their families, and health care providers. A health care provider's decisions regarding medical care may have a financial impact on the Member and/or the provider. For example a provider in his/her provider contract with Capital Health Plan may agree to accept financial responsibility for medical expenses of Members. Consequently, Capital Health Plan encourages Members to discuss with their providers how, and to what extent, the acceptance of financial risk by the provider may affect the provider's medical care decisions.

SECTION 12: RELATIONSHIPS BETWEEN THE PARTIES

Capital Health Plan and Health Care Providers

Capital Health Plan does not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care provider. Any decisions made by Capital Health Plan concerning appropriateness of setting, or whether any service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether Covered Services are due, and not for purposes of recommending any treatment or non-treatment. Neither Capital Health Plan nor the Employer Plan Sponsor will assume liability for any loss or damage arising as a result of acts or omissions of any health care provider.

Members and Contracting Providers

The relationship between Members and Contracting Providers shall be that of a health care provider-patient relationship, in accordance with any applicable professional and ethical standards.

Capital Health Plan and the Employer Plan Sponsor

Neither the Employer Plan Sponsor, nor any Member, is the agent or representative of Capital Health Plan and neither shall be liable for any acts or omissions of Capital Health Plan, its agents, servants, or employees. Additionally, neither the Employer Plan Sponsor, any Member, nor Capital Health Plan shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which Capital Health Plan has made, or hereafter makes, arrangements for the provision of Covered Services. Capital Health Plan is not the agent, servant, or representative of the Employer Plan Sponsor or any Member, and shall not be liable for any acts or omissions of the Employer Plan Sponsor, its agents, servants, employees, any Member, or any person or organization with which the Employer Plan Sponsor has entered into any agreement or arrangement. By acceptance of Covered Services hereunder, each Member agrees to the foregoing.

Medical Decisions--Responsibility of Member's Physician, Not Capital Health Plan

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services or supplies, must be made solely

by the Member, the Member's family and the Member's treating Physician in accordance with the patient/physician relationship. It is possible that the Member or the Member's treating Physician may conclude that a particular procedure or service is needed, appropriate, or desirable, even though such procedure or service may not be covered by Capital Health Plan.

SECTION 13: GENERAL MEMBER HANDBOOK PROVISIONS

Access to Information

Capital Health Plan shall have the right to receive, from any health care provider rendering services to a Member, information that is reasonably necessary, as determined by Capital Health Plan, in order to administer the coverage and/or benefits it provides, subject to all applicable confidentiality requirements set forth below. By accepting Membership, each Member authorizes every health care provider who renders services or furnishes supplies to such Member, to disclose to Capital Health Plan or to entities affiliated with Capital Health Plan, upon request, all facts, records, and reports pertaining to such Member's care, treatment, and physical or mental Condition, and to permit Capital Health Plan to copy any such records and reports so obtained.

Amendment

This Agreement may be amended at the time of annual coverage renewal so long as such modification is consistent with the laws of this State, approved by the Department of Financial Services, Office of Insurance Regulation and effective on a uniform basis among all Employer Plan Sponsors with this Agreement. In the event the amendment is unacceptable to the Employer Plan Sponsor, the Employer Plan Sponsor may terminate this Agreement upon at least ten days prior written notice to Capital Health Plan. Any such amendment shall be without prejudice to claims filed with Capital Health Plan prior to the date of such amendment. No agent or other person, except a duly authorized officer of Capital Health Plan, has the authority to modify this Agreement, or to bind Capital Health Plan in any manner not expressly set forth in this Agreement in any way, including but not limited to the making of any promise or representation, or by giving or receiving any information. This Agreement may not be amended by the Employer Plan Sponsor unless such amendment is evidenced in writing and signed by a duly authorized representative of the Employer Plan Sponsor and a duly authorized officer of Capital Health Plan. The Employer Plan Sponsor shall immediately notify each Subscriber of any such amendment.

Assignment and Delegation

The obligations arising hereunder may not be assigned, delegated, or otherwise transferred by either party without the written consent of the other party; provided, however, that Capital Health Plan may assign its coverage and/or benefit obligations to its successor in interest or an affiliated entity without the consent of the Employer Plan Sponsor at any time. **Any assignment, delegation, or transfer made in violation of this provision**

shall be void.

Attorney Fees: Enforcement Costs

Unless otherwise agreed to in writing, if any legal action or other proceeding is brought under the Employer Sponsored Plan to enforce the terms of coverage and/or benefits provided, or to be provided, by Capital Health Plan, or because of an alleged dispute concerning, or breach of such terms, the successful or prevailing party or parties shall be entitled to recover reasonable attorney's fees, court costs, and other reasonable expenses incurred in connection with maintaining or defending such action or proceeding. Such entitlement to recover shall include attorney's fees, costs, or expenses incurred in connection with any appeal. These recoveries are in addition to any other relief to which such party or parties may be entitled.

Changes in Premium

Capital Health Plan may modify the Premium, without the consent of the Subscriber or any Member, upon at least 30 days prior notice to the Employer Plan Sponsor.

Complaint and Grievance Process

Capital Health Plan has established and will maintain a process for hearing and resolving grievances raised by Members. Members are required to first bring grievances to the attention of a Member Service Representative or to Capital Health Plan Grievance Manager, at Capital Health Plan Office's. Details regarding the grievance resolution process are provided in the Capital Health Plan Complaint and Grievance Process Section.

If any Member or former Member files any action or complaint regarding services received by the Member (including, without limitation, the filing of a lawsuit, administrative action, or grievance) against Capital Health Plan or a Contracting Provider, Capital Health Plan shall have the right to receive from any health care provider rendering services to the Member or former Member information and records reasonably necessary to investigate the allegations in such action or complaint. This right includes, without limitation, authorization by the Member or former Member for Capital Health Plan, or its legal representatives, to discuss the Member's or former Member's Condition with, and receive all relevant reports and records from, Contracting Providers and Non-Contracting Providers who provided services to, or consulted with, the Member or former Member as a result of injuries alleged in any action or complaint, even if such services or consultations are provided subsequent to termination of Membership. The authorization

set forth in this section survives the termination of coverage by Capital Health Plan.

Compliance with State and Federal Laws and Regulations

The terms of coverage and/or benefits to be provided by Capital Health Plan under the Employer Sponsored Plan shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of a Member, the Employer Plan Sponsor, or Capital Health Plan.

Confidentiality

Except as otherwise specifically provided herein the Employer Sponsored Plan, and except as may be required in order for Capital Health Plan to administer coverage and/or benefits under the Employer Sponsored Plan, specific medical information concerning Members received by Contracting Providers shall be kept confidential by Capital Health Plan. Such information shall not be disclosed to third parties without the written consent of the Member involved, except for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and/or benefits under the Employer Sponsored Plan, specifically including Capital Health Plan's quality assurance and utilization review activities. Additionally, Capital Health Plan may disclose such information to entities affiliated with Capital Health Plan. However, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

Capital Health Plan's financial arrangements with Contracting Providers may require that Capital Health Plan release certain claims and medical information about Members even if the Member has not sought treatment by or through that provider. By accepting Membership, each Member hereby authorizes Capital Health Plan to release to its Contracting Providers claims information, including related medical information, pertaining to the Member, in order for the Contracting Providers to evaluate financial responsibility under their contracts with Capital Health Plan.

Evidence of Coverage

Each Subscriber will be provided with a Member Handbook and a Membership Card for enrolled Members.

Governing Law

The terms of coverage and/or benefits to be provided by Capital Health Plan under the Employer Sponsored Plan and the rights of the parties hereunder shall be construed in accordance with the laws of the State of Florida and/or the United States, when applicable.

Membership Cards

The Membership Cards issued to Members in no way create, or serve to verify, eligibility to receive coverage and/or benefits hereunder.

Modification of Provider Network

The Capital Health Plan provider network is subject to change at any time without prior notice to, or approval of, the Employer Plan Sponsor or any Member. Additionally, Capital Health Plan may, at any time, terminate or modify the terms of any provider contract and may enter into additional provider contracts without prior notice to, or approval of, the Employer Plan Sponsor or any Member.

Non-Waiver of Defaults

Any failure by Capital Health Plan at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect the right of Capital Health Plan at any time to enforce or avail itself of any such remedies as it may be entitled to under applicable law.

Notices

Any notice required or permitted hereunder 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.

If to Capital Health Plan:

To the address printed on the Employer Plan Sponsor's Application and/or the Membership Card.

If to Member:

To the latest address provided by the Member or to the Subscriber's latest address on the Capital Health Plan Member Enrollment Application for Employer Sponsored Insurance/Membership or Member Status Change Form actually delivered to Capital Health Plan.

If to Employer Plan Sponsor:

To the address indicated on the Employer Plan Sponsor's Application.

Obligations of Capital Health Plan Upon Termination

Upon termination of an individual's Membership for any reason, Capital Health Plan shall have no further liability or responsibility under the Employer Sponsored Plan with respect to such individual, except as specifically set forth herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Member Handbook.

SECTION 14: COVERED SERVICES INTRODUCTION

The sections that follow describe the Covered Services for which expenses are covered. It is very important that these sections be reviewed with the Exclusions and Limitations Section and other provisions. Important information is also contained in the Schedule of Copayments. The level of coverage and/or benefits for certain Covered Services depends on whether the Member has followed the Coverage Access Rules. (See the Coverage Access Rules Section.) Coverage hereunder is not limited for Pre-existing Conditions. **ALL OF THE PROVISIONS OF THIS MEMBER HANDBOOK SHOULD BE READ CAREFULLY TO UNDERSTAND THE COVERAGE AND/OR BENEFITS PROVIDED.**

Covered Services

Expenses for the health care services listed below will be covered under the Employer Sponsored Plan only if the services are:

1. within the service categories set forth in the Covered Services sections;

2. medically necessary;

3. rendered while coverage is in force;

4. not specifically limited or excluded; and

5. received in accordance with the Coverage Access Rules.

The applicable Copayments for which the Member is responsible for each category of Covered Services are set forth in the Schedule of Copayments.

Medical Necessity

Except for any preventive care benefits specifically described in the Covered Services sections, Capital Health Plan does not cover or provide benefits for any service which is otherwise covered if, in the opinion of Capital Health Plan, such service is not Medically Necessary, as defined in the Glossary Section. Capital Health Plan will make Medical Necessity decisions for coverage and payment purposes only. In some instances, these decisions are made by Capital Health Plan after the Member has been hospitalized or has received other health care services and after a claim for payment has been submitted.

Capital Health Plan's Medical Necessity decisions under this Member Handbook are solely for the purpose of coverage or payment. In this respect, Capital Health Plan may review medical facts in making a coverage or payment decision, however, any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services, must be made solely by the Member and the Member's treating Physicians. It is possible that a Member or the Member's treating Physician may conclude that a particular service is beneficial, appropriate, or desirable even though expenses for such service may be denied as not being Medically Necessary.

Continuing Care Facility/Resident Facility Resident Member Rights

If the Member is a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the Member's PCP must refer the Member to that facility's skilled nursing unit or assisted living facility if:

1. requested by the member and agreed to by the facility;

2. the Member's PCP finds that such care is Medically Necessary;

3. the facility agrees to be reimbursed at the Capital Health Plan contract rate negotiated with similar providers for the same covered services and supplies; and

4. the facility meets all guidelines established by Capital Health Plan related to:
    a. quality of care;
    b. utilization;
    c. referral authorization;
    d. risk assumption;
    e. use of the Capital Health Plan provider network; and
    f. other criteria applicable to providers under contract with Capital Health Plan for the same services.

If a Member's request to be referred to the skilled nursing unit or assisted living facility that is part of that Member's place of residence is not honored, the Member has the right to initiate a grievance under the process described under the Complaint and Grievance Process.

SECTION 15: PHYSICIAN AND OTHER MEDICAL SERVICES

The following Physician and other medical services may be Covered Services, subject to the Copayment amount set forth in the Schedule of Copayments, when provided to a Member by Contracting Providers:

Accidental dental care: Dental services rendered within 62 days of an Accidental Dental Injury provided such services were for the treatment of damage to sound natural teeth, resulting from an Accidental Dental Injury occurring while a Member of Capital Health Plan. See the definition of Accidental Dental Injury in the Glossary Section.

Allergy treatment, including testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

Anesthesia services for medical care by a Physician, other than the operating Physician or his or her partner or associate.

Anesthesia services for dental care, pursuant to Florida Statute 641.31(34), including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Member in a Hospital or Ambulatory Surgical Center if:

1. the Member is under 8 years of age when it is determined by a dentist and the Member's Primary Care Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Member has a developmental disability in which patient management in the dental office has proved to be ineffective; or

2. the Member has one or more medical Conditions that would create significant or undue medical risk for the Member in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Autism Spectrum Disorder Services are provided to an Eligible Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday. Services and terms for receiving services consist of:

1. Well baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.

2. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section 393.17 of the Florida Statutes or licensed under Chapters 490 or 491 of the

Florida Statutes; and

3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

4. Coverage is subject to general exclusions and limitations, including but not limited to, coordination of benefits, Contracting Provider requirements, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

5. In order to determine whether Autism Spectrum Disorder services are covered, we reserve the right to request a formal written treatment plan signed by a trained Contracting psychologist in accordance with our *Clinical Practice Guideline for the Assessment and Treatment of Children with Autism Spectrum Diso*rders. The Treatment Plan will address communication, social interactions, and family function. The proposed treatment type(s) will include frequency and duration of the treatment along with the outcomes stated as goals. Once a treatment plan has been established and approved by the Member's Primary Care Physician (PCP), it is important that close follow-up occur to evaluate the progress and efficacy of treatment. The Contracting psychologist will reassess the child diagnosed with Autism Spectrum Disorder on an annual basis to assess for improvements and to rule out the development of co-morbid conditions. The Treatment Plan will be adjusted based on an annual assessment and new goals established for treatment over the following twelve months.

6. Prior Coverage Authorization/Pre-Service Notification for new members of Capital Health Plan that have been diagnosed with Autism Spectrum Disorder prior to enrollment in Capital Health Plan and receiving treatment from a Non-Contracting Provider at the time of enrollment:
    i. It is the Member's sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by a Non-Contracting Provider before Autism Spectrum Disorder services are provided. **The member's failure to obtain prior coverage authorization will result in denial of coverage for such services.**
    ii. Once the necessary medical documentation has been received from you/or the provider, Capital Health Plan will review the information in accordance with our Utilization Management process and make a prior coverage authorization decision, based on Capital Health Plan's established criteria then in effect and approved by the Medical Director. The Member will be notified of the prior authorization decision.
    iii. For additional details on how to obtain prior coverage authorization for Autism Spectrum Disorder services, please call the Member Service phone number on the back of your ID card.

Breast Reconstructive Surgery and implanted prostheses, incident to Mastectomy. The term "Breast Reconstructive Surgery" means surgery to reestablish symmetry between the two breasts. In order to be covered, such surgery must be in a manner chosen by the Member's Contracting Physician, consistent with prevailing medical standards, and in consultation with the Member.

Casts, splints, and trusses when part of treatment in a health care provider facility or office or in a Hospital emergency room. This does not include the replacement of dental splints or trusses.

Child cleft lip and cleft palate treatment services: Pursuant to Florida Statute 641.31(35), covered services include medical, dental, speech therapy, audiology, and nutrition services for treatment of a child under the age of 18 who has cleft lip or cleft palate. In order for such services to be covered, the Member's Primary Care Physician, or a Contracting Provider on referral from the Member's Primary Care Physician, must specifically (1) prescribe such services and (2) certify, in writing, that the services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Dermatology services are limited to the following: Medically Necessary minor surgery, tests, and office visits provided by a dermatologist who is a Contracting Provider.

Diabetes treatment services: Pursuant to Florida Statute 627.6408, covered Services include diabetes outpatient self- management training and educational services and nutrition counseling, including all medically appropriate and necessary equipment and supplies, when used to treat diabetes, if the Member's Primary Care Physician, or a Contracting Provider on referral from the Primary Care Physician who specializes in the treatment of diabetes, certifies that such services are necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. In order to be covered under this Agreement, nutrition counseling must be provided by a licensed dietitian.

Diagnostic services, including radiology, ultrasound, laboratory, pathology, approved machine testing (e.g., electrocardiogram (EKG)). Diagnostic services involving bones or joints of the jaw and facial region if, under accepted medical standards, such diagnostic services are Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury.

Infertility services for a Member who meets the criteria established by Capital Health Plan, for diagnostic procedures to determine the cause of infertility, limited to endometrial biopsy, sperm count and hysterosalpingography.

Mammogram screening services: Mammograms performed for breast cancer screening are covered when performed by a Contracting Provider in a medical office, medical

treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies for breast cancer screening. Covered Services are subject to all other terms and conditions applicable to other Covered Services.

Mastectomy services, pursuant to Florida Statute 627.64171(2), for breast cancer treatment and outpatient post-surgical follow-up in accordance with prevailing medical standards. As used in this subsection, the term "Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician. Outpatient post-surgical follow-up care for Mastectomy services shall be covered when provided by a Contracting Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Member. The treating Physician, after consultation with the Member, may choose the appropriate setting.

Maternity Care: Hospital services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the Capital Health Plan Service Area only, unless the need for such services was not, and could not reasonably have been anticipated before leaving the Service Area.

Employer Sponsored health plans and health insurance issuers generally may not under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Newborn child care: Covered Services applicable for children shall be provided with respect to a newborn child of a Member from the moment of birth provided that the newborn child is properly enrolled. Covered Services for a covered newborn child shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity.

Care for a newborn child may be provided at the Hospital, at the attending Physician's office, at a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife. These services include physical assessment of the newborn child, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Ambulance services when necessary to transport the newborn child to and from the nearest appropriate facility which is appropriately staffed and equipped to treat the newborn child's Condition, as determined by Capital Health Plan and certified by the

Primary Care Physician or a Contracting Physician as Medically Necessary to protect the health and safety of the newborn child.

NOTE: Coverage for a newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes age 26 will automatically terminate 18 months after the birth of the newborn child. For a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes age 26, but has not reached the end of the Calendar Year in which he/she becomes age 30, if the Covered Dependent child obtains a dependent of their own (e.g. through birth or adoption), such newborn child will not be eligible for this coverage and cannot enroll and the Covered Dependent child loses his or her eligibility as described in the Dependent Enrollment section.

Non-surgical spine and back disorder treatments consisting of Medically Necessary manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by X-ray.

Oxygen, including the use of equipment for its administration.

Osteoporosis screening: Diagnosis and Medically Necessary treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Physician services, medical and surgical care, in a Physician's office, a Hospital, or a Skilled Nursing Facility. Both Specialist and Primary Care Physician services are available.

Prescription drugs prescribed for a Member by a Physician and dispensed by a Pharmacist may be Covered Services if provided for as an Endorsement to this Employer Sponsored Plan. The benefits for Prescription Drugs are subject to, in addition to all of the other provisions of this Member Handbook, certain limitations. Please refer to the Pharmacy Program Endorsement for information on the Pharmacy Program provided in this Employer Sponsored Plan.

Preventive health services include a broad range of services (including screening tests, counseling, immunizations/vaccines). Capital Health Plan has adopted the definition of Preventive Services as defined by the Patient Protection and Affordable Care Act, which includes:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee

on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Second medical opinion: Members who elect to obtain a second medical opinion must notify their Primary Care Physician of their intent to do so prior to obtaining the second medical opinion. The Member is entitled to request and to obtain a second medical opinion when the Member disputes either Capital Health Plan's or a Contracting Physician's opinion of the reasonableness or necessity of a surgical procedure or is subject to a serious injury or illness. A Member may request and obtain a second medical opinion if they feel that they are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated. Capital Health Plan also may require a Member to obtain such a second medical opinion. In either case, the Member may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion. **All tests in connection with rendering the second medical opinion, including tests deemed necessary by a Non-Contracting Physician, must be Medically Necessary and must be performed within the Capital Health Plan network of Contracting Providers.**

Services rendered by a Contracting Provider related to a second medical opinion will be subject to the same Copayment requirement as set forth in the Schedule of Copayments. Services rendered by a Non-Contracting Provider for a second medical opinion are subject to a Copayment amount equal to 40% of the Allowance. Subscribers are responsible for the payment of any charges billed by a Non-Contracting Provider in excess of the Allowance.

Capital Health Plan may deny benefits, granted under this provision, in the event a Member seeks in excess of three (3) second medical opinions per Calendar Year if the second medical opinion costs are deemed by Capital Health Plan to be evidence that the Member has unreasonably over-utilized the second medical opinion privileges. The decision of the Medical Director, derived after review of the documentation from the second medical opinion which the Member obtained, will be controlling as to Capital Health Plan's coverage obligations for the treatment.

Surgical sterilization including tubal ligations and vasectomies.

Surgical assistant services rendered by a Physician or a Physician Assistant. Surgical assistant services only rendered by a Physician Assistant when acting as a surgical assistant when such assistance is Medically Necessary.

Surgical procedures including:

1. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;

2. surgical procedures involving bones or joints of the jaw and facial region if, under accepted medical standards, such surgery is Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and

3. surgery resulting from a traumatic injury or disease and for a congenital anomaly, performed to restore normal bodily function as determined by the Medical Director of Capital Health Plan.

Vision care, limited to routine examinations for vision correction and the diagnosis/treatment of eye disease when provided in Capital Health Plan's Health Centers. Lenses, frames and contact lenses are available from the Plan for the Member's convenience on a fee schedule structured to be competitive with the current local market. Initial eyeglasses or contact lenses following cataract surgery or accidental injury which would necessitate corrective lenses (initial pair of eyeglasses is limited to the cost of the lens and up to $25.00 for the frames and obtained only at Capital Health Plan's Eye Care Centers.)

SECTION 16: HOSPITAL SERVICES

Hospital services provided at Contracting Hospitals for a Member when such Member is an outpatient or inpatient admitted upon the instruction, written authorization, or referral by a Primary Care Physician. Such services may include:

- Room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
- Intensive care units, including cardiac, progressive and neonatal care;
- Use of operating and recovery rooms;
- Use of emergency rooms;
- Respiratory therapy (e.g., oxygen);
- Drugs and medicines administered by the Hospital;
- Intravenous solutions;
- Administration of, including the cost of, whole blood or blood products;
- Dressings, including ordinary casts;
- Anesthetics and their administration;
- Transfusion supplies and equipment;
- Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
- Chemotherapy treatment for proven malignant disease;
- Physical Therapy (in connection with a covered Condition);
- Other Medically Necessary services; and
- Transplants as set forth in the Transplants section.

Maternity Care

Hospital services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the Capital Health Plan Service Area only, unless the need for such services was not, and could not reasonably have been anticipated before leaving the Service Area.

Employer Sponsored health plans and health insurance issuers generally may not under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SECTION 17: AMBULATORY SURGICAL CENTER SERVICES

The following health care services may be Covered Services, subject to the Copayment amount set forth in the Schedule of Copayments, when furnished to a Member by a Contracting Provider when such Member receives care at an Ambulatory Surgical Center that is a Contracting Provider:

- Use of operating and recovery rooms;
- Respiratory therapy (e.g., oxygen);
- Drugs and medicines administered at the Ambulatory Surgical Center;
- Intravenous solutions;
- Dressings, including ordinary casts;
- Anesthetics and their administration;
- Administration of, including the cost of, whole blood or blood products;
- Transfusion supplies and equipment;
- Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
- Chemotherapy treatment for proven malignant disease; and
- Other Medically Necessary services.

SECTION 18: EMERGENCY SERVICES AND CARE

Emergency Services and Care

IN THE EVENT OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR CLOSEST EMERGENCY ROOM OR CALL 911.

Emergency Services and Care for an Emergency Medical Condition, in or out of the Service Area, shall be Covered Services without prior notification to Capital Health Plan, subject to the Copayment amount set forth in the Schedule of Copayments. It is the Member's responsibility, however, to notify Capital Health Plan as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination will be the responsibility of the Member.

Follow-up care must be received, prescribed, directed or authorized by the Member's Primary Care Physician. If the follow-up care is provided by other than the Member's Primary Care Physician, coverage may be denied.

Ambulance Services for Emergency Services and Care

Medically Necessary transportation by ambulance to the nearest medical facility capable of providing required Emergency Services and Care to determine if an Emergency Medical Condition exists. Any non-emergency related ambulance, or other transportation services, must be authorized by Capital Health Plan and ordered by the Member's Primary Care Physician.

SECTION 19: SPECIAL SERVICES

Durable Medical Equipment

Durable Medical Equipment which has been prescribed by the Member's Primary Care Physician, or a Contracting Provider on referral from the Primary Care Physician and which has been authorized by Capital Health Plan as a Covered Service. Capital Health Plan reserves the right to rent or purchase the most cost-effective durable medical equipment which meets the Member's needs. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. Supplies and services to repair medical equipment, which have been authorized by Capital Health Plan, may be a Covered Service only if the Member owns the equipment or is purchasing the equipment, or when necessitated due to growth of a Dependent child or due to change in the Member's Condition.

The wide variety of durable medical equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered durable medical equipment, however, some Durable Medical Equipment has been specifically excluded. Please refer to the Exclusions and Limitations Section.

Enteral Formulas

Prescription and non-prescription enteral formulas for home use which are prescribed by a Primary Care Physician or Contracting Physician as Medically Necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Coverage to treat inherited diseases of amino acid and organic acids shall include food products modified to be low protein, in an amount not to exceed $2,500 annually for any Member, through the age of 24. This section applies to any person or family notwithstanding the existence of any Pre-existing Condition.

Home Health Care

The following home health care services only when provided by or through a Home Health Agency within the Service Area if: (1) the Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician submits a written treatment plan to Capital Health Plan; (2) Capital Health Plan approves the written treatment plan; and (3) the Member is confined to home and is unable to carry out the basic activities of daily living:

1. Part-time or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse; Physical Therapy by a Physical Therapist;
2. Occupational Therapy by an Occupational Therapist;
3. Speech Therapy by a Speech Therapist;
4. Home health aide services;
5. Medical social services;
6. Nutritional guidance; and
7. Respiratory or inhalation therapy (e.g., oxygen).

The following home health care services are not Covered Services:

1. Homemaker services;
2. Domestic maid services;
3. Sitter services;
4. Companion services;
5. Services rendered by an employee or operator of an adult congregate living facility, an adult foster home, and adult day care center, or a nursing home facility; and
6. Custodial Care.

Hospice Services

Home Care: When available in the Service Area, Hospice home care will be provided as part of a Hospice program approved by Capital Health Plan, limited to those outpatient services which are Covered Services.

Hospice Outpatient Care: Outpatient services which are Covered Services, when received while the Member is in a Hospice outpatient program approved by Capital Health Plan.

Hospice Inpatient Care: Inpatient services, which are Covered Services, received while the Member is in a Hospice program approved by Capital Health Plan and the inpatient status is Medically Necessary, as determined by the Medical Director of Capital Health Plan.

Prosthetic and Orthotic Devices

Coverage includes the following, when authorized in advance by Capital Health Plan and arranged by a Primary Care Physician or a Contracting Provider on referral from the Primary Care Physician or Capital Health Plan:

Prosthetic and Orthotic Devices - braces, cardiac pacemakers, and artificial limbs and eyes to replace natural limbs and eyes lost while a Member. Covered prosthetic devices (except cardiac pacemakers and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be Medically Necessary) prescribed for each specific Condition. Coverage for Prosthetic and Orthotic Devices is based on the most cost-effective Prosthetic and Orthotic Device which meets the Member's medical needs as determined by Capital Health Plan.

Benefits may be provided for necessary replacement of a Prosthetic or Orthotic Device which is owned by the Member when due to irreparable damage, wear, a change in the Member's Condition, or when necessitated due to growth of a Dependent child.

Rehabilitation Services

Prescribed short-term inpatient and outpatient rehabilitation services limited to the therapy categories listed below.

In order to be covered: (1) Capital Health Plan must review, for coverage purposes only, a Rehabilitation Plan submitted or authorized by the Member's Primary Care Physician or a Contracting Provider on referral from the Primary Care Physician; (2) Capital Health Plan must agree that the Member's Condition is likely to improve significantly within 62 days from the first date such services are to be rendered; (3) such services must be provided to treat functional defects which remain after an illness or injury; and (4) such services must be Medically Necessary for the treatment of a Condition.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of rehabilitation services to be provided to a Member with rehabilitation potential. Such a plan must have realistic goals which are attainable by the Member within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such services are to be rendered. The Rehabilitation Plan must be renewed every 30 days.

Outpatient

Outpatient rehabilitation services are limited per Member per Condition to the number of Medically Necessary rehabilitation services which are received by the Member within the consecutive 62-day period which immediately follows the first date that the Member begins such services. Outpatient rehabilitation services are limited to the therapy categories listed below:

Speech Therapy*:* Services of a Speech Therapist or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from illness, injury, stroke,

or surgical procedure while this coverage was in force.

Physical/Occupational Therapy*:* Services of a Physical Therapist or Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to illness, injury, stroke or a surgical procedure while this coverage was in force.

Inpatient

Rehabilitation services of the therapy categories described above provided during a covered inpatient confinement will be covered for the duration of the confinement.

Skilled Nursing Facilities

Those Skilled Nursing Facility services which are authorized in writing by a Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician, and for which coverage is approved by the Medical Director of Capital Health Plan. Such services may include:

1. Room and board;
2. Respiratory therapy (e.g., oxygen);
3. Drugs and medicines administered while an inpatient;
4. Intravenous solutions;
5. Administration of, including the cost of, whole blood or blood products;
6. Dressings, including ordinary casts;
7. Transfusion supplies and equipment;
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. Chemotherapy treatment for proven malignant disease;
10. Physical Therapy (in connection with a covered Condition); and
11. Other Medically Necessary services.

Benefits for Covered Services at a Skilled Nursing Facility are limited to the number of days per Member per Calendar Year set forth in the Schedule of Copayments.

Transplant Services

Transplants as set forth below, if coverage is pre-determined by Capital Health Plan and if performed at a facility acceptable to Capital Health Plan, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge services, expenses related to the donation or acquisition of an organ or tissue for a Member once the

donor has been identified and has agreed to donate the organ, and treatment of complications after transplantation. Capital Health Plan will pay Covered Services only for services, care and treatment received for, or in connection with a:

1. Bone Marrow Transplant, as defined in this Agreement, which is specifically listed in Chapter 10D-127.001 of the Florida Administrative Code or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Health Care Financing Administration. Coverage for the reasonable costs of searching for a donor will be limited to a search among family members and donors identified through the National Bone Marrow Donor Program;
2. Corneal transplant;
3. Heart transplant;
4. Heart-lung combination transplant;
5. Kidney transplant;
6. Liver transplant;
7. Lung-whole single or whole bilateral transplant; or
8. Pancreas transplant performed simultaneously with a kidney transplant.

For a transplant to be covered, a written prior benefit determination from Capital Health Plan's Medical Director is required in advance of the procedure. The Member or the Member's Physician must notify Capital Health Plan's Medical Director prior to the Member's initial evaluation for the transplant in order for Capital Health Plan to determine if the transplant services are covered. Capital Health Plan's Medical Director must be given the opportunity to evaluate the clinical results of the Member's evaluation. Capital Health Plan's benefit determination will be based on the terms of this Member Handbook as well as written criteria and procedures established by Capital Health Plan's Medical Director. If prior benefit determination is not given, the transplant will not be covered. No benefit is payable for, or in connection with, a transplant if:

1. The transplant is excluded.

2. Capital Health Plan's Medical Director and the Member's Primary Care Physician are not contacted for authorization prior to referral for evaluation of the transplant.

3. Capital Health Plan's Medical Director does not pre-authorize coverage for the transplant.

4. The expense relates to the transplantation of any non-human organ or tissue.

5. The expense relates to the donation by a Member of an organ or tissue for a recipient who is not covered by Capital Health Plan.

6. The expense relates to the acquisition of an organ or tissue for a recipient who

is not covered by Capital Health Plan.

7. The following services/supplies/expenses are also not covered:

    a. Artificial heart devices used as a bridge to transplant.

Once a coverage decision is made, Capital Health Plan's Medical Director will advise the Member or the Member's Physician of the coverage decision. Covered Services are payable only if the pre-transplant services, the transplant and post-discharge services are performed in a facility acceptable to Capital Health Plan.

For covered transplants and all related complications, Capital Health Plan will cover Hospital expenses and Physician's expenses provided that such services will be paid under the Hospital Services Section and Physician and Other Medical Services Section in accordance with the same terms and conditions for care and treatment of any other covered Condition.

SECTION 20: MENTAL HEALTH AND SUBSTANCE USE DISORDER

OVERVIEW

Capital Health Plan provides members with high quality mental health and addiction services that are medically necessary, and take place in the least restrictive environment necessary to assist members with resolving their issues. This program treats medically necessary mental health and addiction issues in compliance with State and Federal regulations by ensuring that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than the predominant treatment limitations placed on substantially all medical/surgical benefits.

Mental Health and Addiction Services

Capital Health Plan defines Mental Health and Addiction Services as treatment provided for a member with selected mental health disorder(s) which must be diagnosed by either the member's Primary Care Physician or a network Behavioral Health Specialist. The disorder(s) must be included in the most recent *Diagnostic and Statistical Manual of Mental Disorders-IV TR* and not be one of the diagnoses excluded from coverage (see Diagnosis Exclusion List).

Behavioral Health Network

Capital Health Plan's Behavioral Health Network is that group of credentialed professionals licensed by the State of Florida which specializes in the treatment of mental health and substance use disorders and who are contracted with Capital Health Plan to provide services to plan members. Capital Health Plan's behavioral health network includes specialists trained as Psychiatrists, Psychologists, and Therapists who work with members experiencing problems from mental health and/or substance use disorders.

Least Restrictive Environment

Least restrictive environment is the appropriate level of care provided to the member for treating their mental health and/or addiction disorder. Capital Health Plan offers a continuum of care for its members from the least restrictive form of treatment (outpatient therapy) to the most restrictive form of treatment (inpatient crisis intervention and stabilization). Capital Health Plan ensures members receive the level of mental health and addiction care required to help them resolve their current problem. Levels of care from least restrictive to most restrictive are as follows:

- Outpatient counseling
- Intensive outpatient treatment (addiction treatment)
- Partial hospitalization
- Residential treatment
- Acute inpatient hospitalization

Limited Access Prior to Preauthorization

Outpatient Counseling

Capital Health Plan defines outpatient counseling as those services provided in the office of a network credentialed Behavioral Health practitioner for the treatment of a mental health and/or addiction problem. The services are provided by a practitioner with a current Florida license, such as a Psychiatrist, Psychologist, or Therapist. Outpatient services include individual, group and family therapy; and psychiatric and psychological evaluation and assessment and medication management.

Members may access outpatient behavioral health services for up to a total of 15 sessions per calendar year without prior authorization. After the 15th session in the calendar year, Capital Health Plan requires an assessment by a network psychiatrist to determine whether the member is experiencing a mental health and/or substance abuse problem with co-morbid conditions, or a problem that would be more effectively treated with the combination of medication and therapy. It is up to the member and the therapist to keep track of the number of outpatient sessions provided. A consultation with a psychiatrist for a psychiatric evaluation should be scheduled between sessions ten and fifteen each year. Once the psychiatrist has made an assessment and diagnosis with treatment recommendations, the physician will send a report to the member's PCP and therapist. The member will need to contact their PCP with a request for authorization for counseling sessions beyond the initial 15 sessions. The member's PCP will submit a referral requesting authorization of addition sessions for treatment of the issue diagnosed in the psychiatrist's letter. However, if the consulting psychiatrist indicates further sessions are not necessary, no further sessions will be authorized. The member's therapist is expected to submit subsequent claims based on the psychiatrist's recommended treatment plan and diagnostic codes.

Access Requiring Preauthorization

Partial Hospitalization

Capital Health Plan defines partial hospitalization as mental health or addiction services provided in a hospital setting with treatment that lasts 7 hours per day, with the member leaving the treatment facility in the evenings. Partial hospitalization is used either as a step-down transition level from inpatient care to outpatient care, or to avoid a hospital admission. The member may qualify for partial hospitalization if he or she does not meet criteria for an inpatient stay, but the treating psychiatrist believes the member requires more structure than traditional outpatient therapy would provide. Admission for partial hospitalization treatment requires there be a benefit for partial hospitalization, a review of medical records and a PCP referral. A Capital Health Plan Medical Director will review the records and make a determination about coverage prior to the start of services.

Residential Treatment

Residential treatment involves a sub-acute level of care provided in a treatment center or facility that specializes in the treatment of addictions or eating disorders. Limitations on length of stay for residential treatment facilities are the same as limitations of length of stay placed on Skilled Nursing Facility (SNF) programs. Approval for admission to a residential treatment facility requires that all clinical criteria for the requested program are met, and the Medical Director has approved the admission. All residential treatment is preauthorized for two weeks and then continuation of treatment requires re-authorization, including review of clinical records. The treating facility must maintain a residential treatment license and current accreditation with an appropriate accreditation body, such as the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission.

No Preauthorization Required

Acute Inpatient Hospitalization

Inpatient services are approved for emergent care when the patient's condition prevents similar services from being provided in a practitioner's office, the outpatient department of a hospital or a non-residential facility.

Capital Health Plan defines an acute inpatient hospitalization as services requiring emergent medically necessary care as determined by a psychiatrist through evaluations in the office or in an Emergency Department. In Florida, patients are admitted to an acute inpatient facility under a Baker Act either voluntarily (Ba-40) or involuntarily (Ba-52 or Ba-1). Admission to a psychiatric hospital indicates the member has either thoughts of harming self or others or has acted on these thoughts to harm self or others by overdosing, cutting, or threatening self or others with a gun or other deadly weapon. The purpose of an acute inpatient hospitalization is for crisis management and stabilization. Once the member no longer meets criteria for hospitalization, i.e., Baker Act Status, as determined by the attending psychiatrist, the member is discharged back to a less restrictive level of service.

Intensive Outpatient Treatment

Capital Health Plan defines intensive outpatient treatment (IOP) as care provided 3-4 days a week that lasts 3 hours per day, over a period of at least 4 weeks. These services also include an ongoing aftercare program. The purpose of an IOP Program is to focus on addiction treatment and the prevention of relapse. Services are provided within the Capital Health Plan Behavioral Health Network by licensed clinicians.

Diagnoses Exclusion List:

Inpatient Treatment

- Specific Anxiety disorders including: Agoraphobia, specific phobias (insects, spiders, heights etc.), and social phobia.

Inpatient and Outpatient Treatment

- All relationship problems with the exception of bereavement.
- Assessment and treatment of all sexual and gender identity disorders, specifically all diagnoses in the Sexual and Gender Identity Disorders section of the *Diagnostic and Statistical Manual of Mental Disorders-IV TR*, which are categorically excluded regardless of medical necessity.
- Treatment specific to, and solely for, learning, communication and motor skills disorders, mental retardation, academic or career counseling.
- Feeding and eating disorders of infancy or early childhood including: pica and rumination disorder.
- Other disorders of infancy, childhood or adolescence, such as separation anxiety disorder, selective mutism and reactive attachment disorder.
- Services for nicotine/caffeine abuse or addiction.
- All Personality Disorders without a primary diagnosis of a covered mental health or substance abuse disorder.

The following Treatment modalities are not covered:

- Scholastic/Educational Testing, Intelligence, and Learning Disability testing and evaluations. These tests should be requested and conducted by the child's school district.
- Court-ordered counseling or treatment, as a condition of release or probation, such as residential substance abuse treatment, intensive outpatient counseling and individual or family counseling.
- Work or school ordered assessment and treatment in the absence of a clinical need.
- Counseling for marital and relationship enhancement and religious purposes including counseling provided by a religious counselor.
- Experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, methadone maintenance, neurofeedback, light boxes for phototherapy and outward bound or other wilderness type therapies.
- Cognitive remediation.
- Elective therapies such as Gestalt, Transactional Analysis, Transcendental Meditation, Z-therapy, Mind expansion therapy and Erhard Seminar Training (EST).
- Transcranial Magnetic Stimulation.
- Applied Behavioral Analysis (except for State mandated treatment for specific diagnoses meeting Capital Health Plan clinical criteria and approved by the Medical Director).
- Custodial Care or basic care provided in a residential, institutional or assisted living setting. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aides, and personal care designed to help the member in activities of daily living or to keep the member from continuing unhealthy activities.
- Transitional living centers, non-licensed programs, therapeutic boarding schools, and services typically provided by community mental health services program settings.

SECTION 21: EXCLUSIONS AND LIMITATIONS

Exclusions

The following are excluded from coverage:

1. Any services not specifically listed in the Covered Services sections or in any rider, or endorsement attached hereto, unless such expenses are specifically required to be covered by applicable law.

2. If the Member does not follow Capital Health Plan's Coverage Access Rules, any services provided to, or received by, the Member are not covered. For further information, please refer to the Coverage Access Rules Section.
    a. Any service which, in the opinion of Capital Health Plan was, or is, not Medically Necessary. The ordering of a service by a health care provider, including without limitation, a health care provider who is a Contracting Provider, other than as authorized by Capital Health Plan, does not in itself make such service Medically Necessary or a Covered Service.

3. **Abortion**, elective (by Capital Health Plan; not Medically Necessary) unless otherwise mandated by State or Federal law.

4. **Ambulance services** other than those specifically provided for in the Covered Services sections.

5. **Arch supports**, orthopedic shoes, sneakers, or support hose, or similar type devices/appliances regardless of intended use.

6. **Autopsy** or postmortem examination services, unless specifically requested by Capital Health Plan.

7. **Cardiac Therapy s**ervices provided for cardiac rehabilitation for the purpose of aiding in the restoration of normal heart function lost due to illness, injury, stroke, or a surgical procedure.

8. **Complementary and alternative healing methods** including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; massage; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy,

reflexology, rolfing, shiatsu, Swedish massage, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

9. **Complications of non-Covered Services**, including the diagnosis or treatment of any Condition which arises as a complication of a non-Covered Service (e.g., services or supplies to treat a complication of cosmetic surgery are not covered).

10. **Contraceptive devices or appliances**, except when dispensed for specific treatment of a Condition.

11. **Copayments**, whether or not the Copayment has been waived by the provider.

12. **Cosmetic services**, including any service to improve the appearance or self-perception of an individual, including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A).

13. **Costs** related to telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.

14. **Custodial Care**, and any service of a custodial nature, including without limitation: services or supplies primarily to assist the Member in the activities of daily living; rest homes; home companions or sitters; home mothers; domestic maid services; and respite care.

15. **Dental care**, care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, dental x-rays and anesthesia (except those services specifically listed as covered benefits in the *Physician and Other Medical Services* section).

16. **Drugs** prescribed for uses other than the United States Food and Drug Administration (FDA)-approved label indications. This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Member's cancer in a Standard Reference Compendium or recommended for treatment of the Member's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

17. **Durable Medical Equipment** which is for patient convenience and/or comfort or which has not been authorized by Capital Health Plan. This exclusion includes,

but is not limited to, modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, dental braces, air conditioners, humidifiers, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails, heat appliances and dehumidifiers. Also excluded is coverage for repair or replacement except when authorized by Capital Health Plan.

18. **Experimental or Investigational** services except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection, and except for any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Member's cancer in a Standard Reference Compendium or recommended for treatment of the Member's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

19. **Family planning services**, other than those services specifically described in the Covered Services section.

20. **Foot care (routine)**, including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, corns, or calluses, unless determined by Capital Health Plan to be Medically Necessary.

21. **Hearing aids** (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

22. **Immunizations and physical examinations**, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements; or except immunizations necessary in the course of other medical treatments of an illness or injury.

23. **Infertility treatment** services and In Vitro Fertilization except as specified in Section 15 of this member Handbook.

24. **Mental health services** as outlined in Section 20, Mental Health and Substance Use Disorder, of this member Handbook.

25. **Military service-connected medical care** received at military or government facilities.

26. **Non-Prescription drugs or products,** except insulin, including any non-

Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

27. **Obesity treatment**, including but not limited to, surgical operations and medical procedures for the treatment of morbid obesity.

28. **Oral surgery** for any reason including oral surgery where the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided under the Covered Services sections.

29. **Orthomolecular therapy**, including nutrients, vitamins, and food supplements.

30. **Penile prosthesis** and surgery to insert penile prosthesis except when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

31. **Personal comfort, hygiene or convenience items**, and services deemed to be not Medically Necessary and not directly related to the care of the Member, including, but not limited to, beauty and barber services, clothing, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the Covered Services sections, motel/hotel accommodations, air conditioners, humidifiers or physical fitness equipment.

32. **Prescription drugs**, unless covered by endorsement, purchased, prescribed, or dispensed while other than an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital, except for immunosuppressant therapy following a major human organ/tissue transplant, or chemotherapy in connection with a diagnosed malignancy.

33. **Private duty nursing care**.

34. **Rehabilitation services**, including physical, speech, occupational and other rehabilitation therapy, except as described in the Covered Services section. This exclusion includes:

    i. Services or supplies provided to a Member as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, where the admission is primarily to provide rehabilitative services;

ii. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Member's Condition within a 62-day period;

iii. Inpatient and/or Outpatient long term rehabilitation services (i.e., services in excess of 62 days from the first date the Member begins such services).

35. **Reversal of voluntary, surgically-induced sterility**, including the reversal of tubal ligations and vasectomies.

36. **Services or supplies** that are:

i. Determined to be not Medically Necessary;

ii. Not specifically listed in the Covered Services sections unless such services are specifically required to be covered by state or federal law. Capital Health Plan will provide coverage on a primary or secondary basis as required by applicable COB state or federal laws;

iii. Court ordered care or treatment, unless otherwise covered;

iv. Received prior to a Member's Effective Date or received on or after the date a Member's Coverage terminates under the Employer Sponsored Plan, unless coverage is extended in accordance with the Extension of Benefits subsection;

v. Provided by a Physician or other health care provider related to the Member by blood or marriage;

vi. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;

vii. For treatment of non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

viii. Supplied at no charge;

ix. For elective care, routine care, or any care other than Medically Necessary Emergency Services and Care for an Emergency Medical

Condition, required by a Member while outside of the Service Area; or

x. For normal pregnancy and delivery outside the Service Area, unless the need for such services was not, and reasonably could not have been, anticipated before leaving the Service Area.

37. **Sexual reassignment, or modification services,** including but not limited to any service or supply related to such treatment, including psychiatric services.

38. **Skilled Nursing Facility services** not provided in lieu of hospitalization.

39. **Smoking cessation programs**, including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches).

40. **Sports-related devices** used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

41. **Tobacco** or tobacco related products.

42. **Training and educational programs**, including programs primarily for pain management, or vocational rehabilitation.

43. **Transplantation or implantation** services, including the transplant or implant, other than those specifically listed in the Covered Services sections. This exclusion includes:

i. Any service in connection with the implant of an artificial organ, including the implant of the artificial organ.

ii. Any organ which is sold rather than donated to the Member.

iii. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the most recently published Medicare National Coverage Determinations Manual.

iv. Any service in connection with identification of a donor from a local, state or national listing.

44. **Travel, lodging, or vacation expenses** even if prescribed or ordered by a provider.

45. **Transportation service** that is non-emergency transportation between institutional care facilities, or to and from the Member's residence.

46. **Vision care** including:

    i. the purchase, examination, or fitting of eyeglasses or contact lenses, except **only the first** glasses or contact lenses following cataract surgery or following an accident;

    ii. any surgery for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error (e.g., radial keratotomy, myopic keratomelusis); and

    iii. training or orthoptics, including eye exercises.

47. **Volunteer services** or services which would normally be provided free of charge to a Member including services which would normally be provided free of charge in a Hospice program; services of a person who ordinarily resides in the home of the terminally ill Member, or is a member of the Member's family, or of the Member's spouse's family; or any service not provided through the Hospice program approved by Capital Health Plan.

48. **Weight control services** including any service to lose, gain, or maintain weight, regardless of the reason for the service or whether the service is part of a treatment plan for a Condition. This exclusion includes, but is not limited to: weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs and membership; exercise or other equipment; or surgical and non-surgical procedures designed to restrict the member's ability to assimilate food.

49. **Wigs** or cranial prosthesis.

50. **Work related condition services** to the extent the Member is covered or required to be covered by Workers' Compensation law. Any service or supply to diagnose or treat any Condition resulting from or in connection with a Member's job or employment will not be covered under the Employer Sponsored Plan, except for Medically Necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

Limitations

The rights of Members and obligations of Capital Health Plan hereunder are subject to the limitations set forth on the Schedule of Copayments and the following limitations:

Circumstances Beyond the Control of Capital Health Plan

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of Capital Health Plan, results in facilities, personnel or financial resources of Capital Health Plan being unable to arrange for provision of the Covered Services, Capital Health Plan shall have no liability or obligation for any delay in the provision of, or any failure by any provider to provide, such Covered Services, except that Capital Health Plan shall make a good faith effort to arrange such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of Capital Health Plan if Capital Health Plan cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

SECTION 22: STATEMENT ON ADVANCE DIRECTIVES

The following information is provided in accordance with the Patient Self-Determination Act to advise you of your rights under Florida law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to formulate an advance directive, and explain the policy of Capital Health Plan with respect to advance directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make treatment decisions for him or her in the event that such person should be found to be incompetent and suffering from a terminal condition. Advance directives provide patients with a mechanism to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own healthcare decisions.

An "advance directive" is a witnessed oral or written statement which indicates the individual's choices and preferences with respect to medical care made by the individual while he or she is still competent. An advance directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care provider should consult in making treatment decisions.

There are four types of documents recognized in Florida commonly used to express an individual's advance directives: a Living Will, a Healthcare Surrogate Designation, a Do Not Resuscitate Order (DNRO), and an Anatomical Donation.

A Living Will is a declaration of a person's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal condition and is not able to express his or her wishes. It does not become effective until the patient's physician and one other physician determine that the patient suffers from a terminal condition and is incapable of making decisions.

Another common form of advance directive is the Healthcare Surrogate Designation. When properly executed, a Healthcare Surrogate Designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient's wishes. The surrogate's authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions which by law the surrogate cannot make, such as consent to abortion or electroshock therapy, any specific limits on the surrogate's power to make decisions should be clearly expressed in the Healthcare Surrogate Designation document. Another name for Healthcare Surrogate Designation is a Durable Power of Attorney. This

document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical condition as well as legal or financial decisions.

Do Not Resuscitate Order **(DNRO)**, a specific yellow form available from the Florida Department of Health that tells medical personnel you do not want to be resuscitated from respiratory or cardiac arrest. The DNRO is used, for example, with patients having terminal cancer or untreatable organ failure.

Anatomical Donation, a document indicating your wish to donate all or part of your body at death.

A suggested form of Living Will and Designation of Healthcare Surrogate is contained in Chapter 765 of the *Florida Statutes*. There is no requirement for a patient to have an advance directive. Additionally, your health care provider cannot condition treatment on whether or not you have one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. a judicially appointed guardian;
2. a spouse;
3. an adult child or a majority of the adult children who are reasonably available for consultation;
4. a parent;
5. siblings who are reasonably available for consultation;
6. an adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health, or religious or moral beliefs;
7. a close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending physician an affidavit stating that he or she is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, or religious and moral beliefs.

Deciding whether to have an advance medical directive, and if so, the type and scope of the directive, is a complex understanding. It may be helpful for you to discuss advance directives with your spouse, family, friends, religious or spiritual advisor, or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, physician, and whomever else will be faced with the task of carrying out those wishes knows what that person would want.

It is the policy of Capital Health Plan to recognize the right of each Member to make health care treatment decisions in accordance with your own personal beliefs. You have a

right to decide whether or not to execute an advance directive to guide treatment decisions in the event you become unable to do so. Capital Health Plan will not interfere with your decision in accordance with the laws of the State of Florida. It is your responsibility to provide notification to your providers that an advance directive exists. If you have a written advance directive, we recommend that you furnish your providers with a copy so that it can be made a part of your medical record.

Pursuant to §765.308 of the *Florida Statutes*, Florida law does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a provider or facility in the Capital Health Plan network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another provider or facility. Capital Health Plan providers have, in accordance with state law, varying practices regarding the implementation of an individual's advance directive. Therefore, we recommend that you have discussions about advance directives with your medical care givers, family members and other friends and advisors. Your physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical condition or environment.

Complaints concerning noncompliance with advance directives may be submitted to the following address:

Florida Health Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275
Phone: 850-245-4339
Toll Free: 1-888-419-3456

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law. For more information about Five Wishes call 850-523-7422. To learn more about DNRO's, visit the Department of Health at http://www.doh.state.fl.us/ or http://www.MyFlorida.com/ and type DNRO in these website search engines or call (850) 245-4440

SECTION 23: MEMBER'S RIGHTS AND RESPONSIBILITIES

Capital Health Plan is committed to provide and/or arrange for the provision of quality health care coverage in a cost-effective manner. Consistent with our commitment, the following statement of Member's Rights and Responsibilities has been adopted.

You have a Right to:

1. Receive information about Capital Health Plan, the services, benefits, member rights and responsibilities, and participating practitioners and facilities that provide care.

2. Receive medical care and treatment from practitioners and providers who have met the credentialing standards of Capital Health Plan.

3. Expect Capital Health Plan participating practitioners to permit you to participate in decision-making about your health care consistent with legal, ethical, and relevant patient-practitioner relationship requirements. If you are unable to fully participate in treatment decisions you have a right to be represented by your parents, guardians, family members, health care surrogates or other conservators to the extent permitted by applicable laws.

4. Expect health care practitioners who participate with Capital Health Plan to provide treatment with courtesy, respect, and with recognition of your dignity and right to privacy.

5. Communicate complaints or appeals about Capital Health Plan or the care provided through the established Complaint and Grievance procedures found in your Member Handbook, the master policy, or the contract provided to your employer.

6. Have candid discussions with practitioners about the best treatment options for you no matter what the cost of the treatment or your benefit coverage.

7. Refuse treatment if you are willing to accept the responsibility and consequences of that decision.

8. Have access to your medical records, request amendments to your records, and have confidentiality of these records and member information protected and maintained in accordance with State and Federal law and Capital Health Plan policies.

9. Make recommendations regarding Capital Health Plan's rights and responsibilities policies.

10. Call or write us anytime with helpful comments, questions, and observations, whether concerning something you like about our plan, or something you feel is a problem area. Expect to receive a timely response from Capital Health Plan staff.

You have a Responsibility to:

1. Seek all non-emergency care through your Primary Care Physician (PCP), to obtain a referral from your PCP for medical services from a specialist, and to cooperate with those providing care and treatment.

2. Be courteous; respect the rights, needs and privacy of other patients, office staff, and providers of care.

3. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care for you.

4. Follow the plans and instructions for care that you have agreed to with your practitioners.

5. Ask questions and seek clarification as necessary to enable you to participate fully in your care.

6. Pay copayments and to provide current information concerning your Capital Health Plan membership status to any Capital Health Plan participating practitioner or provider.

7. Follow established procedures for filing a complaint, appeal, or grievance concerning medical or administrative decisions that you feel are in error.

8. Review and understand the benefit structure, both covered benefits and exclusions, as outlined in the Member Handbook. Cooperate and provide information that may be required to administer benefits.

9. Seek access to medical and member information through your Primary Care Physician, CHPConnect, or through Capital Health Plan Member Services.

10. Follow the coverage access rules in your Member Handbook.

SECTION 24: COMPLAINT AND GRIEVANCE PROCESS

Capital Health Plan has established a process for reviewing Member complaints and grievances. The purpose of this process is to facilitate review of, among other things, any Member's dissatisfaction with Capital Health Plan, Capital Health Plan administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent contracting provider. The Complaint and Grievance Process also permits the Member, or his or her physician, to expedite Capital Health Plan review of certain types of grievances. The process described below must be followed if the Member has a complaint or grievance.

Under the Complaint and Grievance Process, a complaint will be handled informally in accordance with the Informal Review subsection set forth below. A grievance will be handled formally in accordance with the Formal Review subsection described below. A request to review an adverse benefit determination of a pre-service claim, post-service claim, or a concurrent care decision will be handled in accordance with the terms of this section.

Capital Health Plan encourages the Member to attempt informal resolution of any dissatisfaction by calling Capital Health Plan Member Services at 850-383-3311 (toll-free 1-877-247-6512); TDD 850-383-3534 (toll-free 1-877-870-8943); Florida Relay 1-800-955-8771 or 711. If Capital Health Plan is unable to resolve the matter on an informal basis, the Member may submit his or her formal request for review in writing.

Definitions

Adverse Benefit Determination means any denial, reduction, or termination of coverage, benefits, or payments (in whole or in part) under the Member's benefit package with respect to a pre-service claim or a post-service claim. Any reduction or termination of coverage, benefits, or payment in connection with a concurrent care decision, as described in this section, also is considered an adverse benefit determination.

Clinical Grievance Review Panel means a panel established by Capital Health Plan to review grievances related to adverse benefit determinations made by Capital Health Plan that an admission, the availability of care, a continued stay, or another health care service has been reviewed and, based on the information provided, does not meet the Capital Health Plan requirements for medical necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of physicians who have appropriate expertise, and who were not involved previously in the initial adverse benefit determination.

Complaint means an oral (i.e., non-written) expression of dissatisfaction, whether the dissatisfaction was made in person, by telephone, or on the Member's behalf.

Concurrent Care Decision means a decision by Capital Health Plan to deny, reduce, or

terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if Capital Health Plan previously had approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a concurrent care decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the case management subjection as described in the Member Handbook.

Expedited Grievance means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to the Member with respect to which the application of time periods for making non-urgent care determinations: (1) seriously could jeopardize the Member's life or health or his or her ability to regain maximum function; or, (2) in the opinion of a physician with knowledge of the Member's condition, would subject the Member to severe pain that cannot be managed adequately without the proposed service being rendered.

External Review means a process through which a Member can request a review of a Capital Health Plan grievance denial from an independent external review entity. This external review may be performed by the Federally Authorized External Review Process or by the State of Florida's Subscriber Assistance Program. The Subscriber Assistance Program is a program within the State of Florida Agency for Health Care Administration that provides assistance to subscribers of health maintenance organizations whose grievances are not resolved by the organization to the satisfaction of the member.

Grievance means a written expression of dissatisfaction. The Member, a provider acting on his or her behalf, another person designated by the Member, or a state agency may submit a grievance.

Health Care Service(s) or Service(s) means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of providers.

Medically Necessary or Medical Necessity means, for coverage and payment purposes, that a medical service or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of Capital Health Plan:

1. consistent with the symptom, diagnosis, and treatment of the Member's condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not experimental or investigational;
5. not for cosmetic purposes;

6. not primarily for the convenience of the Member, the Member's family, the physician or other provider; and
7. the most appropriate level of service, care or supply which can safely be provided to the Member.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a service actually provided to the Member (not just proposed or recommended) that is received by Capital Health Plan in a format acceptable to Capital Health Plan.

Pre-Service Claim means any request or application for coverage or benefits for a service that has not yet been provided to the Member and with respect to which the terms of the Member Handbook condition payment for the service, (in whole or in part) on approval by Capital Health Plan of coverage or benefits for the service before the Member receives the service. A pre-service claim may be a claim involving urgent care. As defined herein, a pre-service claim shall not include a request for a decision or opinion by Capital Health Plan regarding coverage, benefits, or payment for a service that has not actually been rendered to the Member if the terms of this Member Handbook do not require approval by Capital Health Plan of coverage or benefits (or condition payment) for the service before it is received.

Informal Review – Complaints

To advise Capital Health Plan of a complaint, the Member first should contact a Capital Health Plan Member Services Representative, either by telephone or in person. The telephone number is listed on the membership card, and the address of the Member Services office is listed in the Telephone Numbers and Addresses subsection. The Member Services Representative, working with appropriate personnel, will review the complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction. If the Member remains dissatisfied with the Capital Health Plan resolution of the complaint, he or she may submit a grievance in accordance with the Formal Review subsection below.

Important Note:

The Member must provide the Member Services Representative all of the facts relevant to the complaint. The Member's failure to provide any requested or relevant information may delay the Capital Health Plan review of the complaint. Consequently, the Member is obliged to cooperate with Capital Health Plan in our review of the matter.

Formal Review – Grievances

The Member, a provider acting on behalf of the Member, a state agency, or another person designated by the Member, may submit a grievance. The Member must give written permission for another person to represent him or her in a grievance. To submit or pursue a grievance on behalf of a Member, a health care provider previously must have been directly involved in treatment or diagnosis of the Member. A letter must be mailed to the Capital

Health Plan address listed in the Telephone Numbers and Addresses subsection.

If the Member needs assistance in preparing the grievance, he or she may contact Capital Health Plan for assistance. Hearing impaired Members may contact Capital Health Plan via TDD at 850-383-3534 (1-877-870-8943 toll-free) or the Florida Relay at 1-800-955-8771 or 711.

1. Formal Grievance Review

a. Standard Grievances

To begin the formal review process, the Member must write a letter explaining the facts relating to the grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation. The Grievance Review Panel will review the grievance and advise the Member of its decision in writing. If the grievance involves a pre-service claim, the Capital Health Plan decision regarding the grievance will be made within 30 calendar days of receipt of the grievance. If the grievance involves a post-service claim, the Capital Health Plan decision regarding the grievance will be made within 60 calendar days of receipt of the grievance.

If the Member remains dissatisfied with the decision of the Grievance Review Panel, he or she may request a reconsideration of the decision by an External Review Program.

If Capital Health Plan's final appeal level results in an adverse benefit determination, the following information will be provided to the Member or authorized representative as soon as possible so that they have enough time to respond to Capital Health Plan prior to the final adverse determination deadline:

- new or additional evidence considered, relied upon, or generated by Capital Health Plan in connection with the appeal, and
- new or additional rationale on which the final adverse determination will be based.

b. Request for Clinical Grievance Review

When a Member has a grievance that involves an adverse benefit determination that an admission, availability of care, continued stay, or other health care service does not meet the Capital Health Plan requirements for medical necessity, appropriateness of care, health care setting, level of care, or effectiveness, the grievance will be reviewed by the Clinical Grievance Review Panel.

The Clinical Grievance Review Panel will include health care professionals, including at least one physician who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the condition, process, or treatment that the Member or the provider is asking to be reviewed.

If the grievance involves a pre-service claim, the Capital Health Plan decision regarding the grievance will be made within 30 calendar days of receipt of the grievance. If the grievance involves a post-service claim, the Capital Health Plan decision regarding the grievance will be made within 60 calendar days.

The Clinical Grievance Review Panel will review the grievance and may make a decision based on medical records, additional information, and input from health care professionals in the same or similar specialty as typically manages the condition, procedure, or treatment under review. Capital Health Plan will advise the Member of its decision in writing.

If Capital Health Plan's final appeal level results in an adverse benefit determination, the following information will be provided to the Member or authorized representative as soon as possible so that they have enough time to respond to Capital Health Plan prior to the final adverse determination deadline:

- new or additional evidence considered, relied upon, or generated by Capital Health Plan in connection with the appeal, and

- new or additional rationale on which the final adverse determination will be based.

If the Member provides additional information in response to the above, such information shall be presented to the panel for a final decision.

If the Member remains dissatisfied with the decision of the Clinical Grievance Review Panel, he or she may request a reconsideration of the decision by an External Review Program.

c. Request for Expedited Review

For a grievance involving an adverse benefit determination, the Member, or a person acting on behalf of the Member, may request that the review of the grievance be expedited. To be eligible for an expedited review, a grievance (i.e., a request for expedited review) must meet the following criteria as

determined by Capital Health Plan:

(1) The Member must be dissatisfied with a Capital Health Plan adverse benefit determination;

(2) As determined by Capital Health Plan, a delay in the provision of health care services for the length of time permitted under the standard grievance procedure timeframes (approximately 30 calendar days) seriously could jeopardize the Member's life or health or the Member's ability to regain maximum function, or in the opinion of a physician with knowledge of the Member's condition, would subject the Member to severe pain that cannot be managed adequately with the care or treatment that is the subject of the claim; and

(3) The health care provider involved has refused to or will not provide the needed health care service without a guarantee of coverage or payment from the Member or Capital Health Plan.

The Member, the Member's authorized representative, or a provider acting on behalf of the Member, specifically must request an expedited review. For example, this request may be made by saying, "I want an expedited review." Only the following services that have yet to be rendered are subject to this expedited review process: (a) pre-service claims; or (b) requests for an extension of concurrent care services made within 24 hours before the termination of authorization for those services.

Information necessary to evaluate a review for expedited review may be transmitted by telephone, facsimile transmission, or other expeditious methods appropriate under the circumstances.

A request for expedited review will be evaluated by a health care professional who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the condition, process, or treatment that the Member, the representative, or the provider is asking to be reviewed.

Capital Health Plan will make a decision and notify the Member, the Member's representative, or the provider acting on the Member's behalf, as expeditiously as the condition requires, but in no event longer than 72 hours after receipt of the request for an expedited review. If additional information is necessary, Capital Health Plan will notify the provider and the Member within 24 hours of receipt of the request for expedited review and Capital Health Plan must receive the requested additional information within 48 hours of request. After receipt, Capital Health Plan will make its determination within an additional 48 hours.

If the Member's request for expedited review arises out of a utilization

review determination by Capital Health Plan, that a continued hospitalization or continuation of a course of treatment is not medically necessary, coverage for the hospitalization or course of treatment will continue until the Member has been notified of the determination.

Capital Health Plan will provide written or verbal confirmation of its decision concerning an expedited review within 72 hours of receipt of the request. If the decision is given verbally, written confirmation will be sent within two working days after providing notification of the decision. If the Member is not satisfied with the decision, he or she may submit the grievance to an External Review Program

Independent Review by Outside Agencies

The Member has the right at any time to submit a complaint or grievance to the Florida Department of Financial Services, the Agency for Health Care Administration, the Subscriber Assistance Program, or the Federally Authorized External Review Program. (The Member must submit the grievance to the Subscriber Assistance Program within 365 days of the final Capital Health Plan decision. The Member must submit the grievance to the Federally Authorized External Review Program within four months of the final Capital Health Plan decision.) Telephone numbers and addresses are listed in the Telephone Numbers and Addresses subsection below.

Ordinarily, the Member must complete the entire complaint and grievance process and receive a final disposition from Capital Health Plan before pursuing review by an external review program. However, Florida law permits the Subscriber Assistance Program to investigate any complaint or grievance that it has been provided before Capital Health Plan makes its final determination.

Timeframes for Resolution of a Grievance

Capital Health Plan will resolve grievances in a timely manner. In resolving grievances, timeframes may vary, depending on the circumstances. Capital Health Plan will; however, resolve the Member's grievance within 30 calendar days after receipt for pre-service claims, or within 60 calendar days for post-service claims.

General Rules

General rules regarding the Capital Health Plan Complaint and Grievance Process include the following:

1. The Member must cooperate fully with Capital Health Plan in its effort to promptly review and resolve a complaint or grievance. If the Member does not cooperate

fully with Capital Health Plan, he or she will be considered to have waived his or her right to have the complaint or grievance processed within the timeframes set forth above.

2. The timeframes set forth herein may be modified by the mutual consent of Capital Health Plan and the Member; however, any mutually agreed timeframe extension does not preclude the Member from asking the State of Florida Subscriber Assistance Program or the Federally Authorized External Review Program to review a Capital Health Plan decision at any time.

3. Capital Health Plan will not honor a request for expedited review that relates to services that have already been performed or provided to the Member or a request that is not eligible for expedited review in accordance with the criteria set forth in the Request for Expedited Review subsection. Capital Health Plan will review any grievance in accordance with the Standard Grievance procedure.

4. Capital Health Plan must receive all grievances within one year of the date of the occurrence that initiated the grievance.

5. If the grievance involves a determination that the service did not meet the Capital Health Plan medical necessity guidelines or is experimental or investigational (or a similar exclusion or limitation), the Member may request an explanation of the scientific or clinical judgment relied on, if any, that applies the terms of the Member Handbook to the Member's medical circumstances.

6. During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination. The members of the Capital Health Plan Grievance Review Panel will not have been involved in a previous denial of the request for coverage or payment, nor will they be a subordinate of an individual who was involved previously in the denial of the request.

7. The Member may ask to review pertinent documents, such as any internal rule, guideline, protocol, or similar criteria relied on to make the determination, and submit issues or comments in writing.

8. If a grievance has been denied by Capital Health Plan and the denial has been upheld by the External Review Program, and nothing regarding the matter has changed (i.e., the benefits, employer, medical condition are unchanged), Capital Health Plan will not be required to reopen the grievance.

Telephone Numbers and Addresses

The Member may contact a Capital Health Plan Member Service Representative at the number listed on the membership card or the numbers listed below. If a grievance is unresolved, the Member may, at any time, contact Capital Health Plan at the telephone

numbers and addresses listed on this page.

Capital Health Plan Member Services
1545 Raymond Diehl Road, Suite 300
Tallahassee, FL 32308
Office hours: Monday – Friday, 8 a.m. to 5 p.m.
850-383-3311 (M-F, 8 a.m. – 5 p.m.)
Toll-free: 877-247-6512 (24 hours a day, 7 days a week)
TDD: 850-383-3534 (M-F, 8 a.m. – 5 p.m.)
TDD Toll-Free: 1-877-870-8943
For expedited reviews fax to 850-383-3413
Florida State Relay: 800-955-8771 or 711 (for the hearing impaired, after business hours)

Mailing Address:
P.O. Box 15349
Tallahassee, FL 32317-5349

Website: http://www.capitalhealth.com

Florida Department of Financial Services
Office of Insurance Regulation
Division of Insurance Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0322
1-877-693-5236 (toll free)

Subscriber Assistance Program
2727 Mahan Drive, Building 1
Mail Stop 26
Tallahassee, FL 32308
850-921-5458
1-888-419-3456 (toll-free)

Agency for Health Care Administration
2727 Mahan Drive, Building 1, Mail Stop 26
Tallahassee, FL 32308
1-888-419-3456 (toll free)

Federally Authorized External Review Program
Mail: Disputed Claims
P.O. Box 791
Washington, DC 20044
Fax: 202-606-0036
Phone: 877-549-8152
Email: DisputedClaim@opm.gov

SECTION 25: GLOSSARY

For purposes of this Member Handbook and any attachments, amendments, and endorsements, the following terms shall have the meanings set forth below:

Accident *means accidental bodily injury sustained by the covered person that results in and is the direct cause of medical expenses independent of illness.*

Accidental Dental Injury *means an injury to sound natural teeth (not previously compromised by decay), caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.*

Allowance *means the maximum amount Capital Health Plan will pay to Non-Contracting Providers for Covered Services other than Emergency Services and Care. This amount is determined solely by Capital Health Plan and is based upon many factors, including but not limited to: the cost of providing the Covered Services; the charge(s) of the provider; the charge(s) of similar providers within a particular geographic area; various pre-negotiated payment amounts and Capital Health Plan's pre-established fee schedules. In no event will the Allowance be greater than the amount the provider actually charge(s). The Allowance may be modified by Capital Health Plan at any time without the consent or notice to the Employer Sponsor or any Member.*

Ambulance *means any private or publicly owned land, air, or water vehicle licensed under Chapter 401, Part III, Florida Statutes, or for services rendered outside Florida, other states' applicable laws, that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, air, land, or water transportation of persons who are in need of medical or surgical attention.*

Ambulatory Surgical Center *means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other states' applicable laws, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.*

Anniversary Date *means the date one year after the Effective Date stated on the Employer Sponsor Application, and subsequent annual anniversaries of that date.*

Applied Behavior Analysis *means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.*

Autism Spectrum Disorder *means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:*

1. *Autistic disorder.*
2. *Asperger's syndrome.*
3. *Pervasive developmental disorder not otherwise specified.*

Artificial Insemination (AI) *means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care provider for the purpose of producing a pregnancy.*

Birth Center *means any facility, institution, or place, licensed pursuant to Chapter 383 of the Florida Statutes, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy. A Birth Center is not an Ambulatory Surgical Center or Hospital.*

Bone Marrow Transplant *means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the Member 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 the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "bone marrow transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all hospital, physician or other health care provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).*

Calendar Year *begins January 1st and ends December 31st in any given calendar year.*

Certified Nurse Midwife *means a person who is licensed pursuant to Chapter 467 of the Florida Statutes, or other states' applicable laws, as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.*

Certified Registered Nurse Anesthetist *means a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or other states' applicable laws.*

Capital Health Plan, Inc., (d/b/a Capital Health Plan*), is a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under*

applicable provisions of federal and/or state law.

Condition *means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Member.*

Confinement *means an approved medically necessary covered stay as an inpatient in a hospital that is due to a condition, and authorized by a licensed medical health care provider with admission privileges. Each "day" of confinement includes an overnight stay for which a charge customarily is made.*

Contracting Provider *means any health care institution, facility, pharmacy, Physician, or other health care provider who has entered into a contract with Capital Health Plan for the provision of health care services.*

Copayment *means the dollar amount established solely by Capital Health Plan which is required to be paid to a health care provider by a Member at the time certain Covered Services are rendered by that provider. While this amount may vary depending on, among other things, the contracting status of the health care provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Schedule of Copayments for the service. Except as otherwise established solely by Capital Health Plan, if more than one Covered Service is rendered by a health care provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Copayments for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.*

Covered Person *means eligible employees, retirees, surviving spouses, COBRA participants, or any eligible dependents included for coverage under Capital Health Plan.*

Covered Services *means those Medically Necessary health care services and/or supplies described in the Covered Services sections. The terms "health care services" and "services" include treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals and chemical compounds.*

Creditable Coverage *means health care coverage which is continuous to a date within 63 days of the Member's Effective Date. Such health care coverage may include any of the following:*

1. *An Employer Sponsored health plan;*
2. *Individual health insurance;*
3. *Part A and Part B Medicare;*
4. *Medicaid;*
5. *Benefits to members and certain former members of the uniformed services and their dependents;*
6. *A medical care program of the Indian Health Service or of a tribal*

organization;

7. *A State health benefits risk pool;*
8. *A health plan offered under chapter 89 of Title 5, United States Code;*
9. *A public health plan; or*
10. *A health benefit plan of the Peace Corps.*

Crisis Intervention *means acute inpatient psychiatric care which is required for evaluation of an acute psychosis or crisis situation in which the patient presents as a danger to self or others. The acute or crisis situation may be an exacerbation of a history of mental illness or the sudden onset of a psychiatric disorder. The crisis or acute period normally extends 48 to 72 hours, but may be of greater duration depending upon the response to therapy.*

Custodial or Custodial Care *means care that serves to assist an individual in 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. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. 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.*

Dependent *means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection, is properly enrolled hereunder through submission of applicable forms through the Plan Sponsor and is eligible to enroll as a Covered Dependent, and for whom, or on whose behalf, premium and any supplemental charges have been received by Capital Health Plan.*

Detoxification *means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent Member is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the Member at a minimum.*

Diabetes Educator *means a person who is properly certified pursuant to Florida law, or other states' applicable law, to supervise diabetes outpatient self-management training and educational services.*

Durable Medical Equipment *means equipment furnished by a supplier or a home health agency that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) is not for comfort or convenience; (4) generally is not useful to an individual in the absence of a Condition; and (5) is appropriate for use in the home.*

Effective Date *with respect to the Employer Sponsor and to Members properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the Employer Sponsor Application; and with respect to Members subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section.*

Eligible Dependent *means an individual who meets all of the eligibility requirements set forth in the Eligibility Requirements for Dependents subsection and is eligible to enroll as a Dependent.*

Eligible Employee *means an individual who meets all of the eligibility requirements set forth in the Eligibility Requirements for Subscribers subsection and is eligible to enroll as a Subscriber.*

Emergency Medical Condition*, as indicated in the Member's chart by a Physician or, to the extent permitted by law, by other appropriate licensed professional Hospital personnel under the supervision of a Hospital Physician, 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 immediate 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; or*
    c. *Serious dysfunction of any bodily organ or part.*

2. *With respect to a pregnant woman:*

    a. *That there is inadequate time to effect safe transfer to another hospital prior to delivery;*
    b. *That 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.*

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

Employer Sponsor *means the employer, labor union, trust, association, partnership,*

department, other organization or entity through which coverage and/or benefits are issued by Capital Health Plan, and through which Eligible Employees and Eligible Dependents become entitled to the Covered Services described herein.

Employer Application *means the form acceptable to Capital Health Plan which the Employer must submit to Capital Health Plan when applying for coverage.*

Employer Plan Sponsor *means the Employer Sponsored health benefit plan established and maintained by the Employer through the purchase of comprehensive health care coverage and benefits from Capital Health Plan.*

Experimental or Investigational *means 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 if, as determined solely by Capital Health Plan:*

1. *such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to the Member;*

2. *such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;*

3. *such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;*

4. *reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;*

5. *reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;*

6. *reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in*

question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

7. *there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or*

8. *such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.*

"Reliable evidence" shall mean (as determined by Capital Health Plan):

1. *records maintained by physicians or hospitals rendering care or treatment to the Member or other patients with the same or similar Condition;*

2. *reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;*

3. *published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;*

4. *the written protocol or protocols relied upon by the treating physician or institution or the protocols of another physician or institution studying substantially the same evaluation, treatment, therapy, or device;*

5. *the written informed consent used by the treating physician or institution or by another physician or institution studying substantially the same evaluation, treatment, therapy, or device; or*

6. *the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.*

NOTE: Services or supplies which are determined by Capital Health Plan to be Experimental or Investigational are excluded (see Exclusions and Limitations Section). In making benefit determinations, Capital Health Plan may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

Home Health Agency *means a properly licensed agency or organization which provides health services in the home pursuant to Chapter 400 of the Florida Statutes, or other states' applicable laws.*

Hospice *means a public agency or private organization which is duly licensed by the state to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.*

Hospital *means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other state's applicable laws, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.*

The term Hospital does not include: an Ambulatory Surgical Center, a Skilled Nursing Facility, a stand-alone Birthing Center; a facility for diagnosis, care and treatment of Mental and Nervous Disorders or alcoholism and drug dependency; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or rehabilitative care.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Illness *means physical sickness or disease, pregnancy, bodily injury, or congenital anomaly.*

Intensive Care Unit *means a specialized area in a hospital in which an acutely ill patient receives intensive care or treatment. Included in the hospital's charge, in the intensive care unit, are the services of specially trained professional staff, nurses, supplies, the use of any and all equipment, and the patient's board. A coronary care unit also is considered an intensive care unit.*

Individual Application for Employer Coverage/Membership *means the form(s) provided by or acceptable to Capital Health Plan, which an individual must complete and submit to Capital Health Plan when applying for Membership as a Subscriber.*

In Vitro Fertilization (IVF) *means a process in which an egg and sperm are combined in*

a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

Medical Director of Capital Health Plan *means a Physician serving as the Medical Director in the Service Area of Capital Health Plan in which the Member is enrolled.*

Medical Literature *means scientific studies published in a United States peer-reviewed national professional journal.*

Medically Necessary *or* ***Medical Necessity*** *means, for coverage and payment purposes, that a medical service or supply is required for the identification, treatment, or management of a Condition, and is, in the opinion of Capital Health Plan:*

1. *consistent with the symptom, diagnosis, and treatment of the Member's condition;*
2. *widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;*
3. *universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;*
4. *not Experimental or Investigational;*
5. *not for cosmetic purposes;*
6. *not primarily for the convenience of the Member, the Member's family, the Physician or other provider; and*
7. *the most appropriate level of service, care or supply which can safely be provided to the Member. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Member in an alternative setting.*

Medically Necessary Leave of Absence *means for the purposes of continued coverage in accordance with Michelle's Law, a leave of absence from a post-secondary educational institution or any change in enrollment of an eligible dependent child at the institution, that:*

1. *begins while the eligible dependent child is suffering from a serious illness or injury on such date as determined by the dependent child's treating provider;*

2. *is medically necessary, as determined and evidenced by written certification provided by the eligible dependent child's treating provider to Capital Health Plan; and*

3. *causes the eligible dependent child to lose student status for purposes of coverage under this plan.*

Medical Supplies or Equipment *shall mean supplies or equipment that are:*

1. *ordered by a physician;*
2. *of no further use when medical need ends;*
3. *usable only by the covered person;*
4. *not primarily for the patient's comfort or hygiene;*
5. *not for environmental control;*
6. *not for exercise;*
7. *manufactured specifically for medical use.*

Medicare *means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.*

Member *means any Subscriber or Dependent.*

Membership *means having the status of being a current Member.*

Membership Card *means the identification card issued by Capital Health Plan to Members. The Membership Card is the property of Capital Health Plan, and is not transferable to another person. Possession of such Membership Card in no way verifies that a particular individual is eligible for or covered under the Employer Plan.*

Member Status Change Request Form *means the form(s) provided by or acceptable to Capital Health Plan, which a Subscriber must complete and submit to Capital Health Plan when adding or deleting a Dependent.*

Mental Health Professional *means a person properly licensed to treat mental health problems pursuant to Chapter 491 of the Florida Statutes, or other states' applicable laws. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination or sect who provide counseling services.*

Mental or Nervous Disorder *means any and all disorders listed in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.*

Midwife *means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or other states' applicable laws.*

Nursing Services *means services that are provided by an advanced registered nurse practitioner (A.R.N.P.), registered nurse (R.N.), or a licensed practical nurse (L.P.N.), who is licensed under Chapter 464, Florida Statutes, and is:*

1. *acting within the scope of that person's license;*
2. *authorized by a physician; and*
3. *not a member of the covered person's immediate family.*

Non-Contracting Provider *means any health care institution, facility, pharmacy, Physician, or other health care provider with whom Capital Health Plan does not have a contract in effect at the time the health care services are provided.*

Occupational Therapy *means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.*

Occupational Therapist *means a person properly licensed to practice occupational therapy pursuant to Chapter 468 of the Florida Statutes, or other states' applicable laws.*

Orthotic Device *means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.*

Outpatient Healthcare Facility *means a licensed facility other than a doctor's, physical therapist's, or midwife's office, that provides medically necessary outpatient services for treatment of an illness or injury other than mental or nervous disorders, drug addiction, or alcoholism.*

Palliative Therapy *means the reduction or abatement of pain and other troubling symptoms through services provided by members of the hospice team of health care providers.*

Participating Provider *means a hospital, doctor, pharmacy, medical laboratory, or other health care provider who has entered into a contractual agreement with Capital Health Plan to provide services to covered persons at a negotiated rate.*

Partial Hospitalization *means treatment in which the patient receives at least seven (7) hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.*

Physical Therapy *means the treatment of disease or injury by physical or mechanical means. Such therapy may include traction, active or passive exercises, or heat therapy.*

Physical Therapist *means a person properly licensed to practice physical therapy pursuant to Chapter 486 of the Florida Statutes, or other states' applicable laws.*

Physician Assistant *means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.*

Physician *means any individual who is properly licensed by the State of Florida, or other states' applicable laws, as a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Chiropractic, Doctor of Dental Surgery or Dental Medicine, or Doctor of Optometry.*

Premium *means the amount required to be paid periodically by the Employer Plan Sponsor on behalf of Members enrolled hereunder.*

Primary Care Physician *means the Physician who is the Primary Care Physician for the Member, according to Capital Health Plan's records, and who provides primary care medical services to Members under a Primary Care Physician provider contract with Capital Health Plan then in effect. A Primary Care Physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with Capital Health Plan as a Primary Care Physician. Refer to the Primary Care Physicians section(s) of the provider directory for Physicians who are Primary Care Physicians.*

Prosthetic Device *means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.*

Psychiatric Facility *means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For coverage purposes, a psychiatric facility is not a Hospital, as defined herein.*

Psychologist *means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or other states' applicable laws.*

Residential facility *means a licensed facility providing an inpatient rehabilitation program for the treatment of alcohol or drug abuse or mental or nervous conditions. The program must be accredited by the Joint Commission of the Accreditation of Hospitals (JCAH) and licensed by the Department of Children and Family Services.*

Semi-Private Room *means a hospital room with two bed accommodations in which an inpatient receives board and general nursing care included in the hospital's charge for that room.*

Service Area *means the geographic area(s) in Florida that Capital Health Plan is licensed to service: Calhoun County, Franklin County, Gadsden County, Jefferson County, Leon County, Liberty County, and Wakulla County.*

Skilled Nursing Facility *means an institution or part thereof which is licensed as a skilled nursing facility by the State of Florida, or other states' applicable laws, accredited as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by Capital Health Plan; and which provides Covered Services that are skilled nursing services, as determined by Capital Health Plan, to Members under a contract then in effect.*

Skilled Nursing Care *means care furnished by, or under the direct supervision of, licensed registered nurses (under the general direction of the physician) to achieve the medically desired result and to ensure the covered person's safety. Skilled nursing care may include providing direct care when the ability to provide the service requires specialized and/or professional training, observation and assessment of the covered person's medical needs, or supervision of a medical treatment plan involving multiple services when specialized health care knowledge must be applied to attain the desired medical results.*

Specialist *means a Physician, who is a Contracting Provider, or a Physician who is a Non-Contracting Provider when authorized by Capital Health Plan, who limits practice to specific services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics or geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board. (Refer to the Physicians who are listed under Specialty Physicians in the Capital Health Plan Directory of Physicians & Service Providers.)*

Speech Therapy *means the treatment of speech and language disorders by a qualified health care provider including language assessment and language restorative therapy services.*

Speech Therapist *means a person properly licensed to practice speech therapy pursuant to Chapter 468 of the Florida Statutes, or other states' applicable laws.*

Standard Reference Compendium *means (1) The United States Pharmacopoeia Drug Information; (2) The American Medical Association Drug Evaluation; (3) The American Hospital Formulary Service Hospital Drug Information.*

State or state *means the State of Florida or any other state of the United States in which Capital Health Plan is authorized and licensed to operate and in which a Service Area has been established.*

Subscriber *means an Eligible Employee who meets and continues to meet all applicable eligibility requirements of the Eligibility Requirements for Subscribers subsection, who*

enrolls hereunder, and for whom the payment(s) required by Capital Health Plan has been received.

Substance Dependency *means a condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.*

Terminally Ill *means that a person has a life expectancy of one year or less because of a chronic, progressive illness that is incurable according to the person's doctor.*

Well Baby Hospital Nursery Services *means those covered services and supplies associated with the care of a healthy newborn child.*

Waiting Period *means the period of time specified on the Employer Plan Sponsor Application, if any, which must follow the date an individual is initially employed by the Employer Plan Sponsor before such individual may become a Member.*

Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Program Prescription Drug Endorsement

Copayments: $7 Tier 1; $30 Tier 2; $50 Tier 3

This Endorsement is to be attached to and made a part of your Capital Health Plan, Inc. (CHP) Member Handbook/Certificate of Coverage. The Member Handbook/Certificate of Coverage hereby is amended by adding to the Covered Services Section a subsection titled "**CHP Pharmacy Program**."

The Exclusions and Limitations Section of the Member Handbook/Certificate of Coverage is amended by deleting the applicable exclusion for **Prescription Drugs.**

All other provisions of the Member Handbook/Certificate of Coverage shall remain unchanged.

CHP PHARMACY PROGRAM

The CHP Pharmacy Program provides benefits for covered prescription drugs and supplies. Each covered prescription drug, when purchased from a participating pharmacy, will be subject to a copayment amount. The copayment amount is determined by the type of prescription drug dispensed (i.e., tier 1 drug, tier 2 drug, tier 3 drug or, if applicable, tier 4 drug). A preferred brand name prescription drug on the Commercial Formulary then in effect will be reclassified as a non-preferred prescription drug on the date the FDA approves a bioequivalent generic prescription drug. Non-preferred prescription drugs are subject to a higher copayment as set forth under "copayments" below. CHP reserves the right to add, remove or reclassify any prescription drug on the Commercial Formulary at any time.

Covered prescription drugs must be medically necessary, prescribed by a medical professional acting within the scope of his or her license, and dispensed by a pharmacist.

Copayments

For each covered prescription drug obtained from a participating pharmacy	$7 Tier 1 – Generic Drugs $30 Tier 2 - Preferred Brand Name Drugs (excluding Preferred Specialty products) $50 Tier 3 - Non-Preferred Brand Name Drugs

Definitions Specific to the CHP Pharmacy Program

Brand Name Prescription Drug
A prescription drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer drug, or a drug that is licensed to another company by the brand name drug manufacturer for distribution or sale, whether or not the other company markets the drug under a generic or other non-proprietary name.

Copayment
The amount that the member pays the participating pharmacy at the time of service for each covered prescription drug, as specifically set forth in this Endorsement.

Covered Prescription Drugs
All drugs that:

- Require a prescription under federal or state law
- Are covered by this Endorsement when filled at participating pharmacies
- Are prescribed by a participating prescriber
- Are authorized by Capital Health Plan

Drug
Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical, or chemical compound.

FDA
United States Food and Drug Administration.

Generic Drug
A prescription drug containing the same active ingredients as a brand name prescription drug that either (i) has been approved by the FDA for sale or distribution as the bioequivalent of a brand name prescription drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (ii) is a prescription drug that is not a brand name prescription drug, is legally marketed in the United States and, in the judgment of CHP, is marketed and sold as a generic competitor to its brand name prescription drug equivalent. All generic drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the brand name prescription drug.

Medically Necessary
For coverage and payment purposes, that a medical service, drug, or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of CHP:

1. consistent with the symptom, diagnosis, and treatment of the member's condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based on scientific evidence;
3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not experimental or investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of the member, the member's family, or the prescriber; and,
7. the most appropriate level of service, care or supply which can safely be provided to the Member.

Non-participating Pharmacy
A retail pharmacy that has not signed an agreement with CHP to furnish services to members.

Non-preferred Drug
A prescription drug that is not otherwise noted as preferred on the Commercial Formulary then in effect. **Note:** The Commercial Formulary is subject to change at any time. Please refer to our web site at www.capitalhealth.com for the most current Commercial formulary or you may call the member services number on your Identification Card.

Participating Pharmacy
A retail pharmacy that has signed an agreement with CHP to render services to members, as set forth in this Endorsement.

Provider
"Provider" is the general term that we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by the state to provide health care services.

Pharmacist
A person properly licensed to practice the profession of pharmacy under Chapter 465, Florida Statutes, or other states' applicable laws.

Preferred Brand Name Drug
A drug that is noted as preferred on the Commercial Formulary then in effect. A preferred brand name drug on the Commercial Formulary then in effect will be reclassified as a non-preferred prescription drug on the date the FDA approves a bioequivalent generic prescription drug. **Note:** The Commercial Formulary is subject to change at any time. Please refer to our web site at www.capitalhealth.com for the most current formulary or you may call the member services number on your Identification Card.

Preferred Specialty Drug
A medication that meets the definition of a specialty drug and is noted as preferred on the Commercial Formulary. A trial of a preferred specialty drug in treating the indicated disease state may be required before an alternative non-preferred drug will be approved for use. A preferred specialty drug has the same member co-payment or co-insurance as a non-preferred specialty drug.
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Prescriber
A medical professional (e.g., physician, optometrist, nurse practitioner) whose state license authorizes him or her to prescribe drugs.

Prescription
An order for drugs by a physician authorized by the laws of the state to prescribe such drugs or supplies.

Prescription Drug
Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that can be dispensed only under a prescription and/or that is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription."

Primary Care Physician (PCP)
The physician who is the primary care physician for the member, according to CHP's records, and who provides primary care medical services to members under a primary care physician provider contract with CHP then in effect.

Prior Authorization
Approval in advance to get covered prescription drugs. Some covered prescription drugs require approval in advance from Capital Health Plan.

Specialty Drug
Medications that generally have unique uses, require special dosing, handling or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies

Standard Reference Compendium
The United States Pharmacopoeia Drug Information; The American Medical Association Drug Evaluation; and, The American Hospital Formulary Service Hospital Drug Information.

Covered Items

This Endorsement provides benefits for covered drugs.

To be covered under this Endorsement, prescriptions must be prescribed by a medical professional acting within the scope of his or her license and dispensed by a participating pharmacy.

Unless otherwise excluded, all prescription drugs are covered under this program.

Insulin and chemstrips are covered if prescribed by a medical professional acting within the scope of his or her license. Insulin needles and syringes will be covered only when prescribed in conjunction with insulin. A separate brand copayment is required for syringes and needles.

Anaphylactic kits are covered only when self-administered and prescribed by a medical professional acting within the scope of his or her license.

Limitations and Exclusions

The following limitations and exclusions apply to benefits for covered prescription drugs and supplies, in addition to all of the other provisions and exclusions of the Member Handbook/Certificate of Coverage:

Limitations

1. A prescription unit or refill will be covered up to a 90-day supply for generic drugs (at 3 copays per 90 day supply) or a prescription unit or refill up to a 30-day supply for brand name drugs if a generic is not manufactured. Refills on prescriptions shall not be covered until at least 75% of the previous prescription has been used by the member based on the dosage schedule prescribed.
2. Refills that are authorized by the prescriber must be filled within six months or one year from the original prescription date, depending on federal law designations.
3. Syringes and needles will be covered only when prescribed and obtained with a prescription for insulin.
4. Certain prescription drugs, including some injectables, require prior authorization. For a list of these drugs, refer to www.capitalhealth.com. For instructions about how to get prior authorization, call Member Services at 850-383-3311 (toll-free 1-877-247-6512); TTY 850-383-3534 (Florida Relay toll-free 1-800-955-8771).
5. If a generic drug is available, and a more expensive brand name prescription drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug.
6. CHP retains the right to limit coverage of the quantities of drugs that may be prescribed on a p.r.n (as needed) basis.

7. CHP retains the right to designate a specific pharmacy or pharmacies that may cover certain covered drugs.

Exclusions

1. Drugs that can be purchased over the counter without a prescription, except insulin, even though a prescription was provided by prescriber.
2. Drugs that are administered or dispensed and billed by a hospital or prescriber.
3. Drugs that are dispensed before the effective date, or after the termination date, of this Endorsement.
4. All contraceptive devices, appliances, services, or supplies.
5. All syringes and needles except as otherwise covered under this Endorsement.
6. Prescriptions refilled in excess of the amount specified by the prescriber.
7. Drugs in excess of the limitations specified in this Endorsement.
8. Drugs that are obtained by the member without charge.
9. Drugs that are experimental or investigational.
10. Appetite suppressants and other prescription drugs indicated for weight reduction or control.
11. Mineral supplements or vitamins, except for the following: prescription prenatal vitamins, prescription sustained release niacin, prescription folic acid, prescription oral hematinic agents, dihydrotachysterol, fluorinated vitamins, and calcitriol.
12. Immunization agents, biological sera, blood, blood plasma, and injectable drugs other than as described in **Limitations,** item 4.
13. Fertility drugs or any drugs used for the purpose of enhancing the probability of conception.
14. Drugs used for cosmetic purposes.
15. Drugs prescribed by a pharmacist.
16. Smoking cessation drugs.
17. Drugs listed in the Homeopathic Pharmacopeia.
18. Drugs prescribed for uses other than the FDA-approved label instructions. (This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for treatment in medical literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.)
19. Drugs that are not approved by the FDA.
20. Drugs and supplies that are not medically necessary.
21. Certain prescription drugs approved for sexual dysfunction (Edex, Caverject, papaverine, Yocon, and phentolamine).
22. Drugs purchased from a non-participating pharmacy, except as a result of an emergency medical condition or when authorized by CHP.
23. All new prescription drugs that are approved by the FDA for marketing are excluded during the 12 consecutive months that immediately follow the date of the FDA's approval unless CHP, at its sole discretion, decides to waive this exclusion with respect to a particular prescription drug.
24. Any drug administered by intravenous infusion or injection, regardless of the setting in which it is administered or the type of provider administering the drug, except as specified in the Covered Items section of this Endorsement.
25. All prescription drugs for which prior authorization is required by this Endorsement and for which prior authorization is not obtained before the prescription is filled.
26. Any prescription drug prescribed in excess of the manufacturer's recommended specifications for dosage, frequency of use, or duration of administration, as set forth in the manufacturer's insert for that prescription drug. This exclusion does not apply if:
    a. the dosage, frequency of use, or duration of administration of a prescription drug has been shown to be safe and effective as evidenced in published, peer-reviewed medical or pharmacy literature;

b. the dosage, frequency of use, or duration of administration of a prescription drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or,
c. CHP, at its sole discretion, waives this exclusion with respect to a particular prescription drug or therapeutic classes of prescription drugs.

Drugs Purchased from a Participating Pharmacy

The member must present the CHP membership card to the participating pharmacy to be identified as a member of this program.

The participating pharmacy will dispense covered prescription drugs to the member. The member will be responsible at the time of purchase for required copayments or cost sharing for each covered prescription drug.

The participating pharmacy will obtain the necessary information from the member (e.g., name, contract number, and date of birth) and file the claim. Payment for the covered prescription drugs will be made directly to the participating pharmacy.

Drugs Purchased From a Non-Participating Pharmacy

When covered prescription drugs are purchased from a non-participating pharmacy (because of an emergency medical condition or when authorized by CHP), the member will be required to pay the full cost of the drug at the point of service. To obtain reimbursement, the member must submit an itemized paid receipt to CHP within 90 days of purchase for each covered prescription drug purchased from a non-participating pharmacy. The itemized paid receipt must be submitted to CHP Member Services, P.O. Box 15349, Tallahassee, FL 32317-5349.

Prescription Drug Coverage Prior Authorization Program

Certain drugs need to be approved by CHP before they can be covered for payment; the list of these drugs is available at www.capitalhealth.com. If any of these drugs is prescribed, the person covered by this Endorsement will need to call Member Services (850-383-3311, toll-free 1-877-247-6512); TTY 850-383-3534 (Florida Relay toll-free 1-800-955-8771)) to obtain prior authorization. Member Services will process the request and the person covered by this Endorsement will be notified if the drug is approved for coverage. **Failure to obtain authorization will result in denial of coverage.**

NOTE: This does not mean that the member cannot obtain the prescription drug from the pharmacy. It only means that CHP will not cover or pay for the prescription. The member may always purchase the prescription drug.

To obtain prior authorization:

1. The member, the prescriber, or the pharmacist must call Member Services and provide the information requested by the Member Services Representative. This information may include, but is not limited to, the member's name, date of birth, and prescriber's name and telephone number.

2. CHP will contact the prescriber to get documentation for medical review.

3. Once a decision is made by CHP regarding coverage, the member, the prescriber, and the member's primary care physician will be informed. Denial decisions will be provided to the member in writing together with an explanation of the member's appeal rights.

4. If the decision is made to allow coverage, the member will be able to have the prescription filled at a participating pharmacy for the required copayment.

5. If the decision is made not to allow the coverage, the member will be able to have the prescription filled, but the member will have to pay the full cost of the drug.

The Prescription Drug Coverage Prior Authorization Program has been established solely to determine whether coverage or benefits for prescription drugs will be provided under the terms of the Member Handbook/Certificate of Coverage. Ultimately, the final decision whether the prescription drug should be prescribed must be made by the member and the prescriber. **Decisions made by CHP in administering the Prescription Drug Coverage Prior Authorization Program are made only to determine whether coverage or benefits are available under the Member Handbook/Certificate of Coverage.**

Any and all decisions that require or pertain to independent professional medical judgments or training, or the need for a prescription drug, must be made solely by the member and the prescriber. It is possible that the member or the prescriber may conclude that a particular prescription drug is needed, appropriate, or desirable, even though that prescription drug may not be authorized for coverage under the Prescription Drug Coverage Prior Authorization Program. In that case, it is the member's right and responsibility to decide whether the prescription drug should be purchased even if CHP has indicated that coverage and payment will not be made under the Member Handbook/Certificate of Coverage.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Member Handbook/Certificate of Coverage, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Member Handbook/Certificate of Coverage, the provisions contained in this Endorsement shall control to the extent necessary to accomplish the intent of Capital Health Plan, Inc., as expressed herein.

CAPITAL HEALTH PLAN, INC.

John Hogan
President and Chief Executive Officer

www.capitalhealth.com

P.O. Box 15349 • Tallahassee, Florida 32317-5349 • 850-383-3311

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MEMBER HANDBOOK ENDORSEMENT

FITNESS CENTER REIMBURSEMENT PROGRAM

This endorsement is to be attached to and made a part of your Capital Health Plan Member Handbook/Certificate of Coverage and any endorsements attached thereto.

Effective January 1, 2008, Capital Health Plan subscribers (the holders of the contract) will be eligible to be reimbursed for certain payments that they make during the calendar year towards health and fitness center membership for themselves and any covered dependents. The maximum fitness reimbursement per subscriber (inclusive of any and all covered dependents) is $150.00 each calendar year.

The subscriber or covered dependent for whom reimbursement is sought must be a member of Capital Health Plan (CHP) and a member of the health and fitness center for at least four consecutive months in the calendar year for which reimbursement is sought. The subscriber also must be a current member of CHP at the time CHP receives the request for reimbursement. All reimbursements will be made to the subscriber.

To obtain reimbursement, the subscriber must send the following items to Capital Health Plan, Post Office Box 15349, Tallahassee, FL 32317-5349:

- A signed and dated Health/Fitness Center Reimbursement Form.
- All applicable receipts, credit card records, cancelled checks, and pay stubs that show payment to the health or fitness center.
- A copy of the health center agreement or contract, showing the name and address of the health center and the name of contractee, including beginning and ending dates of membership or class.

The Health/Fitness Center Reimbursement Form is available from Member Services (850-383-3311 or TTY 850-383-3534) and on the Capital Health Plan website, www.capitalhealth.com.

Fitness reimbursement requests may be filed only once each calendar year and no later than March 31st of the year following the year for which reimbursement is requested. To be reimbursed for two or more qualifying expenses, each expense must be included on the same form.

Fitness centers eligible for the fitness center reimbursement are facilities for exercising and improving physical fitness that include cardiovascular and strength training equipment.

The following **do not qualify** for fitness reimbursement:

- Country or social clubs
- Spas
- Gymnastics centers
- Martial arts studios
- Tennis facilities
- Sports teams or leagues
- Personal trainers
- Uniforms/clothing
- Exercise/fitness equipment
- Weight loss programs

Any provisions of the Member Handbook/Certificate of Coverage that exclude fitness reimbursement are superseded by this endorsement.

All other provisions of the Member Handbook/Certificate of Coverage shall remain unchanged.

This endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Member Handbook/Certificate of Coverage, other than as stated specifically in this endorsement. In the event of any inconsistencies between the provisions contained in this endorsement and the provisions contained in your Member Handbook/Certificate of Coverage, the provisions contained in this endorsement shall control to the extent necessary to effectuate the intent of Capital Health Plan, Inc. as expressed herein.

CAPITAL HEALTH PLAN, INC.

John Hogan
President & Chief Executive Officer

www.capitalhealth.com

P.O. Box 15349 • Tallahassee, Florida 32317-5349 • 850-383-3311

Large Group
MEMBER HANDBOOK ENDORSEMENT

Domestic Partnership Endorsement

P.O. Box 15349
Tallahassee, FL 32317-5349
www.capitalhealth.com

This Endorsement is to be attached to and made a part of your Capital Health Plan, Inc. (CHP) Member Handbook/Certificate of Coverage. The member handbook/certificate of coverage hereby is amended with this endorsement. All other provisions of the member handbook shall remain unchanged.

This endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the member handbook, other than as specifically stated in the provisions this endorsement. In the event of any inconsistencies between the provisions contained in this endorsement and the provisions contained in the member handbook, the provisions contained in this endorsement shall control to the extent necessary to accomplish the intent of Capital Health Plan, Inc., as expressed herein.

Capital Health Plan, Inc.

John Hogan
President and Chief Executive Officer

NON-FEDERALLY QUALIFIED FOR LARGE GROUPS
MEMBER HANDBOOK ENDORSEMENT

This endorsement is to be attached to and made a part of your Capital Health Plan Non-Federally Qualified for Large Groups Member Handbook and any endorsements attached thereto. The group plan is amended as described below to provide coverage for a Domestic Partner of a Subscriber (employee only).

Glossary

Domestic Partner means a person of the same or opposite sex with whom the Subscriber (employee only) has established a Domestic Partnership.

Domestic Partnership means a relationship between a Subscriber (employee only) and one other person of the same or opposite sex that meets at a minimum the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;

2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;

3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;

4. both individuals are financially interdependent and have resided together continuously in the same residence for at least 12 months before applying for coverage under this Member Handbook and intend to continue to reside together indefinitely;

5. the Subscriber has submitted to the Group acceptable proof of common residence and joint financial responsibility; and,

6. the Subscriber has completed and submitted any required forms to the Group and the Group has determined that the Domestic Partnership eligibility requirements have been met.

Domestic Partner Eligibility

The Subscriber's (employee only) present Domestic Partner is eligible to apply for coverage under this Group Plan.

Domestic Partner Enrollment Forms/Electing Coverage

When an eligible employee is making application for coverage for his/her Domestic Partner, the eligible employee must complete and submit through his/her employer any required Enrollment Forms.

When an eligible employee is electing coverage for himself/herself and his/her Domestic Partner, and Employee/Spouse Coverage is available under the Group's program, Employee/Spouse Coverage is redefined as Employee/Domestic Partner Coverage.

Representation on the Application and any Required Forms

Capital Health Plan (CHP) relies on the information provided by the Subscriber with respect to a specific Domestic Partnership and on the information provided by individuals applying for coverage under this Group Plan on any required enrollment forms to determine whether to issue this endorsement, to determine the appropriate premium, and to determine whether an individual is eligible for and entitled to coverage under this Group Plan. All information provided must be accurate and complete; however, statements made on the application and any required forms are representations and not warranties.

Any misrepresentations, omission, concealment of facts, or any incorrect statement, on any forms required for Domestic Partnership may result, in addition to any other legal right Capital Health Plan may have, in denial of a claim, cancellation or rescission of an individual's coverage under this Group Plan, if such representation, omission, concealment of facts, or incorrect statement is:

1. fraudulent;
2. material to CHP's decision to issue this endorsement;
3. material to CHP's decision to issue this Member Handbook to the Subscriber for the Premium charged or with the finance method utilized; or,
4. material to CHP's decision to provide coverage under this Group Plan for any individual.

Domestic Partner Enrollment Periods

An Eligible Employee may make application for an eligible Domestic Partner during the following enrollment periods:

1. employee's Initial Enrollment Period;

2. Annual Open Enrollment Period; or,

3. within the 30-day period immediately following the satisfaction of the eligibility requirements of the Domestic Partnership.

Termination of a Domestic Partner's Coverage

In addition to the Member Handbook provisions stated in the *Termination of Dependent Membership* subsection, a Domestic Partner's coverage under this Group Plan will terminate at 12:01 a.m. on the last day of the first month that the Domestic Partnership terminates. The Subscriber must notify the Group within 10 days of when the Domestic Partnership eligibility requirements no longer are met or within 10 days of the death of the Domestic Partner.

Continuation of Coverage under COBRA

Covered Domestic Partners are not entitled to continuation of coverage under COBRA, but may be entitled to apply for a CHP conversion policy as set forth in the Conversion Privilege Section of the Member Handbook.

Group Responsibilities

The Group is responsible for determining eligibility of the Domestic Partner and for submitting any required forms completely and accurately to CHP on a timely basis. CHP reserves the right, however, to audit the Group's eligibility determinations with respect to coverage under this Group Plan. The Group and Subscriber agree to cooperate fully with CHP with respect to any audit and agree to provide CHP with information and documentation necessary to verify the existence of a Domestic Partnership as defined in this endorsement.

Miscellaneous

The term, "Dependent," is modified to include the reference to Domestic Partner when spouse is referenced.
