Capital Health Plan Small Employer Member Handbook

Capital Health PLAN™
An Independent Licensee of the Blue Cross and Blue Shield Association

www.capitalhealth.com

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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. Capital Health Plan may require acceptable documentation that an individual meets and continues to meet the eligibility requirements such as a court order naming the Member as the legal guardian or appropriate Adoption documentation described in the *Enrollment and Effective Date of Coverage* section.

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 must work for the Employer Plan Sponsor on a full time basis, with a normal work week of 25 hours or more;

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

3. the employee must maintain their primary residence in the Service Area or be regularly employed in the Service Area;

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

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

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). (Note: Ex-spouses are not Eligible Dependents even if coverage is court ordered); 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 their 26th birthday); or

   b. in the case of a Foster Child, is no longer eligible under the Foster Child Program; or

   c. between the end of the Calendar Year in which they become 26, but has not reached the end of the Calendar Year in which they become 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.

Note: If a Dependent child who has reached the end of the Calendar Year in which they become age 26, but has not reached the end of the Calendar Year in which they become age 30, obtains a dependent of their own (e.g. through birth or adoption), the Covered Dependent child will lose their eligibility for this coverage. It is the Subscriber'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.

   d. 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 and is 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.

e. in the case of a handicapped Dependent child, such child is eligible to continue coverage beyond the limiting age, if the child:

   i. is already covered by the Subscriber and would otherwise lose coverage due to attainment of the applicable limiting age;

   ii. is, in the opinion of Capital Health Plan, incapable of self-sustaining employment by reason of mental retardation or physical handicap which commenced prior to the time such Dependent reached their 26th birthday;

   iii. is chiefly dependent on the Subscriber for support and maintenance; and

   iv. maintains their primary residence in the Service Area.

Note: The subscriber must request continuation of a handicapped child through Capital Health Plan's Member Services department no more than 60 days prior to (but no later than 30 days after) the child's coverage would be, or has been, terminated due to having reached the limiting age. Requested documentation must be submitted to Capital Health Plan for review and approval of continuation.

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 and their Employer Plan Sponsor as soon as possible (but no later than 30 days) when a Dependent 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 end of the month in which such eligibility requirement was not met, and to recover an amount equal to the allowed amount 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 disqualification for or termination of coverage, in addition to any other legal right(s) Capital Health Plan may have. Time limit on certain defenses: Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period.

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, less Premium received by Capital Health Plan for coverage for 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 their Employer Plan Sponsor, a Capital Health Plan Enrollment Application. The form must be received by Capital Health Plan no more than 30 days after the Effective Date of the coverage;

2. provide any additional information needed to determine eligibility, if requested by

Capital Health Plan; and

3. agree to pay their portion of the required Premium.
When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Employer Plan Sponsor's program.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period

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

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 determined by the applicable Waiting Period set forth on the Employer Plan Sponsor Application.

Special Enrollment

An Eligible Employee who declined coverage in writing at the time of their 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 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 or Florida Continuation of Coverage, at the time they were initially eligible to enroll with Capital Health Plan provided that:

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

b. demonstrates that they have 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 Florida Continuation, or reduction in the number of hours of employment; and

c. 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 for an Eligible Dependent, the Eligible Employee must complete the Enrollment Application (if the Eligible Employee also is enrolling) or the Member Status Change Request Form (if the Eligible Employee is already enrolled and is only enrolling their Eligible Dependents) and submit it to their Employer Plan Sponsor. The Employer Plan Sponsor must forward it to Capital Health Plan. The applicable form and any applicable supporting documentation must be received by Capital Health Plan 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). Note: the Subscriber must also use the Member Status Change Request Form to disenroll a Dependent.

The Effective Date of coverage for an Eligible Employee and any 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.

NOTE: Loss of coverage for failure to pay the Member 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.

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 also may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the Enrollment Application and submit it to their Employer Plan Sponsor. The Enrollment Application and any applicable supporting documentation must be received by 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.

For Subscribers that are already enrolled and wish to add their Eligible Dependents due to birth of a child, placement for adoption or marriage, the following eligibility rules apply:

Newborn Child -- To enroll a newborn child who is an Eligible Dependent, submit a Member Status Change Request Form to the Employer Plan Sponsor. The Member Status Change Request Form and any applicable supporting documentation must be received by Capital Health Plan no more than 60 days 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: Grandchild/Dependent of a Dependent - Coverage for a newborn child of a Covered Dependent child will automatically terminate 18 months after the birth of the newborn child. The Dependent parent must have been covered at the time of birth for the contract holder's grandchild to be covered from the date of birth. Grandchildren (dependent of a Dependent) may remain on the contract, up to 18 months of age, even if the Dependent parent terminates.

Adopted Newborn Child -- To enroll an adopted newborn child, who is an Eligible Dependent, submit a Member Status Change Request Form to the Employer Plan Sponsor. The Member Status Change Request Form and any applicable supporting documentation must be received by Capital Health Plan no more than 60 days prior to, or during the 60-day period immediately following, the date of birth. 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 the first 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 and the Employer Plan Sponsor within ten (10) calendar days if the adopted newborn child is not placed in the residence of the Subscriber.

Adopted Child -- To enroll an adopted child, who is not a newborn and is an Eligible Dependent, submit a Member Status Change Request Form to the Employer Plan Sponsor. The Member Status Change Request Form and any applicable supporting documentation must be received by Capital Health Plan no more than 30 days immediately following the date of placement. 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 and the Employer Plan Sponsor within ten (10) calendar days 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 Capital Health Plan's receipt of the written notice.

Marriage -- A Subscriber may apply for coverage of an Eligible Dependent due to marriage. To apply for coverage, submit a Member Status Change Request Form to the Employer Plan Sponsor. The Member Status Change Request Form and any applicable supporting documentation must be received by Capital Health Plan no more than 30 days immediately following the date 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.

Court Order -- A Subscriber may apply for coverage for an Eligible Dependent if a court has ordered coverage to be provided for a minor child under the Subscriber's plan. To apply for coverage, submit a Member Status Change Request Form to the Employer Plan Sponsor. The Member Status Change Request Form and any applicable supporting documentation must be received by Capital Health Plan no more than 30 days immediately following the date 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.

3. Loss of Coverage under a Children's Health Insurance Program [CHIP] or 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 (if the Eligible Employee is enrolling) or the Member Status Change Request Form (if the Eligible Employee is already enrolled and is only enrolling their Eligible Dependents) and submit it to their Employer Plan Sponsor. The Employer Plan Sponsor must forward it to Capital Health Plan. The applicable form and any applicable supporting documentation must be received by Capital Health Plan 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.

Annual Open Enrollment

The Annual 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. 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, provided that they have met the applicable Waiting Period as set forth on the Employer Plan Sponsor Application. The Eligible Employee may enroll by submitting the Capital Health Plan Enrollment Application to the Employer Plan Sponsor 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. The Eligible Employee must make the election prior to the Employer Plan Sponsor's Annual Renewal Date, and the Enrollment Application must be received by Capital Health Plan no later than 30 days after 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.

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. 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 or within the applicable Grace Period.

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 their Employer Plan Sponsor, an accurate Member Status Change Request Form to Capital Health Plan. The Member Status Change Request Form must be received by 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; and

3. agree to pay their 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. their 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;

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

6. the Subscriber divorces the natural parent of a step child, or the Subscriber is not the natural parent, and the natural parent dies.

Note: As further clarification for purposes of this subsection, a covered Dependent child who has reached the end of the Calendar year in which they become 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 disenrolling 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, Grievance, and Appeal Process (refer to the Complaint, Grievance, and Appeal 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, Grievance, and Appeal Process described herein.

Rescission of Coverage

We reserve the right to Rescind the coverage under this Booklet for any individual covered under this Booklet as permitted by law.

We may only Rescind your coverage if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

We will provide at least 45 days advance written notice to the Covered Employee of our intent to Rescind coverage.

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review standards described in the CLAIMS PROCESSING section and the appeal procedures described in the APPEAL AND GRIEVANCE PROCESS sections.

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 within the Grace Period, 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 then 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 Summary of Benefits and Coverage. The Subscriber shall also be responsible for the payment of all Copayments for Covered Services with respect to every individual enrolled as their 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. If the Allowed Amount or the provider's actual charge for a Covered Service rendered is less than the Copayment amount, the Member must pay the lesser of Capital Health Plan's Allowed Amount or the provider's actual charge for the Covered Service.

Non-Covered Services

Members are responsible for the payment of charges for non-Covered Services.

Contributions

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

Maximum Out-of-Pocket

Out-of-Pocket Maximums
An out-of-pocket maximum is the limit on Cost Share amounts that a Member has to pay for a given Calendar Year for Health Care Services that are Covered Services under this Member Handbook. After a Member has paid this dollar amount in Cost Share, the Member will have no additional Cost Share for the rest of that Calendar Year, and Capital Health Plan will pay 100 percent of Capital Health Plan's Allowed Amount for Covered Services rendered during the rest of that time period.

Individual Out-of-Pocket Maximum
Once a Member has reached the individual out-of-pocket maximum amount listed in their Summary of Benefits and Coverage, the Member will have no additional out-of-pocket responsibility for the remainder of that Calendar Year, and Capital Health Plan will pay 100 percent of the Allowed Amount for Covered Services rendered to that individual during the remainder of that time period.

Family Out-of-Pocket Maximum
If a Member's plan includes a family out-of-pocket maximum, once their family has reached the family out-of-pocket maximum amount listed in their Summary of Benefits and Coverage, neither the Member nor their Dependents will have any additional out-of-pocket responsibility for Covered Services for the remainder of that Calendar Year, and Capital Health Plan will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that time period. The maximum amount any one Covered Person in the family can contribute toward the family out-of-pocket maximum, if applicable, is the amount applied toward the individual out-of-pocket maximum. Please see the Summary of Benefits and Coverage for more information.

All Cost Share amounts a Member pays toward the Covered Services explained in this Booklet, such as Copayments, will apply to the out-of-pocket maximum. The following charges **will not apply** to the out-of-pocket maximums and when a Member has reached the out-of-pocket maximum, **the Member will still have to pay** these charges: Premium amounts Members must pay and charges for Services that are not covered.
Note : A Member's Cost Share is applied to their out-of-pocket maximum as claims are received and paid by Capital Health Plan.

SECTION 5: EXTENSION OF BENEFITS

Extension of Benefits
Florida Statute 641.3111

If the Employer Sponsored Plan is terminated, coverage will end on the termination date. Capital Health Plan will not provide coverage or benefits for any Covered Services received on or after the termination date, except as listed below. The extension of benefits described below only applies when the Employer Sponsored Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Member Handbook.

Note: A Member must provide proof that they are entitled to an extension of benefits.

Extension of Benefits

1. If a Member is pregnant on the termination date of the Employer Sponsored Plan, Capital Health Plan will provide a limited extension of the maternity benefits as long as the pregnancy started while the Member was covered by Capital Health Plan. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate the earlier of the date the child is born or coverage is obtained through another carrier.

2. If a Member is totally disabled on the termination date of the Employer Sponsored Plan because of a specific Accident or illness that happened while they were covered under the Employer Sponsored Plan, Capital Health Plan will provide a limited extension of benefits for that Member only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the earlier of the end of the 12-month period beginning on the termination date of the Employer Sponsored Plan, at such time as the Member is no longer totally disabled, or when coverage is obtained through another carrier.

Note: For purposes of this subsection, a Member will be considered totally disabled only if, in Capital Health Plan's opinion, the Member is unable to engage in any employment for which they are or may become qualified for, through education, training, or experience, and the Member continues to require regular care from a Physician for the disability. This applies, even if the Member is not working (e.g., a student, non-working spouse, or children), if the Member is unable to perform the normal day-to-day activities which they would otherwise be able to perform.

Capital Health Plan is not required to provide an extension of benefits if a Member leaves the Service Area with the intent to relocate or establish a new residence outside the Service Area; if the Member intentionally left out or provided false information on any Enrollment Form in order to obtain coverage or Covered Services; or if the Member was terminated for disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that the Member's continued coverage with 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 the Member or any other Covered Person.

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 the primary payer, claims for Covered Services should be filed with Capital Health Plan first.

As provided in more detail below, if the Member's Employer Sponsored Plan coverage is based on their employment or a family member's current employment, who pays first generally depends on the Member's age, the size of the employer, and whether the Member is enrolled in Medicare based on age, disability, or End-Stage Renal Disease (ESRD). There are exceptions to these rules, so to be certain, a Member should always check with their Employer Plan Sponsor to determine whether Medicare pays first or second.

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 their Employer Sponsored health coverage and elect Medicare as their 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.

Medicare and Age

If a Member has Medicare based on age, and the Member's Employer Sponsored Plan coverage is based on their or a family member's current employment, who pays first depends on the size of the Employer Plan Sponsor.

1. If the Member is 65 or older, and the Member or their spouse is still working, Capital Health Plan pays first if the Employer Plan Sponsor has 20 or more employees.
2. If the Member is 65 or older, and the Member or their spouse is still working, Capital Health Plan pays second if the Employer Plan Sponsor has fewer than 20 employees.

Medicare and Disability

If a Member has Medicare due to a disability, and the Member's Employer Sponsored Plan coverage is based on their or a family member's current employment, who pays first depends on the size of the employer.

1. If the Member is under 65 and disabled, and the Member or their family member is still working, Capital Health Plan pays first if the employer has 100 or more employees.
2. If the Member is under 65 and disabled, and the Member or their family member is still working, Capital Health Plan pays second if the employer has fewer than 100 employees.
3. If the Member is over 65 and disabled, and the Member or their family member is still working, see the Section *Medicare and Age* to understand who pays first or second depending on the employer size.

Individuals with End Stage Renal Disease (ESRD)

For a Member who is entitled to Medicare coverage because of ESRD, Capital Health Plan will provide Employer Sponsored Plan 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 Sponsor Plan will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, Capital Health Plan will provide Employer Sponsored Plan coverage, as set forth herein, on a primary basis for 30 months.

Miscellaneous

1. This 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 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 Member 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 Medicare Advantage coverage to its Retirees and their eligible dependents, once the Retiree and/or their eligible dependent is eligible for Medicare parts A & B, the Retiree and/or their dependent must elect to convert to the Employer Plan Sponsor's Medicare Advantage coverage, or the Retiree will become ineligible for Capital Health Plan coverage through the Employer Plan Sponsor.

SECTION 7: CONTINUATION OF COVERAGE UNDER COBRA AND FLORIDA HEALTH INSURANCE COVERAGE CONTINUATION ACT

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 their Employer Sponsored Plan 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 they are 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 their 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan coverage for a period not to exceed 36 months from the date the child lost coverage because they ceased to meet such eligibility requirements.

5. Subscribers and Dependents may qualify to elect to continue Employer Sponsored Plan coverage if coverage would otherwise be lost due to termination of employment or reduction of hours 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.

6. 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.

7. If a Member is receiving continuation of coverage under paragraph 6 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 them eligible for coverage.

8. If a bankruptcy or other proceeding under Title XI 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 Plan 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 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 Plan 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 islater.

3. The qualified Member who elects continuation of coverage must not become covered under any other employer sponsored health coverage plan.

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 their 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 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 Plan coverage to its employees through Capital Health Plan unless the employee or dependent no longer resides in the Capital Health Plan Service Area, and the Employer Plan Sponsor offers alternate coverage through a different health insurance carrier or health maintenance organization for the area in which the employee or dependent 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. For other, potential, post-termination coverage options, see the *Conversion Privilege* Section of this Member Handbook.

Florida Continuation of Coverage Provisions (Generally for employers with one to 19 employees)

Effective January 1, 1997, *Florida Statute 627.6692*, known as the Florida Health Insurance Coverage Continuation Act, requires that an Employer Plan Sponsor with fewer than 20 employees who does not qualify for the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), offer to Subscribers and their Dependents the opportunity for a temporary extension of health coverage (called "continuation of coverage") in certain instances where coverage under the Employer Sponsored Plan would otherwise end. The Member has certain rights and obligations under the continuation of coverage provision of the law.

Initial Notice of Rights to Continuation of Coverage

Each Subscriber and their covered Dependents should review this provision and refer to it in the event that any action is required on the part of the Subscriber or their covered Dependents.

Types of Qualifying Events

If a Subscriber's employer has fewer than 20 employees and the Subscriber is covered by its Employer Sponsored Plan, the Subscriber has the right to choose this continuation of coverage of this Employer Sponsored Plan if:

1. The Subscriber loses Employer Sponsored health coverage because of a reduction in their hours of employment; or
2. The Subscriber's employment is terminated (for reasons other than gross misconduct on the part of the Subscriber).

The Dependent spouse of a Subscriber has the right to choose continuation of coverage if their Employer Sponsored Plan coverage is lost for any of the following four reasons:

1. The death of the Subscriber;
2. The termination of the Subscriber's employment (for reasons other than gross misconduct) or a reduction in the Subscriber's hours of employment;
3. Divorce or legal separation from the Subscriber; or
4. The Subscriber becomes entitled to Medicare.

The Dependent Child of a Subscriber has the right to continuation of coverage if their Employer Sponsored Plan coverage is lost for any of the following five reasons:

1. The death of the Subscriber;
2. The termination of the Subscriber's employment (for reasons other than gross misconduct) or a reduction in the Subscriber's hours of employment;
3. Parents' divorce or legal separation;
4. The Subscriber becomes entitled to Medicare; or
5. The dependent ceases to be a "dependent Child" under the terms of the Employer Plan Sponsor.

Members also have a right to elect continuation of coverage if the Member is covered under the plan as a retiree, or spouse or child of a retiree, and loses coverage within one year before or after the commencement of proceedings under Title XI (bankruptcy), United States Code, by the employer from whose employment the Subscriber retired. Under the law, the Subscriber or a family member has the responsibility to inform Capital Health Plan's Enrollment Department of a divorce, legal separation, or a child losing dependent status under the Employer Sponsored Plan. This notification must be made within 63 days of the date of the qualifying event which would cause a loss of coverage.

The notice must be in writing and include:

1. the name of the qualified beneficiary;
2. the date of the qualifying event;
3. one of the types of qualifying events as listed above;
4. the name of the employer;
5. the Employer Sponsored Plan number; and
6. the name and address of all qualified beneficiaries; and the contract number, identification number or social security number of all qualified beneficiaries.

When Capital Health Plan receives the timely written notice as described above, Capital Health Plan will send to the Member by certified mail an election and premium notice form that describes the continuation coverage options available. Under the law, Members have 30 days from the date of receipt of the election and premium notice form to elect continuation coverage. To elect continuation coverage, complete and return the election and premium notice form with applicable premium payment to Capital Health Plan. Continuation coverage begins on the day after coverage would otherwise be terminated, only if the election and premium notice form and full premium payment are sent and received by Capital Health Plan within the allotted time period and all other eligibility requirements are satisfied.

If the Member does not elect coverage and pay the premium, the Member's Employer Sponsored Plan coverage will terminate in accordance with the provisions outlined in this Member Handbook or other applicable Employer Sponsored Plan documents.

If the Member chooses continuation of coverage, the coverage will be identical to the coverage provided under the plan to similarly situated subscribers or family members. The law requires that Members be afforded the opportunity to maintain continuation coverage for 18 months. (Certain exceptions may apply for Subscribers that are military reserve or National Guard, allowing continuation coverage for periods that are longer than 18 months.) However, the law also provides that a Member's continuation of coverage may be terminated for any of the following reasons:

1. The employer/former employer no longer provides Employer Sponsored Plan coverage to any of its employees;
2. The premium for a Member's continuation of coverage is not paid by the grace period expiration date, which is 30 days;
3. The Member first becomes, after electing continuation coverage, covered under any other employer sponsored health plan (as an employee or otherwise);
4. The Member is approved, after electing continuation coverage, for Medicare.

Note: A Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act, to have been disabled as of the date of termination of employment or reduction in hours may be eligible to continue coverage for an additional 11 months (29 months total). The Qualified Beneficiary must notify Capital Health Plan within 60 days of receipt of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The carrier can charge up to 150 percent of the Employer Plan Sponsor rate during the 11-month extension. The disabled individual must notify the carrier within 30 days of any final determination that they are no longer disabled.

Members do not have to show insurability to choose continuation of coverage. However, a Member may have to pay up to 115 percent of the applicable premium for continuation of coverage. The law also requires that, at the end of the 18-month or 29-month continuation of coverage period, a Member must be allowed to enroll in an individual conversion health plan provided under the Employer Sponsor Plan.

Any questions regarding this should be directed to the person or office shown below. Also if the Member has changed marital status, or has changed addresses, please notify in writing the person or office shown below:

Capital Health Plan
Enrollment Department
P. O. Box 15349
Tallahassee, Florida 32317-5349
(850) 383-3311

If any covered Dependent child is at a different address, please notify Capital Health Plan in writing, so that a separate notice may be sent by Capital Health Plan to the separate household.

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 their 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 Employer Plan Sponsored 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 an Employer Sponsored Plan;

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; or

5. if an individual has not been continuously covered under an Employer Sponsored Plan agreement for at least 3 months prior to termination.

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 under this Employer Sponsored Plan. However, until such time as coverage under the conversion contract becomes effective, the individual shall pay the allowed amount 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 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;

3. Medicare, as described in the *Effect of Medicare Coverage/Medicare Secondary Payer Provisions* Section; or

4. 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 it 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 their treating providers must do, under the terms of this Member Handbook, 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 they may have under ERISA. If the Member is not sure of their rights under ERISA, the Member should contact the plan administrator or an attorney of their 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 they have 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 Member Handbook, 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 for this Section

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 other coverage determination that 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; or

- 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 their 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 a 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 Member Handbook.

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 Member Handbook 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 their treating providers will 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 six (6) months of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such six (6) month 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 Member Handbook, Capital Health Plan will use its best efforts to pay (in whole or in part) for 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) for paper Post-Service Claims within 40 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,Grievance, and Appeal 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 Member Handbook 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 Member Handbook. 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 Member Handbook 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 them 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, Grievance, and Appeal 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 Member Handbook or termination of the Member's coverage as provided by this Member Handbook.

Capital Health Plan will use its best efforts to notify the Member of such reduction or termination in advance so that they will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Compliance, Grievance, and Appeal Process described in this Member Handbook. In no event shall Capital Health Plan be required to provide more than a reasonable period of time within which the Member may develop their 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, Grievance, and Appeal Process* section.

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 Member Handbook 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 what scientific source and/or clinical judgment was used in making 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 shall 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 Member Handbook 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 or material misrepresentation 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

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

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

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

- the specific reason or reasons for the Adverse Benefit Determination;
- reference to the specific Member Handbook 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, 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 set forth in this Member Handbook, responsible for providing, authorizing and coordinating all medical services for the Member.

2. Except as may otherwise be set forth in this Member Handbook, the Member must look to the Primary Care Physician to provide or coordinate their 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 by authorization of the Primary Care Physician, or through another health care provider designated by 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 their contract with Capital Health Plan, is unable to perform their 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 provider, such as a Specialist, for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Each Member's primary care physician will refer them to a participating Specialist or other health care service provider, if they cannot personally provide the necessary care. 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 Service under the Member's Employer Sponsored Plan. Authorizations are only required for certain services. A Member's 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 the Member 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 (850-383-3311), for the list of services requiring an authorization.

Specialist Care

Except as specified in the Coverage Access Rules set forth in this Member 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 Physicians to coordinate any necessary authorizations that may be required.

The Member's Primary Care Physician may consult with Capital Health Plan and with the Specialists 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 their 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.

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 to 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.

Note that a Member's Emergency Department Copayment and Coinsurance is waived if Inpatient admission occurs; however, if moved to observation status, Member will pay $100 Copayment +25% Coinsurance for the ER visit and 25% Coinsurance for services rendered while in Observation status.A Member should always ask the emergency department to clarify whether it is moving them to observation status, as observation status may take place in or near the Hospital's emergency services locations.

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 available, located on Capital Health Plan's web site (www.capitalhealth.com), listing those Primary Care Physicians and Contracting Providers under the Employer Sponsored Plan, or 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 vary, 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 not 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. Capital Health Plan does not discriminate against or fail to contract with a Hospital based solely on the fact that the Hospital's medical staff is comprised of physicians licensed under Florida Statute Chapter 459.

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 direct access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need of referrals from the Primary Care Physician

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

Obstetricians and Gynecologists: Members have direct 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. Members may select an Obstetricition/Gynocologist who is a Contracted Provider as their Primary Care Physician.

Physician Assistant: Members have access to surgical assistant services rendered by a Physician 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 the anesthesia services 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 whenCapital Health Plan's agreement with a Contracting Provider (including a PCP) is terminated without cause, the member may continue to be covered for treatment of that Condition by the terminated provider after the date of the Contracting Provider's termination. Coverage for that Condition will be covered with that provider only until the earlier of:

1. the completion of treatment for the Condition;
2. the member selects another Contracting Provider; or
3. the next Open Enrollment Period.

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

For a pregnant Member who has initiated a course of prenatal care prior to the termination of the Contracting Provider's contract, Capital Health Plan 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.

Capital Health Plan is not required to cover or pay for any Services under this subsection for an individual whose coverage under this Employer Sponsored Plan 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.

Inter-Plan Programs

Out-of-Area Services

Overview

Capital Health Plan has a variety of relationships with other Blue Cross and/
Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Programs." These Inter-Plan Arrangements operate based on rules and procedures issued by the Blue Cross Blue Shield Association

("Association").Whenever a Member obtains Covered Services outside of the Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

When a Member receives care for Covered Services outside of the Service Area, the Member will receive the care from one or two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") do not contract with the Host Blue. Capital Health Plan explains below how Capital Health Plan pays both kinds of providers.

Capital Health Plan covers only limited healthcare services that are received outside of the Service Area. As used in this section "Out-of-Area Covered Healthcare Services" include emergency care, urgent care, or care authorized by Capital Health Plan obtained outside the Service Area. Any other services will not be covered when processed through any Inter-Plan Programs arrangements unless they are authorized by the Member's Primary Care Physician .

A. BlueCard® Program

Under the BlueCard® Program, when a Member obtains Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Capital Health Plan will remain responsible for doing what Capital Health Plan has agreed to in this Member Handbook. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers. The BlueCard Program enables Members to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to complete. The Member will be responsible for the Copayment amount, as stated in the Summary of Benefits and Coverage.

Emergency Care Services: If a Member experiences a Medical Emergency while traveling outside Capital Health Plan's Service Area, the Member should go to the nearest Emergency (or Urgent Care) facility.

When a Member received Out-of-Area Covered Healthcare Services outside the Service Area, and the claim is processed through the BlueCard® Program, the amount the Member pays for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services; or
- The negotiated price that the Host Blue makes available to Capital Health Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group. These arrangments may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price Capital Health Plan uses for your claim, because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Capital Health Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

B. Nonparticipating Healthcare Providers Outside the Service Area

1. Your Liability Calculation

   When Out-of-Area Covered Services are provided outside of the Service Area by nonparticipating providers, the amount the Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Capital Health Plan will make for the Out-of-Area Covered Healthcare Services as set forth in Employer Sponsored Plan. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

   In certain situations, Capital Health Plan may use other payment bases, such as billed covered charges, the payment Capital Health Plan would make if the healthcare services had been obtained within the Service Area, or a special negotiated payment, to determine the amount Capital Health Plan will pay for services provided by nonparticipating providers. In situations where services are provided by nonparticipating providers, the Member may be liable for the difference between the amount that the nonparticipating healthcare

provider bills and the payment Capital Health Plan will make for the Out-of-Area Covered Services

C. BlueCross BlueShield Global® Core Program

If a Member is outside the United States, they may be able to take advantage of the BlueCross BlueShield Global® Core Program to access covered emergency healthcare services. The BlueCross BlueShield Global® Core Program is unlike the BlueCard Program available in the United States in certain ways. For instance, although the BlueCross BlueShield Global® Core Program assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when a Member receives care from providers outside the United States, they *may* have to pay the providers and submit the claims as provided below to obtain reimbursement for these services. If a Member needs to access emergency services (including locating a doctor or hospital) outside the United States, they should (a) go to https://bcbsglobalcore.com or download the BlueCross BlueShield Global® Core mobile app to access a list of providers and facilities, or (b) call the BlueCross BlueShield Global® Core Program Service Center at 1.800.810.BLUE (2583) or collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or Hospitalization, if necessary. Please note: Medical services obtained internationally that are not urgent or emergent in nature are not covered services.

- Inpatient Services

  In most cases, if a Member contacts the BlueCross BlueShield Global® Core Program Service Center for assistance, Hospitals will not require the Member to pay for covered inpatient services, except for their cost share amount. In such cases, the Hospital will submit the Member's claims to the BlueCross BlueShield Global® Core Program Service Center to begin claims processing. However, if the member paid in full at the time of service, they must submit a claim to receive reimbursement for covered healthcare services.

- Outpatient Services

  Physicians, urgent care centers, and other outpatient providers located outside the United States will typically require a Member to pay in full at the time of service. In such cases, the Member must submit a claim to obtain reimbursement for covered healthcare services.

- Submitting a BlueCross BlueShield Global® Core Claim

  When a Member pays for covered emergency healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For

institutional and professional claims, the Member should register and complete the claim form online at https://bcbsglobalcore.com to initiate claims processing. Following the instructions on the website will help ensure timely processing of the claim. If a Member needs assistance with their claim submission, the Member should call the BlueCross BlueShield Global® Core Program Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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 their 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.

Capital Health Plan does not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

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. Pursuant to CFR 147.106(f)(2), Capital Health Plan will provide each plan sponsor written notice of the renewal at least 60 calendar days prior to renewal. 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, Grievance, and Appeal 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 Capital Health Plan Grievance Manager, at Capital Health Plan. Details regarding the grievance resolution process are provided in the Capital Health Plan *Complaint, Grievance, and Appeal 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 in this Member Handbook, 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 Request 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 Summary of Benefits and Coverage. 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.) **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 Summary of Benefits and Coverage.

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, Grievance, and Appeal Process* section.

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 Summary of Benefits and Coverage, 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. 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 their 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.

Breast Reconstructive Surgery, prostheses, and physical complications, including lymphedemas, 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 trusses.

Child cleft lip and cleft palate treatment services: Pursuant to *Florida Statue 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.

Child Health Supervision Services: Periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests, provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Clinical Trials: Clinical trials are research studies in which Physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial.

If a Member is eligible to participate in an Approved Clinical Trial, routine patient care for Services furnished in connection with the Member's participation in the Approved Clinical Trial may be covered when:

1. a Contracting Provider has indicated such trial is appropriate for the Member, or
2. the Member provides Capital Health Plan with medical and scientific information establishing that the Member's participation in such trial is appropriate.

Routine patient care includes all Medically Necessary Services that would otherwise be covered under this Member Handbook, such as doctor visits, lab tests, x-rays and scans and Hospital stays related to the treatment of the Member's Condition and is subject to the applicable Cost Share(s) on the Summary of Benefits and Coverage.

Even though benefits may be available under this Member Handbook for routine patient care related to an Approved Clinical Trial, a Member may not be eligible for inclusion in these trials or there may not be any trials available to treat the Member's Condition at the time they want to be included in a clinical trial.

Clinical Trial Exclusion

1. Costs that are generally covered by the clinical trial, including, but not limited to:

    a. research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
    b. the investigational item, device or Service itself.
    c. services inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Services related to an Approved Clinical Trial received outside of the United States.

Dental care – Pediatric

Pursuant to 45 CFR 156.150 and 1311(d)(2)(B)(ii) of PPACA, Capital Health Plan has elected to provide pediatric dental benefits through the bundled coverage model. As such, the following pediatric dental benefit is provided by your employer through Capital Health Plan's alliance dental plan or through a separate stand-alone dental plan selected by the Employer Sponsor. A Member should refer to the coverage documents received from their dental carrier at the time of enrollment.

Duplication of Dental Coverage

A Member cannot receive coverage under the Dental Services category for a Covered Service under both the general and pediatric dental benefits. Dental Services covered under general dental benefits will not be covered under the pediatric dental benefits, and Dental Services covered under pediatric dental benefits will not be covered as general dental benefits.

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: 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, and trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease, 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 are covered if, under accepted medical standards, such diagnostic services are Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury.

Genetic testing for the purpose of explaining current signs and symptoms of a possible hereditary disease and/or for other purposes in accordance withCapital Health Plan's Medical Necessity criteria.

Infertility services limited to, diagnostic procedures to determine the cause of infertility. These procedures are limited to endometrial biopsy, sperm count and hysterosalpingography.

Mammogram services: Pursuant to Florida Statue 641.31095, Mammograms 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. Coverage is provided as outlined below:

- A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.
- A mammogram every year for any woman who is 50 years of age or older.
- One or more mammograms a year, based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

Mammograms that are performed as diagnostic, are subject to applicable deductible and copayment provisions.

Mastectomy services for breast cancer treatment and outpatient post-surgical follow-up in accordance with prevailing medical standards. Inpatient Hospital coverage is not limited to any period that is less than that determined by the contracted treating physician to be Medically Necessary in accordance with prevailing medical standards and after consultation with the Member. 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: Health Care Services provided to a Member by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Licensed Midwife or Certified Nurse Midwife, 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. Complications of pregnancy are not treated differently from any other illness or sickness.

Under Federal law, Employer Sponsored health plans and health insurance issuers generally may not 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 less than or equal to 48 hours (or 96 hours).

Mental Health and Substance Use Disorder services that are Medically Necessary and take place in the least restrictive environment necessary to assist Members with resolving their issues. Levels of care from least restrictive to most restrictive are as follows: outpatient counseling, intensive outpatient treatment, partial Hospitalization, residential treatment, and acute inpatient Hospitalization.

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: Grandchild/Dependent of a Dependent - Coverage for a newborn child of a Dependent child will automatically terminate 18 months after the birth of the newborn child. The Dependent parent must have been covered at the time of birth for the contract holder’s grandchild to be covered from the date of birth. Grandchildren (dependent of a Dependent) may remain on the contract, up to 18 months of age, even if the dependent parent terminates.

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. 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 *Prescription Drug Program* section for information on the Pharmacy Program provided in this Employer Sponsored Plan.

Preventive health services may be covered for both adults and children based on prevailing medical standards and recommendations which are explained further below. Some examples of preventive services include (but are not limited to) periodic routine health exams, routine gynecological exams, immunizations and related preventive services such as routine mammograms and pap smears. 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 (USPSTF);
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act 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; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

  Note: From time to time medical standards that are based on the recommendations of the entities listed above are changed. Services may be added to the recommendations and sometimes may be removed.

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. Members 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. Second Medical Opinions may be requested by the Health Plan for any elective surgery, when the appropriateness or necessity of a covered surgical procedure is questioned, or for a serious injury or illness.. 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 Summary of Benefits and Coverage. Services rendered by a Non-Contracting Provider for a second medical opinion are subject to a copayment amount equal to 40% of the allowed amount. Subscribers are responsible for the payment of any charges billed by a Non-Contracting Provider in excess of the allowed amount.

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 and 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 are covered 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.

Gender Reassignment surgery and services related to gender dysphoria or gender transition will be covered in accordance with Federal Regulation at the time of service.

Urgent Care services (includes Telehealth services when a contracted Telehealth provider is utilized) for care for an illness, injury, or condition serious enough to seek care right away, but not so severe as to require emergency room care.

Vision care, limited to routine examinations for vision correction when provided in Capital

Health Plan's Eye Care Centers, and the diagnosis/treatment of an injury to or disease of the eyes when provided at a network provider. 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 following cataract surgery or Accidental injury which would necessitate corrective lenses (initial pair of eyeglasses is limited to the cost of the basic plastic lens and up to $65.00 for the frames and obtained only at Capital Health Plan's Eye Care Centers). The Member must pay any additional costs for upgraded frames or lenses. Additional costs will not apply to any applicable out-of-pocket maximum.

Contact lenses (with prior authorization), when glasses cannot correct the Member's vision properly due to an eye condition such as keratoconus, etc. (includes material, evaluation, fitting, and follow-up care as needed.

Vision Services – Pediatric

Pediatric vision Services are covered under this section only if they are:

1. rendered to a Covered Person who has not reached the age of 19;
2. not specifically or generally limited or excluded;
3. authorized for coverage by us, if prior authorization is required; and
4. provided at Capital Health Plan's Eye Care Centers.

Pediatric vision Services are limited to the following:

1. Eye exam including dilation (when professionally indicated), once every Calendar Year.

2. Spectacle lenses, one pair every Calendar Year, including:
    a. clear plastic in single-vision;
    b. lined bi-focal, trifocal or lenticular lenses;
    c. polycarbonate lenses;
    d. standard progressive lenses;
    e. plastic photosensitive lenses;
    f. oversize lenses;
    g. scratch resistant coating;
    h. tinting of plastic lenses; and
    i. ultraviolet coating.

3. Frames covered by this policy are limited to the Pediatric Frame Selection. The network provider will show the Member the selection of frames covered under this Member Handbook. If the Member selects a frame that is not included in the Pediatric Frame Selection covered under this Member Handbook, the Member is responsible for the difference in cost between the network provider reimbursement amount for covered frames from the Pediatric Frame Selection and the retail price of the frame the Member selected. Any amount paid to the provider for the difference in cost of a Non-Selection Frame will not apply to any applicable out-of-pocket maximum.

4. Elective contact lenses, in lieu of eyeglasses, covered by this policy are limited to the Pediatric Contact Lens Selection and includes the evaluation, contact lens fitting and follow-ups for 6 months. The network provider will inform the Member of the contact lens selection covered under this Member Handbook. If the Member selects a contact lens that is not part of the Pediatric Contact Lens Selection covered under this Member Handbook, the Member is responsible for the difference in cost between the network provider reimbursement amount for covered contact lenses available from the Pediatric Contact Lens Selection and the retail price of the contact lenses the Member selected. Any amount paid to the provider for the difference in cost of a Non-Selection Contact Lens will not apply to any applicable out-of-pocket maximum.

5. Contact lenses (with prior authorization), when glasses cannot correct the Member's vision properly due to an eye condition such as keratoconus, etc., (includes material, evaluation, fitting, and follow-up care as needed.)

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. Complications of pregnancy are not treated differently from any other illness or sickness.

Generally under Federal law, Employer Sponsored health plans and health insurance issuers generally may not 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). Employer Sponsored health plans and health insurance 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 of 48 hours (or 96 hours) or less.

SECTION 17: AMBULATORY SURGICAL CENTER SERVICES

The following health care services may be Covered Services, subject to the Copayment amount set forth in the Summary of Benefits and Coverage, 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 Summary of Benefits and Coverage. 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 someone 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 Physican.

SECTION 19: SPECIAL SERVICES

Durable Medical Equipment (DME)

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, for any Member, through the age of 24.

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;
2. Physical Therapy by a Physical Therapist;
3. Occupational Therapy by an Occupational Therapist;
4. Speech Therapy by a Speech Therapist;
5. Home health aide services;
6. Medical social services;
7. Nutritional guidance; and
8. 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; an adult day care center, or a nursing home facility;
6. Custodial Care; and
7. Food, housing , and home delivered meals.

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, artificial limbs and eyes to replace natural limbs and eyes lost. 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. Payment for splints for the treatment of temporomandibular joint (TMJ) dysfunction is limited to one splint in a six-month period unless a more frequent replacement is determined by Capital Health Plan to be Medically Necessary.

Total artificial hearts used as destination therapy are an excluded benefit (See **EXCLUSIONS AND LIMITATIONS** *Transplantation or implantation*).

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 and Habilitative Services

Prescribed short-term inpatient and outpatient rehabilitation and habilitative 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 or Habilitation 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 with these services; (3) rehabilitative services must be provided to treat functional defects which remain after an illness or injury; (4) habilitative services must help a person keep, learn or improve skills and functioning for daily living; 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. The Rehabilitation Plan must be renewed every 30 days.

Outpatient

Outpatient rehabilitation and habilitative services are limited per Member per Condition to the number of Medically Necessary rehabilitation services which are received by the Member, subject to the visit limits as stated in the Summary of Benefits and Coverage for the Plan. Outpatient rehabilitation services are limited to the therapy categories listed below:

Cardiac Therapy: Services provided under the supervision of a Physician, or an appropriate provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Chiropractor Therapy: Services provided by a Chiropractor licensed pursuant to Florida Statutes Chapter 460 (Chiropractic) for manipulation of the spine and extremities.

Habilitative Services: Services provided for Covered Persons with a congenital, genetic, or early acquired disorder that help a person keep, learn or improve skills and functioning for daily living when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

This Benefit does not apply to those services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches their maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allowCapital Health Planto substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, Capital Health Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Massage Therapy: Services provided by a Physician, licensed Massage Therapist, or Physical Therapist are covered when the Massage is prescribed as being Medically Necessary for the treatment of an acute illness or injury by a Physician licensed pursuant to *Florida Statutes* Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry). The Physician’s prescription must specify the number of treatments.

Occupational Therapy: Services provided by an Occupational Therapist for the purpose of aiding in the restoration of of normal physical function lost due to illness, injury, stroke or a surgical procedure.

Physical Therapy: Services provided by an Physical Therapist for the purpose of aiding in the restoration of of normal physical function lost due to illness, injury, stroke or a surgical procedure.

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.

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 Summary of Benefits and Coverage.

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 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; or

6. the expense relates to the acquisition of an organ or tissue for a recipient who is not covered by Capital Health Plan.

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 Service.

SECTION 20: PRESCRIPTION DRUG PROGRAM

The Prescription Drug Benefit provides covered prescription drugs and supplies. Each covered prescription drug, when purchased from a Participating Pharmacy, will be subject to a member cost sharing amount. The Cost Share amount is determined by the tier level of the prescription drug dispensed (i.e., Tier 1, Tier 2, Tier 3, Tier 4, Tier 5, or Tier 6). In general, most generic drugs and competitively priced brand drugs are included on Tiers 1 and 2 and typically represent the lowest cost to plan members. Tier 3 represents the intermediate plan member Cost Share and generally includes preferred drug products. A Tier 3 preferred prescription drug on the Commercial Formulary may be reclassified as a Tier 4 non-preferred prescription drug on the date the FDA approves a bioequivalent generic prescription drug. Tier 4 represents a higher plan member Cost Share and generally includes all brand name drugs not selected for Tier 1, 2, or 3 and some generic drugs (i.e. non-preferred drug products). Tier 5 and 6 prescription drugs are Specialty drugs subject to the highest Cost Share. Capital Health Plan reserves the right to add, remove or reclassify any prescription drug on the Commercial Formulary at any time. Your plan's covered drug list, or formulary, is a list of medicines that your prescription drug plan covers. This formulary is a closed formulary. This means that all available covered medications are shown. Medications that are not shown are not covered.

Covered prescription drugs must be Medically Necessary, prescribed by a medical professional acting within the scope of their license, and dispensed by a pharmacist.

A Member should refer to their Summary of Benefits and Coverage (SBC) document for Cost Share structure and amounts.

Definitions for this Section

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

Brand Name Prescription Drug
A prescription drug which is marketed or sold by 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 (i.e. branded-generic drugs with a multi-source code of M or O).

Cost Share
The amount the member pays the Participating Pharmacy at the time of service for each covered prescription drug, as specifically set forth in the Summary of Benefits and Coverage. Manufacturer (or other third party) rebates, discounts, coupons, or other similar financial assistance programs (whether direct or indirect) cannot be used to satisfy an Insured's out-of-pocket cost-sharing responsibilities; therefore, such amounts will not

accumulate towards any Deductible, Coinsurance, Copayment, or Out-of-Pocket Maximums hereunder, as allowed by state or federal guidelines.

Covered Prescription Drugs
All drugs that:

- Require a prescription under federal or state law;
- Are covered by this Member Handbook when filled at Participating Pharmacies;
- Are prescribed by a participating prescriber; and
- 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.

FormularyA list of medicines and supplies that your prescription drug plan covers.

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 Capital Health Plan, 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. Generic drugs have a Multi-source Code of Y.

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 Capital Health Plan:

1. in accordance with Capital Health Plan’s Medical Coverage Guidelines and Clinical Criteria, then in effect, and;
2. consistent with the symptom, diagnosis, and treatment of the member's condition. and;
3. widely accepted by the practitioners' peer group as efficacious and reasonably safe based on scientific evidence, and;

4. 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, and;

5. not experimental or investigational, and;

6. not for cosmetic purposes, and;

7. not primarily for the convenience of the member, the member's family, or the prescriber; and

8. the most appropriate level of service, care or supply which can safely be provided to the Member.

Non-Participating Pharmacy
A pharmacy that has not signed an agreement with the pharmacy benefit manager (PBM) contracted with Capital Health Plan to furnish services to members.

Non-preferred Drug
A prescription drug, either branded, branded-generic or generic specialty, 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 Capital Health Plan's web site at www.capitalhealth.com for the most current Commercial Formulary or the Member may call the member services number on their Identification Card to obtain the most current Commercial Formulary.

Participating Pharmacy
A pharmacy that has signed an agreement with the PBM contracted with Capital Health Plan to render services to members.

Provider
"Provider" is the general term that Capital Health Plan uses 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 Drug
A drug that is noted as preferred on the Commercial Formulary then in effect. A preferred drug on the Commercial Formulary then in effect may 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 toCapital Health Plan's web site at www.capitalhealth.com for the most current formulary, or a Member may call the member services number on their 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 specialty drug will be approved for use.

Prescriber
A medical professional (e.g., physician, optometrist, nurse practitioner) whose state license authorizes them 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 (or PCP)
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.

Prime Therapeutics
Prime Therapeutics is a Pharmacy Benefit Manager (PBM) that Capital Health Plan contracts with to perform coverage determination, formulary management and prescription reimbursement requests.

Prior Authorization
Approval in advance to get covered prescription drugs. Some covered prescription drugs require approval in advance from Capital Health Plan/Prime Therapeutics.

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 Employer Sponsored Plan provides benefits for covered drugs. To be covered, prescriptions must be prescribed by a medical professional acting within the scope of their license and dispensed by a Participating Pharmacy. Unless otherwise excluded,

prescription drugs are covered under this program.

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 provided in this Member Handbook/Employer Sponsored Plan:

Limitations

1. A prescription unit or refill will be covered up to a 90-day supply for generic and brand drugs (at 3 times the member's Cost Share per 90 day supply) at Retail and Mail Order Pharmacies. Specialty drugs are limited up to a 30-day supply. 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. Certain drugs may be subject to additional requirements or limits on coverage. These requirements and limits may include prior authorization, quantity limits, and/or step therapy. The drugs listed as requiring prior authorization, quantity limits, or step therapy are subject to change at any time. For more information or instructions on how to meet these requirements, please contact Member Services at 850-383-3311, Monday through Friday, 8 a.m. to 5 p.m. or refer to www.capitalhealth.com.

4. Capital Health Plan retains the right to limit coverage of the quantities of prescribed drugs.

5. Capital Health Plan retains the right to designate a specific pharmacy or pharmacies that may dispense certain covered drugs.

6. Capital Health Plan retains the right to limit coverage of some drugs to only when prescribed by specific practitioners.

Exclusions

1. Drugs that can be purchased over the counter without a prescription, even though a prescription was provided by prescriber, with the exclusion of Insulin and over the counter medications covered under the Preventive Services as defined by the Patient Protection and Affordable Care Act (ACA).
2. Drugs that are administered or dispensed and billed by a Hospital or in a Provider's facility.
3. Drugs that are dispensed before the Effective Date, or after the termination date, of members' benefits.
4. Prescriptions refilled in excess of the amount specified by the prescriber.

5. Drugs in excess of the limitations specified in this Member Handbook or formulary document.
6. Drugs that are obtained by the Member without charge.
7. Drugs that are experimental or investigational.
8. Certain immunization agents, biological sera, blood and blood plasma.
9. Fertility drugs or any drugs used for the purpose of enhancing the probability of conception.
10. Drugs used for cosmetic purposes.
11. Drugs prescribed by a pharmacist.
12. Drugs listed in the Homeopathic Pharmacopeia.
13. 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.)
14. Drugs that are not approved by the FDA.
15. Drugs and supplies that are not Medically Necessary.
16. Drugs purchased from a Non-Participating Pharmacy, except as a result of an emergency medical condition or when authorized by Capital Health Plan.
17. 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 Capital Health Plan, at its sole discretion, decides to waive this exclusion with respect to a particular prescription drug.
18. Any Drug that is illegal in Florida pursuant to state or federal law.
19. Certain generic drugs when competitively priced brand drugs are covered on the formulary.
20. All prescription drugs for which prior authorization is required by this Member Handbook and for which prior authorization is not obtained before the prescription is filled.
21. Any prescription drug prescribed in excess of the manufacturer's recommended specifications for dosage, frequency of use, or duration of therapy, 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 therapy 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 therapy of a prescription drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by the 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. Capital Health Plan, 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 Capital Health Plan 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 the required Cost Share 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 Capital Health Plan), 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 Prime Therapeutics within 90 days of purchase for each covered prescription drug purchased from a Non-Participating Pharmacy. The itemized paid receipt must be submitted to Prime Therapeutics Commercial Claims Department PO Box 21870 Lehigh Valley, PA 18002-1870.

Prescription Drug Coverage Prior Authorization Program

Certain drugs need to be approved by Capital Health Plan 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 will need to call Member Services (850-383-3311, toll-free 1-877-247-6512; TTY 850-383-3534 (1-877-870-8943)) to obtain prior authorization. Member Services will process the request and the person covered 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 Capital Health Plan 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, name of prescription drug to be covered and prescriber's name and telephone number.

2. Capital Health Plan/Prime Therapeutics will contact the prescriber to get documentation for medical review.

3. Once a decision is made by Capital Health Plan/Prime Therapeutics 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 Cost Share.

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. Ultimately, the final decision whether the prescription drug should be prescribed must be made by the member and the prescriber. **Decisions made by Capital Health Plan in administering the Prescription Drug Coverage Prior Authorization Program are made only to determine whether coverage or benefits are available under the Member Handbook**

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 Capital Health Plan has indicated that coverage and payment will not be made under the Member Handbook.

Formulary Exception

A Member can ask Capital Health Plan to cover an FDA approved drug that is not on the Capital Health Plan Formulary. This is called a Formulary Exception. Generally, a non-formulary drug is covered only if the alternative drug listed on the formulary would not be as effective in treating the Member's condition and/or would cause them to have adverse medical effects. Drugs that are not FDA approved are excluded from coverage by Capital Health Plan. The Member's doctor or other prescriber must submit a statement and supporting information about the medical need for the exception. A request for an exception will be approved only when Capital Health Plan determines that it is Medically Necessary. The Member's doctor or other prescriber must give Capital Health Plan/Prime Therapeutics information that the requested drug is more effective in treating the Member's disease or condition. The request from the doctor or other prescriber must be supported by sound clinical evidence and scientific literature. The fact that the Member's doctor or other prescriber submits a statement supporting their request does not mean that the Member will automatically receive approval of the request.

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.

3. 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.

4. **Abortions** which are elective.

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

6. **Arch supports**, orthopedic shoes, sneakers, or ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, other than those specifically provided for in the Section 15: *Physician and Other Medical Services* under "Diabetes treatment services".

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

8. **Clinical Trial expenses** including:
    a) Costs that are generally covered by the clinical trial, including, but not limited to:
        i. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
        ii. The investigational item, device or Service itself.
        iii. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
    b) Services related to an Approved Clinical Trial received outside of the United States.
    c) Services related to an Approved Clinical Trial that are not authorized by Capital Health Plan in advance.

9. **Cognitive remediation**, meaning programs which aid persons in the management of specific problems in perception, memory, thinking and problem solving.

10. **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; 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.

11. **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).

12. **Contraceptive devices or appliances**, except when dispensed for specific treatment of a Condition, or covered according to the definition of Preventive Services as defined by the Patient Protection and Affordable Care Act.

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

14. **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) or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty and breast augmentation.

15. **Cost Share**, whether or not the Cost Share has been waived by the provider.

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

17. **Counseling** for marital and relationship enhancement and religious purposes including counseling provided by a religious counselor.

18. **Court-ordered care or testing,** or required as a condition of parole or probation.

19. **Custodial Care**, and any service of a custodial nature, provided in a residential, institutional, assisted living, or home setting, including without limitation: services or supplies primarily to assist the Member in the activities of daily living or to keep the Member from continuing unhealthy activities, rest homes, home companions or sitters, home mothers, domestic maid services, health care aides, and respite care.

20. **Dental care and services**, except as indicated in the *Physician and other Medical Services* section, including:
    a) Dental Services, other than as described in the pediatric dental benefits category, rendered more than 62 days after the date of an Accidental Dental Injury even if the Services could not have been rendered within 62 days.
    b) Orthodontia Services, other than as described in the pediatric dental benefits category.
    c) Any dental Service not listed in the covered benefits section as covered.
    d) Any dental Service listed under Pediatric Dental Benefits that is rendered by a provider who is not a Contracting Provider, except for Emergency Services.
    e) Cosmetic procedures, including, but not limited to veneer restorations, tooth whitening, and non-Medically Necessary orthodontia.
    f) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
    g) Charges for nitrous oxide.
    h) Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth reconstruction, restoration of tooth structure lost from attrition and restoration for crooked teeth.
    i) Any additional treatment required because a Member does not follow instructions or does not cooperate with the Dentist.
    j) General anesthesia and intravenous sedation administered solely for patient management or comfort.
    k) Services related to hereditary or developmental defects or cosmetic reasons, including but not limited to, cleft palate (except as covered under Child Cleft Lip and Cleft Palate Treatment Services category), upper or lower jaw defects, lack of development of enamel, discoloration of the teeth, and congenitally missing teeth.
    l) Services rendered to a Covered Person after reaching age 19, including, but not limited to: 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, and dental x-rays.

21. **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.

22. **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, 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.

23. **Elective therapies** such as Gestalt, Transactional Analysis, Transcendental Meditation, Z-therapy, Mind expansion therapy and Erhard Seminar Training (EST).

24. **Experimental or Investigational** or unproven treatments and services, are specifically excluded from this benefit plan and are deemed not medically necessary under any circumstances. These services include, but are not limited to biofeedback, hypnotherapy, methadone maintenance, neurofeedback, light boxes for phototherapy and outward bound or other wilderness type therapies. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded, 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.

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

26. **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.

27. **Genetic Screening** including the evaluation of genes to determine if a Member is a carrier of an abnormal gene that puts the Member at risk for a Condition, except as provided under the Genetic Testing category in the *Physician and Other Medical Services* section.

28. **Hearing aids** and services related to the fitting or provision of hearing aids, including tinnitus maskers.

29. **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, or if covered as a preventive service, as defined by the Patient Protection and Affordable Care Act, and recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

30. **Infertility treatment** and services except as specified in Section 15 of this Member Handbook, including, but not limited to:
    a) Services provided to treat infertility;
    b) Reversal of voluntary surgical sterilization procedures;
    c) All infertility treatment medications;
    d) Assisted reproductive therapy including, but not limited to, Artificial Insemination (AI); In VItiro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); and any Services associated with these procedures; and
    e) All Services associated with the donation or purchase of sperm.

31. **Massage Techniques** such as application or use of the following or similar techniques or items for the purpose of aiding in the provision of Massage including, but not limited to: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; and/or contrast baths.

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

33. **Music Therapy**.

34. **Non-Prescription drugs or products,** including any non-Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods, with the exclusion of Insulin and over the counter medications covered under the Preventive Services as defined by the Patient Protection and the Affordable Care Act (ACA). Certain Over-the-Counter (OTC) Drugs, listed in the Formulary, may be covered (in accordance with state or federal regulations) when a Member gets a Prescription for the OTC Drug from their Physician. Only OTC Drugs that are listed in the Formulary are covered.

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

36. **Oral surgery** for any reason, including when the primary purpose is to improve the appearance or self-perception of an individual, except as provided under the Cover*ed Services* sections.

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

38. **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.

39. **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, 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.

40. **Private duty nursing care**.

41. **Rehabilitation services**, except as described in the *Covered Services* section. This exclusion includes:
    a) 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;
    b) 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; or
    c) Inpatient and/or outpatient long term rehabilitation services.
    d) All inpatient Rehabilitation Services for Pain Management and respiratory ventilator management Services are excluded.

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

43. **Scholastic/Educational Testing, Intelligence, and Learning Disability testing and evaluations**. These tests should be requested and conducted by the child's school district.

44. **Services or supplies** that are:
    a) determined to be not Medically Necessary;
    b) not specifically listed in the *Covered Services* sections unless such services are specifically required to be covered by state or federal law. If such services are specifically required to be covered, Capital Health Plan will provide coverage on a primary or secondary basis as required by applicable state or federal laws;
    c) court ordered care or treatment;
    d) 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;
    e) provided by a Physician or other health care provider related to the Member by blood, marriage or adoption;
    f) 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;
    g) for treatment of non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient Confinement for environmental change;
    h) supplied at no charge;
    i) 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
    j) 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.

45. **Skilled Nursing Facility services** not provided in lieu of Hospitalization.

46. **Smoking cessation programs, services, or medications**, beyond what is state or federally mandated.

47. **Sports-related devices** used to affect performance primarily in sports-related activities; and/or necessary to exercise, train or participate in sports, e.g. custom-made knee braces; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

48. **Tobacco** or tobacco related products.

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

50. **Transitional living centers**, non-licensed programs, therapeutic boarding schools, therapeutic group homes, community residential homes, and services typically provided by community mental health services program settings.

51. **Transplantation or implantation** services, including the transplant or implant, other than those specifically listed in the *Covered Services* sections. This exclusion includes:
    a) any service in connection with the implant of an artificial organ, including the implant of the artificial organ and a total artificial heart used as destination therapy.
    b) any organ which is sold rather than donated to the Member.
    c) any Bone Marrow Transplant, as defined herein, which is not specifically listed in the most recently published *Medicare National Coverage Determinations Manual*.
    d) any service in connection with identification of a donor from a local, state or national listing.

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

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

54. **Treatment** specific to, and solely for, learning, communication and motor skills disorders, mental retardation, academic or career counseling.

55. **Vision care**, including:
    a) the purchase, examination, or fitting of eyeglasses or contact lenses for a Covered Person age 19 or older, except as listed in the *Covered Services* section;
    b) any surgery for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error (e.g., radial keratotomy, myopic keratomelusis); and
    c) training or orthoptics, including eye exercises.

56. **Volunteer services** or services which would normally be provided free of charge, including, but not limited to, services provided by a family member of the Member.

57. **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, except as may be provided in the *Wellness Program* section of this Member Handbook; exercise or other equipment; or surgical and non-surgical procedures designed to restrict the member's ability to assimilate food.

58. **Wigs** or cranial prosthesis.

59. **Work or school ordered** assessment and treatment in the absence of a clinical need.

60. **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 Summary of Benefits and Coverage 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: WELLNESS PROGRAM

Capital Health Plan Subscribers will be eligible to be reimbursed for certain payments that they make during the Calendar Year towards wellness expenses for themselves and Dependents age 18 or older. The maximum wellness reimbursement per subscriber (inclusive of any and all covered dependents) is $150.00 each Calendar Year.

The Subscriber or Dependent for whom reimbursement is sought must be a Member of Capital Health Plan and a participating member of the wellness program for at least four consecutive months in the Calendar Year for which reimbursement is sought. The subscriber also must be a Member of Capital Health Plan at the time Capital Health Plan 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 Wellness Program Reimbursement Form.
- All applicable receipts, credit card records, cancelled checks, and pay stubs that show payment for the wellness expense.
- A copy of the wellness expense agreement or contract, showing the name and address of the wellness program and the name of contractee, including beginning and ending dates of membership or class.

The Wellness Program 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.

Wellness reimbursement requests may be filed only once each Calendar Year and no later than December 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.

Please see go to https://capitalhealth.com/getfit to see the details of the **Wellness Program** including facilities and/or programs that do and do not qualify for reimbursement.

SECTION 23: STATEMENT ON ADVANCE DIRECTIVES

The following information is provided in accordance with the Patient Self-Determination Act to advise Members of their rights under Florida law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an Advance Directive, and to 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. Members are encouraged to consult with their attorneys for specific advice.

Florida law recognizes the right of a competent adult to make an Advance Directive instructing their physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make treatment decisions for them 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.

Under Florida law, an Advance Directive is a witnessed written document or oral statement where the individual voluntarily provides instruction expressing their desires and preferences concerning any aspect of the individual's health care including but not limited to designation of a health care surrogate, completion of a living will or making an anatomical gift while they are still competent.

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.

1. 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 their 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.

2. 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 the patient's instructions as outlined in the Living Will. The responsibilities of the Health Care Surrogate include but are not limited to:
   - Making all health care decisions for the individual during the period of incapacity
   - Consulting with appropriate health care providers to provide informed consent
   - Providing written consent using an appropriate form whenever consent is

required including a physician's order not to resuscitate
- Applying for public benefits such as Medicare Medicaid or Veterans benefits on behalf of the individual to defray the cost of health care expenses.

3. Do Not Resuscitate Order (DNRO): Identifies individuals who do not wish to be resuscitated in the event of respiratory or cardiac arrest. Do Not Resuscitate Order forms are generally completed on individuals who are suffering from a terminal condition, end-stage condition or are in a persistent vegetative state. The form is available from the Florida Department of Health and must be printed on yellow legal paper to be valid as specified by the Florida Administrative Code.

4. Anatomical Donation: a document indicating the individual's wish to donate all or part of the body after death. The donated human body may be used for transplantation, therapy, research or education.

A suggested form of Living Will and Designation of Healthcare Surrogate is contained in Chapter 765 of the *Florida Statutes*. There is no requirement that a patient have an Advance Directive. Additionally, health care providers cannot condition treatment on whether or not an advance directive is in place. 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. Adult 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 and religious or moral beliefs; or
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 they are 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, religious and moral beliefs.

When completing an Advance Directive, a Member should carefully choose the individual to be designated as the Health Care Surrogate. Once a Member has completed the Living Will, they should discuss their desires for end of life treatment with their Surrogate to ensure the surrogate will be able to carry out the Member's wishes. By holding a frank discussion withtheir surrogate, the surrogate will be better equipped to make decisions on the Member's behalf. The Advance Directive must be signed in the presence of two adult witnesses. The witnesses must be over the age of 18 and may not be related to the Member by marriage, blood or adoption.
The Member should provide both the surrogate as well as the Member's primary care

physician with a copy of their Advance Directive. Additionally, the Member should provide a copy to the Hospital in the event that they are Hospitalized. Members should also keep a copy at home so that the Advance Directive is easily accessible. Emergency medical responders are trained to look for medical information on either the refrigerator or the patient's bedroom door or wall.

It is the policy of Capital Health Plan to recognize the right of each Member to make health care treatment decisions in accordance with their own personal beliefs. Members have the right to decide whether or not to execute an Advance Directive to guide treatment decisions in the event of becoming unable to do so. Capital Health Plan will not interfere with its Member's decision in accordance with the laws of the State of Florida. It is each Member's responsibility to provide notification to their providers that an Advance Directive exists. If a Member has a written Advance Directive, Capital Health Plan recommends that the Member furnish their providers with a copy so that it can be made a part of their 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 a Member's Advance Directive, the Member 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, Capital Health Plan recommends that its Members have discussions about Advance Directives with their medical care givers, family members and other advisors. Members' physicians should be involved in these discussions and informed clearly and specifically of any decisions reached. Those decisions need to be revisited annually or when changes in a Member's medical condition occur.

Complaints concerning noncompliance with Advance Directives may be submitted to the following address:

Florida Health Consumer Services Unit 4052
Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275
Phone: (850) 245-4339
Toll Free: 1-888-419-3456

For additional information on the State of Florida Statute 765 Health Care Advance Directives visit: http://www.leg.state.fl.us/statutes

For additional information on the Do Not Resuscitate Order visit the Florida Department of Health: http://www.floridahealth.gov/

The Florida Department of Health may be reached at: 800-226-1911, extension 2721

SECTION 24: MEMBER'S RIGHTS AND RESPONSIBILITIES

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

Members 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 Contracting Providers to permit them to participate in decision-making about their health care consistent with legal, ethical, and relevant patient-practitioner relationship requirements. If Members are unable to fully participate in treatment decisions, they have a right to be represented by their parents, guardians, family members, health care surrogates or other conservators to the extent permitted by applicable laws.

4. Expect Contracting Providers to provide treatment with courtesy, respect, and with recognition of the Members' dignity and right to privacy.

5. Communicate complaints or appeals about Capital Health Plan or the care provided through the established appeal or grievance procedures found in this Member Handbook and in the master policy or contract provided to the Employer Sponsor.

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

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

8. Have access to their medical records, request amendments to their 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 member rights and responsibilities policies.

10. Call or write Capital Health Plan anytime with helpful comments, questions and observations, whether concerning something a Member likes about Capital Health Plan or the Employer Sponsored Coverage or something a Member feels is a problem area. Members should expect to receive timely responses from Capital Health Plan staff.

Members have a Responsibility to:

1. Seek all non-emergency care through their Primary Care Physician (PCP), obtain a referral from their PCP for medical services by a specialist when required, and 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 them.

4. Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

5. Follow the plans and instructions for care that the Members have agreed to with their practitioners.

6. Ask questions and seek clarification to enable them to participate fully in their care.

7. Pay Copayments and provide current information concerning their Capital Health Plan membership status to any Capital Health Plan participating practitioner or provider.

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

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

10. Seek access to medical and member information through each Members' Primary Care Physician, *CHPConnect* or through Capital Health Plan Member Services.

11. Follow the coverage access rules in their Member Handbook.

SECTION 25: COMPLAINT, GRIEVANCE, AND APPEAL PROCESS

Capital Health Plan has established a process for reviewing Member complaints, grievances, and appeals. 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, Grievance, and Appeal Process also permits the Member, or their physician, to expedite Capital Health Plan's review of certain types of appeals. The process described below must be followed if the Member has a complaint, grievance, or appeal.

Under the Complaint, Grievance, and Appeal 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 Grievance 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 the Appeal 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); TTY 850-383-3534 (toll-free 1-877-870-8943). If Capital Health Plan is unable to resolve the matter on an informal basis, the Member may submit their formal request for review in writing.

Definitions for this Section

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

Adverse Benefit Determination means any denial, reduction, or termination of coverage, benefits, or payments (in whole or in part) under the Member Handbook 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.

Appeal means a written request for Capital Health Plan to review and overturn a previous decision to deny coverage or payment for health care services, supplies or drugs. A Member, a Member's representative, a provider acting on behalf of a Member, or a state agency may submit an appeal. To submit or pursue an appeal on behalf of a Member, a health care provider must previously have been directly involved in the treatment or diagnosis of the Member. Expedited appeals may be submitted verbally.

Appeal Panel means a panel established by Capital Health Plan to review appeals 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 subsection as described in this Member Handbook.

Expedited Appeal 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 their 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 Program means the process for certain coverage denials to be reviewed by independent physician reviewers. Once the Capital Health Plan appeal process has been exhausted, eligible members may request external review if the coverage denial is based on lack of Medical Necessity or on the experimental or investigational nature of the service or supply at issue. The Member bears no cost for this independent review.

Grievance means a written expression of dissatisfaction that is not related to a previous coverage or payment decision made by Capital Health Plan. The Member, a provider acting on their 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.

Independent Review Organization (IRO) means an accredited organization which performs, upon request of the Member, an independent review of certain coverage denials that were not resolved by the health plan to the satisfaction of the Member.

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. in accordance with Capital Health Plan's Medical Coverage Guidelines and Clinical Criteria, then in effect:
2. consistent with the symptom, diagnosis, and treatment of the Member's condition;
3. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
4. 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;
5. not experimental or investigational;
6. not for cosmetic purposes;
7. not primarily for the convenience of the Member, the Member's family, the physician or other provider; and
8. 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 this Member Handbook condition payment for the service, (in whole or in part) on approval by Capital Health Plan of coverage 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 for 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, they may submit a grievance in accordance with the Formal Review subsection below.

Important Note:

The Member must provide all of the facts relevant to the complaint to the Member Services Representative. 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 the 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. 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, faxed, or emailed to the Capital Health Plan contact information provided in the Telephone Numbers and Addresses subsection.

If the Member needs assistance in preparing the grievance, they may contact Capital Health Plan for assistance. Hearing impaired Members may contact Capital Health Plan via TTY at 850-383-3534 (1-877-870-8943 toll-free).

Formal Grievance Review

- Grievances: To begin the formal review process, the Member must submit in writing the facts relating to the grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation. Capital Health Plan will review the grievance and advise the Member in writing of the outcome of its research. Capital Health Plan's response is provided to the Member within 30 calendar days of its receipt.

Formal Review – Appeals

Formal Appeal Review

- Standard Appeals: To begin the formal review process, the Member must submit in writing the facts relating to the appeal. The Member should provide as much detail as possible and attach copies of any relevant documentation. The Appeal Panel will review the appeal and advise the Member of its decision in writing. If the appeal involves a pre-service claim, the Capital Health Plan decision regarding the appeal will be made as quickly as the Member's health requires, but at most within 30 calendar days of receipt of the appeal. If the appeal involves a post-service claim, the Capital Health Plan decision regarding the appeal will be made within 60 calendar days of receipt of the appeal.
- If the Member remains dissatisfied with the decision of the Appeal Review Panel, they may request a reconsideration of the decision by an Independent Review Organization (IRO).

- The Appeal 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.

- The Appeal Panel will review the appeal 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.

- Expedited Appeals: For an appeal involving an adverse benefit determination, the Member, the Member's authorized representative or a treating provider acting on behalf of the Member, may request that the review of the appeal be expedited. To be eligible for an expedited review, an appeal (i.e., a request for expedited review) must meet the following criteria as determined by Capital Health Plan:
    - The Member must be dissatisfied with a Capital Health Plan adverse benefit determination; and
    - As determined by Capital Health Plan Medical Management, a delay in the provision of health care services for the length of time permitted under the standard appeal 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
    - 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 treating 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 authorized representative or a treating provider acting on behalf of the Member, 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, they may request an external review by an Independent Review Organization (IRO).

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 or the Florida Agency for Health Care Administration. The Member also has the right to request an external review by an Independent Review Organization (IRO) for their additional review. (The Member must request this external review 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 appeal process and receive a final disposition from Capital Health Plan before pursuing review by an Independent Review Organization (IRO). However, the Member is permitted to file a concurrent request for expedited appeal review with both Capital Health Plan and with an Independent Review Organization (IRO), before Capital Health Plan makes its final determination.

Timeframes for Resolution of an Appeal

Capital Health Plan will resolve appeals in a timely manner. In resolving appeals, timeframes may vary, depending on the circumstances and the member's health Condition. Capital Health Plan will however, resolve the Member's appeal within 72 hours for expedited reviews, 30 calendar days for pre-service claims, or 60 calendar days for post-service claims.

General Rules

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

1. The Member must cooperate fully with Capital Health Plan in its effort to promptly review and resolve a complaint, grievance, or appeal. If the Member does not cooperate fully with Capital Health Plan, they will be considered to have waived their right to have the complaint, grievance, or appeal 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.

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 that relates to a request that is not eligible for expedited review in accordance with the criteria set forth in the Request for Expedited Review subsection.

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

5. If an appeal 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 this 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 Appeal 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 an appeal has been denied by Capital Health Plan and the denial has been upheld by an Independent Review Organization (IRO), and nothing regarding the matter has changed (i.e., the benefits, employer, medical condition are unchanged), the decision is binding and Capital Health Plan will not be required to reopen the appeal.

Telephone Numbers and Addresses

The Member may contact a Capital Health Plan Member Services Representative at the number listed on the membership card or the numbers listed below. If a complaint, grievance, or appeal 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
1264 Metropolitan Boulevard
Tallahassee, FL 32312
Office hours: Monday – Friday, 8 a.m. to 5 p.m.
850-383-3311 (Monday – Friday, 8 a.m. to 5 p.m.)
Toll-free: 877-247-6512 (24 hours a day, 7 days a week)
TTY: 850-383-3534 (Monday – Friday, 8 a.m. to 5 p.m.)
TTY 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: www.capitalhealth.com

External Review Program
To request an external review, submit your appeal in writing to the independent review organization (IRO). You will need to complete the Request for External Review form, explain the subject of the appeal and the reason you believe your request should be approved. If you have questions about how to obtain the form and/or how to submit your external appeal request you can contact CHP Member Services for assistance. Upon notification from the IRO, the CHP Grievance and Appeals Department will forward the appeal file to the IRO for review.

Member Services: 850-383-3311 (Monday – Friday, 8 a.m. to 5 p.m.)
Toll-free: 1-877-247-6512 (24 hours a day, 7 days a week)

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

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

SECTION 26: 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.*

Allowed Amount *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 allowed amount be greater than the amount the provider actually charge(s). The allowed amount may be modified by Capital Health Plan at any time without the consent or notice to the Employer Plan 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 Plan 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.*

Approved Clinical Trial *means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and meets one of the following criteria:*

1. The study or investigation is approved or funded by one or more of the following:

A. The National Institutes of Health;
B. The Centers for Disease Control and Prevention;
c. The Agency for Health Care Research and Quality;
d. The Centers for Medicare and Medicaid Services;
e. cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs;
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
g. Any of the following if the conditions described in paragraph (2) are met:
i. The Department of Veterans Affairs;
ii. The Department of Defense; or
iii. The Department of Energy.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For a study or investigation conducted by a Department, the study or investigation must be reviewed and approved through a system of peer review that the Secretary of that Department determines: (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For purposes of this definition, the term "Life-Threatening Disease or Condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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 a 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 Covered 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 Summary of Benefits and Coverage 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, which shall include a single encounter with a health care provider in an office, clinic, or Ambulatory care facility/emergency room as an outpatient, the Copayment shall not exceed the highest Copayment specified in the Summary of Benefits and Coverage for any of the services rendered on the same date during such office visit, regardless of the number of services rendered during such office visit. See also the Emergency Services and Care Section and the Summary of Benefits for additional information regarding copayments in emergency department and observation status settings.

Cost Share *means the dollar or percentage amount established solely by Capital Health Plan which is required to be paid to a health care provider by a member at the time Covered Services are rendered by that provider. Cost Share may include, but is not limited to Coinsurance, Copayment and Deductible amounts. Applicable Cost Share amounts are identified in the Summary of Benefits and Coverage.*

Covered Person *means eligible employees, retirees, surviving spouses, COBRA participants, or any Eligible Dependents enrolled 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 "supplies" 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 by their Subscriber of applicable forms through the Employer Plan Sponsor, 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 (DME) *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 Plan 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 Medical 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 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, 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 Sponsored Plan *means the Employer Sponsored health benefit plan established and maintained by the Employer Plan Sponsor through the purchase of comprehensive health care coverage and benefits from Capital Health Plan.*

Excluded Services *means services that are not a covered benefit and for which no payment will be made by 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.

Grace Period *means that if any required premium is not paid on or before the date it is due, it may be paid during the Grace Period. During the Grace Period, the contract will stay in force. This contract has a 10-day Grace Period,*

Habilitative Services *means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.*

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 Sponsored 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. *in accordance with Capital Health Plan's Medical Coverage Guidelines and Clinical Criteria, then in effect:*
2. *consistent with the symptom, diagnosis, and treatment of the Member's Condition;*
3. *widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;*
4. *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;*
5. *not Experimental or Investigational;*
6. *not for cosmetic purposes;*
7. *not primarily for the convenience of the Member, the Member's family, the Physician or other provider; and*
8. *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 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 Dependent child's treating provider to Capital Health Plan; and*
3. *causes the 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 the Employer Plan Sponsor 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 and Nervous Disorders *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.*

Network *means the facilities, providers and suppliers Capital Health Plan has contracted with to provide health care services. The provider directory can be located on Capital Health Plan's website at www.capitalhealth.com.*

Nursing Services *means services that are provided by an Advanced Registered Nurse Practitioner (A.R.N.P.), registered nurse (R.N.), or a licensed pratical nurse (L.P.N.), who is licensed under Chapter 464, Florida Statues, and is:*

1. *acting within the scope of that person's license;*
2. *authorized by a physician; and*
3. *not related to the Member by blood, or marriage or adoption.*

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.*

Ophthalmologist *means a person properly licensed pursuant to Chapter 458 or Chapter 459 of the Florida Statutes, or other states' applicable laws, who specializes in the diagnosis and treatment of diseases and injuries of the eye.*

Optometrist *means a person properly licensed to practice optometry pursuant to Chapter 463 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.*

Osteopathic physician *means a person who is licensed to practice osteopathic medicine pursuant to Chapter 459 of the Florida Statutes, or other states' applicable laws.*

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.*

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.*

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 or PCP *means the Physician, licensed under chapter 458, 459, 460, or 461 of the Florida Statutes, 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 Member'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, 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.*

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 their health; interferes with their social or economic functioning; or causes the individual to lose self-control.*

Telehealth *means remote access technology including web and mobile devices, where Members have access to a network provider who can review medical and prescription history, answer questions, diagnose, treat, and prescribe medication when clinically appropriateTelehealth does not include audio-only telephone calls, emails, patient portal communications or facsimile transmissions and must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.*

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.*

Urgent Care *means care for an illness, injury, or condition serious enough to seek care right away, but not so severe as to require emergency room care.*

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 Small Employer Application, if any, which must be met by an individual before that individual is eligible to enroll for coverage under this Policy. Such waiting period cannot be more than 90 days in accordance with federal law.*

Thank you for choosing Capital Health Plan ("CHP"), an affiliate of Blue Cross and Blue Shield of Florida, Inc. Capital Health Plan is a Florida-based Health Maintenance Organization ("HMO") providing comprehensive HMO-type coverage for groups. This Member Handbook will evidence the existence of the Employer Sponsored Plan and describe the rights and obligations which the Covered Person and Capital Health Plan have with respect to the coverage and/or benefits to be provided by Capital Health Plan.

Capital Health Plan

John Hogan
President and CEO

Capital Health PLAN℠
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