Capital Health Plan℠

An Independent Licensee of the Blue Cross and Blue Shield Association

2023 HMO Individual Contract

For Individual HMO Contract

John Hogan
President & CEO

For Member Service Assistance:
Call 850-383-3311 (Monday–Friday, 8 a.m. to 5 p.m.); Toll-free: 877-247-6512
TTY: 850-383-3534 (Monday–Friday, 8 a.m. to 5 p.m.); TTY Toll-Free: 1-877-870-8943
In person: 1264 Metropolitan Boulevard, Tallahassee, FL 32312, (Monday–Friday, 8 a.m. to 5 p.m.)
Log in to CHPConnect at www.capitalhealth.com.

Contract holder Name: <Name>
Contract Number: <Contract Number>
Contract Type: <Type>
Effective Date: <Effective Date>
Monthly Rate: <Rate>

Capital Health PLAN℠
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IMPORTANT NOTICE

In deciding to issue this Contract to you, we relied on the truthfulness and accuracy of the information provided on the application. Please carefully read your application and notify us within 10 days if any of the information on it is incorrect or incomplete. Fraudulent statements or Material Misrepresentations on your application could result in the cancellation or Rescission of your Contract.

During the term of this Contract, Capital Health Plan (CHP) agrees to provide the HMO coverage and benefits specifically provided in this Contract to covered individuals, subject to all applicable terms, conditions, limitations, and exclusions.

This Contract will stay in effect as long as you remain eligible for coverage and you pay your Premiums on time. This Contract can be Rescinded or canceled if you have made a fraudulent or Material Misrepresentation. This Contract can be canceled if we terminate the policy form for everyone covered by it.

CHP requires the designation of a primary care provider.

- You have the right to designate any primary care provider who participates in the CHP network and who is available to accept you and/or your family members.
- For children, you may designate a pediatrician who participates in the CHP network as the primary care provider.
- You do not need a referral from Capital Health Plan or from your primary care provider to obtain access to obstetrical or gynecological care from a health care professional in the CHP network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain Services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating primary care providers, including health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, access the current CHP Provider directory at www.capitalhealth.com or contact Member Services (850-383-3311).

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SECTION 1: HOW TO USE YOUR CONTRACT

This is your Contract. You should read it carefully before you need Health Care Services. It contains valuable information about:

- your Capital Health Plan benefits;
- what is covered;
- what is not covered;
- how to access your benefits
- coverage and payment rules;
- how and when to file a claim and under what circumstances we will pay;
- what you will have to pay as your share; and
- other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how we will coordinate benefits with other policies or plans; our subrogation rights; and our right of reimbursement.

Refer to the Schedule of Benefits to determine how much you have to pay for particular Health Care Services.

When reading your Contract, please remember:

1. You should read this Contract in its entirety in order to determine if a particular Health Care Service is covered. Sometimes it may be necessary to change the standard language in this Contract. If changes are needed, we will create an Endorsement to this Contract, which will either be inserted after the section that it modifies, or at the end of the Contract. Be sure to always check for these additional documents before making benefit decisions.
2. The headings of sections contained in this Contract are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
3. References to "you" or "your" throughout refer to you as the Contract holder and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Contract holder or solely to your Covered Dependents will be noted as such.
4. References to "we", "us", "our" and "CHP" throughout refer to Capital Health Plan, Inc.
5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the DEFINITIONS section or within the particular section where it is used.

Where do I find information on…	**…go to:**
What is covered?	The WHAT IS COVERED? section.
What is not covered?	The WHAT IS NOT COVERED? section, along with the WHAT IS COVERED? section.
What is covered under my pharmacy plan?	The PRESCRIPTION DRUG PROGRAM section.
How do I know what Providers I can use, and how the Providers I use will affect my Cost Share amount?	The Find a Provider section of our website at https://capitalhealth.com/directories/provider-directory section and the COVERAGE ACCESS RULES section.
How much do I pay for Health Care Services?	The YOUR SHARE OF HEALTH CARE EXPENSES section along with the Schedule of Benefits.
How do I access Services when I am out-of-state?	The BLUECARD® PROGRAM section.
How do I add or remove a Dependent?	The ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and the TERMINATION OF COVERAGE section.
What if I am covered under CHP and another health plan?	The COORDINATION OF BENEFITS section.
What happens when my coverage ends?	The TERMINATION OF COVERAGE section.
What do the terms used throughout this Contract mean?	The DEFINITIONS section.
What do I do if I have questions or complaints?	Call 850-383-3311; Toll-free: 877-247-6512 TTY: 850-383-3534; TTY Toll-Free: 1-877-870-8943 In person: 1264 Metropolitan Boulevard, Tallahassee, FL 32312 Log in to CHPConnect at www.capitalhealth.com.

Introduction

The sections describe Health Care Services that are covered under this Contract. All benefits for Covered Services are subject to: 1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, 2) the applicable Allowed Amount, 3) any limitations and exclusions, as well as any other provisions contained in this Contract including any Endorsements that are part of your Contract. 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 CONTRACT 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 this Contract 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 or Cost Share for which the Member is responsible for each category of Covered Services are set forth in the Schedule of Benefits.

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 that is otherwise covered if, in the opinion of Capital Health Plan, such service is not Medically Necessary, as defined in the Definitions 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 Contract 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 3: PHYSICIAN AND OTHER MEDICAL SERVICES

The following Physician and other medical services may be Covered Services, subject to the Cost Share amount set forth in the Schedule of Benefits, 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 Definitions 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 that 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 Contract, 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) in the Schedule of Benefits.

Even though benefits may be available under this Contract 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 wants 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.

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 with Capital 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, covered services include 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 Contract, 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 that 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:

1. 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);
2. 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;

3. 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
4. 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 Schedule 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 that 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, for the Gold and Platinum plans are limited to adult 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 care, routine (for vision correction), for the Bronze and Silver plans is not covered for adults.

Vision Services – Pediatric

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

- rendered to a Covered Person who has not reached the age of 19;
- not specifically or generally limited or excluded;
- authorized for coverage by us, if prior authorization is required; and
- 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.

1. 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 Contract. If the Member selects a frame that is not included in the Pediatric Frame Selection covered under this Contract, 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.
2. 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 Contract. If the Member selects a contact lens that is not part of the Pediatric Contact Lens Selection covered under this Contract, 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.
3. 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 4: 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:

1. Room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
2. Intensive care units, including cardiac, progressive and neonatal care;
3. Use of operating and recovery rooms;
4. Use of emergency rooms;
5. Respiratory therapy (e.g., oxygen);
6. Drugs and medicines administered by the Hospital;
7. Intravenous solutions;
8. Administration of, including the cost of, whole blood or blood products;
9. Dressings, including ordinary casts;
10. Anesthetics and their administration;
11. Transfusion supplies and equipment;
12. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Chemotherapy treatment for proven malignant disease;
14. Physical Therapy (in connection with a covered Condition);
15. Other Medically Necessary services; and
16. 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 5: AMBULATORY SURGICAL CENTER SERVICES

The following health care services may be Covered Services, subject to the Cost Share amount set forth in the Schedule of Benefits, 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 6: 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 Cost Share amount set forth in the Schedule of Benefits. 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 that results from an Emergency Medical Condition.

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

Ambulance Services for Emergency Services and Care

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

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 that 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:

Part-time or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse;

- Physical Therapy by a Physical Therapist;
- Occupational Therapy by an Occupational Therapist;
- Speech Therapy by a Speech Therapist;
- Home health aide services;
- Medical social services;
- Nutritional guidance; and
- 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 that 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 that 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 that 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 that 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 that 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 that are received by the Member, subject to the visit limits as stated in the Schedule of Benefits 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 allow Capital Health Plan to 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 a 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:

a. Room and board;
b. Respiratory therapy (e.g., oxygen);
c. Drugs and medicines administered while an inpatient;
d. Intravenous solutions;
e. Administration of, including the cost of, whole blood or blood products;
f. Dressings, including ordinary casts;
g. Transfusion supplies and equipment;
h. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
i. Chemotherapy treatment for proven malignant disease;
j. Physical Therapy (in connection with a covered Condition); and
k. Other Medically Necessary services.

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

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 Contract 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 8: 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 Schedule of Benefits 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 Schedule of Benefits. 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 Contract 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.

Formulary

A 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 that 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 to Capital 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 Contract 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 Contract:

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 Contract 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 Contract 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 Contract. 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 Contract**

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 Contract.

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. Capital Health Plan excludes drugs that are not FDA approved from coverage. 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 9: 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 that, 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** that 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 that 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, 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 Services 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 Contract, 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 Vitro 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 testing, or required as a condition of parole or probation;

    d. received prior to a Member's Effective Date or received on or after the date a Member's Coverage terminates under the Contract, 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, bodybuilding, 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 that 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 that 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 Contract; 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 Schedule of Benefits 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 10: 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, https://capitalhealth.com/getfit.

Wellness Program 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 11: 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 is 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 is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, 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 with their 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 is 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 discuss Advance Directives with their medical caregivers, 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 12: 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 with Capital 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 Contract.
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 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 Cost Shares 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 Contract. 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 Contract.

SECTION 13: 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 Contract 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 Contract.

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 that 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 that 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) Capital Health Plan receives 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 Contract 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 Contract 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 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 will evaluate a request for expedited review.
- 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 Contract 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, 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.

Capital Health Plan
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 14: YOUR SHARE OF HEALTH CARE EXPENSES

This section explains what your share of the health care expenses may be for Covered Services you receive. Since not all plans include all the different types of Cost Shares explained in this section, it is important that you look at your Schedule of Benefits to see your share of the cost for specific Covered Services.

Deductibles

A deductible is a fixed dollar amount that you must pay before we begin to pay for Covered Services. There are different types of deductibles; some that apply to most Covered Services on your plan and some that apply only to a specific type of Service. Listed below are the different types of deductibles and a brief explanation of how they work. You will need to look at your Schedule of Benefits to find out what types of deductibles (if any) apply to your plan.

Rules for applying charges to deductibles:

- We can only apply charges for claims we actually receive;
- Only charges for Covered Services will be applied; and
- We will only apply the amount of charges up to our Allowed Amount.

Overall Deductible (DED)

This deductible applies to most of the Covered Services on your plan before we begin to pay for Covered Services. When we talk about this type we just call it "Deductible" and on the Schedule of Benefits "DED". Some Covered Services, such as Preventive Services, do not apply the Deductible, so be sure to look at your Schedule of Benefits. After the Deductible has been met, neither you nor your Covered Dependents (if any) will have any additional Deductible amount for the rest of that Calendar Year. The Deductible starts over every year on January 1st.

There are individual and family Deductibles, both of which apply on a Calendar Year basis:

Individual Calendar Year Deductible

If you are the only person on your plan, you only have to reach the individual Deductible and the family Deductible listed on your Schedule of Benefits does not apply to you. This amount, when applicable, must be satisfied by you each Calendar Year before any payment will be made by us. If more than one person is on your plan, the amount each person has to reach depends on the type of Deductible described below.

Family Calendar Year Deductible

If you have one or more family members on your plan, the family Deductible can be satisfied by any one Covered Person or a combination of Covered Persons depending on the type of family Deductible described below.

Embedded Deductible

If your Schedule of Benefits indicates that the Deductible is embedded, each Covered Person only needs to satisfy the individual Deductible and not the entire family Deductible, prior to us paying for

Covered Services for that Covered Person. We will not begin to pay for Covered Services for the other family members until they either satisfy the individual Deductible or until the family Deductible is met. The family Deductible is met when any combination of family members' costs for Covered Services meets the family Deductible limit. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward that person's individual Deductible.

Shared Deductible

If your Schedule of Benefits indicates that the family Deductible is Shared, the entire family Deductible must be met by any one Covered Person or a combination of any or all Covered Persons before we will begin to pay for Covered Services for any Covered Person under your plan.

Copayments

A Copayment is a fixed dollar amount you must pay when you receive certain Covered Services. Listed below are the different types of Copayments and a brief explanation of how they work. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you will pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

Copayments:

- must be paid at the time you receive the Services;
- apply before any payment will be made by us;
- apply regardless of the reason for the Service; and
- usually apply to all Services rendered during the visit, but there are exceptions to this rule, so be sure to check your Schedule of Benefits and the brief explanations below.

Office Services Copayment

An office Services Copayment applies to each office visit and applies to all Covered Services rendered during that visit, except for Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Copayment.

Inpatient Facility Services Copayment/Coinsurance

The inpatient facility Copayment/Coinsurance only applies to the inpatient facility (such as a Hospital) and you must pay it for each inpatient admission. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment/Coinsurance

The outpatient facility Copayment/Coinsurance only applies to an outpatient facility and you must pay it for each outpatient visit. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while using these facilities.

Note: Copayments for outpatient facility Services may vary depending on the type of facility chosen and the Services received. Please see your Schedule of Benefits for more information. If your plan includes

a Copayment for emergency room Services and you are admitted to the Hospital as an inpatient at the time of the emergency room visit, this Copayment will be waived, and you will pay the Cost Share that applies to inpatient facility Services.

Coinsurance

Coinsurance is a percentage of our Allowed Amount that you must pay before we will pay our portion of the Allowed Amount for Covered Services. The Coinsurance percentage is figured after all other Cost Share amounts for a given Service, such as Deductible.

Application of Multiple Cost Share Types

When a Service is subject to more than one type of Cost Share, the Schedule of Benefits will list the Cost Share types. For example, when the Schedule shows "50% after DED"; this means that the Deductible is applied first and then the Coinsurance. If you have already met the plan Deductible; then only the Coinsurance is applied.

Out-of-Pocket Maximums

An out-of-pocket maximum is the Calendar Year limit on Cost Share amounts that you have to pay for a given Calendar Year for Health Care Services that are Covered Services under this Contract. After you have paid this dollar amount in Cost Share, you will have no additional Cost Share for the rest of that Calendar Year and we will pay 100 percent of our Allowed Amount for Covered Services rendered during the rest of that Calendar Year. Note: A Member's Cost Share is applied to his or her out-of-pocket maximum as claims are received and paid by Capital Health Plan.

Individual Calendar Year Out-of-Pocket Maximum

If you are the only person on your plan, only the individual out-of-pocket maximum applies to you; the family out-of-pocket maximum listed on your Schedule of Benefits does not apply to you. After you have reached the individual out-of-pocket maximum, you will have no additional Cost Share for the rest of that Calendar Year and we will pay 100 percent of our Allowed Amount for Covered Services rendered during the rest of that Calendar Year. If more than one person is on your plan, the amount each person has to reach depends on the type of out-of-pocket maximum described below.

Family Calendar Year Out-of-Pocket Maximum

If you have one or more family members on your plan, any one Covered Person can satisfy the family out-of-pocket maximum or a combination of Covered Persons depending on the type of out-of-pocket maximum described below.

Embedded Out-of-Pocket Maximum

If your Schedule of Benefits indicates that the out-of-pocket maximum is embedded, when any one Covered Person meets the individual out-of-pocket maximum, that Covered Person will have no additional Cost Share for the rest of the Calendar Year. The rest of the family must continue satisfying their out-of-pocket maximum until the family out-of-pocket maximum is met. The maximum amount that any one Covered Person in your family can contribute toward the family out-of-pocket maximum is the amount applied toward that person's individual out-of-pocket maximum.

Shared Out-of-Pocket Maximum

If your Schedule of Benefits indicates that the out-of-pocket maximum is shared, any one Covered Person or a combination of any or all Covered Persons can meet the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, neither you nor your Covered Dependents will have to pay any additional Cost Share for Covered Services for the rest of the Calendar Year.

All Cost Share amounts you pay toward the Covered Services explained in this Contract will apply to the out-of-pocket maximum, such as Deductibles, Copayments and Coinsurance. The following charges will not apply to the out-of-pocket maximums and when you have reached the out-of-pocket maximum, you will still have to pay these charges:

- Premium amounts you must pay;
- charges for Services that are not covered; and
- any benefit penalties.

How We Will Credit Benefit Maximums

We will only credit the amounts we actually pay for Covered Services to any benefit maximums on your plan. The amounts we pay are based on our Allowed Amount for the Covered Services provided. You will need to look at your Schedule of Benefits to find out if any benefit maximums apply to your plan.

Special Rule for Capitated Providers

We typically pay In-Network Providers for Covered Services provided to you based upon that Providers' negotiated Allowed Amount with us. This form of payment to Providers is called "fee-for-service." In these circumstances, the amount you are responsible for paying for Covered Services will be based upon our actual Allowed Amount negotiated with the rendering Provider and will be credited toward applicable Deductibles and out-of-pocket maximums and/or used to calculate your Coinsurance.

In other circumstances under the agreements we have with In-Network Providers we may pay a set monthly amount per individual to cover the cost of providing Covered Services to you, whether or not care is actually provided during the month. This form of payment is called "capitation." In these instances, when you receive Covered Services from such a Provider, the amounts you are responsible for paying and the applicable credit toward any Deductible or out-of-pocket maximums may be, as determined by us, based upon the amounts we could have paid for such Covered Services to an In-Network Provider of the same or similar provider type licensed to provide such Services but not paid on a capitation basis (based on our Allowed Amounts then in effect for such Covered Services). Similarly, in these instances, the amounts you will owe for Coinsurance may be calculated, as determined by us, utilizing the amounts we could have paid an In-Network Provider of the same or similar provider type licensed to provide such Services but not paid on a capitated basis (based upon our Allowed Amounts for such Covered Services). The comparison form of payment utilized for this purpose, in the case of such a same or similar In-Network Provider, is fee-for-service payment. Further, in those circumstances where Services provided were paid on a capitation basis but such Provider may be paid fee-for-service by us for the same or similar Services for other individuals, we may utilize the fee-for-service amounts for such same or similar Services when calculating the credits toward applicable Deductibles and out-of-pocket maximums and/or use such fee-for-service amounts to calculate your Coinsurance.

Calculation of Cost Share

You can get an estimate www.pricing.floridahealthfinder.gov of the Cost Share amount you will have to pay for certain Covered Services, as required under section 641.54 of the Florida Statutes.

Additional Expenses You Must Pay

In addition to your share of the expenses described above, you are also responsible for:

1. charges in excess of any maximum benefit limitation listed in your Schedule of Benefits;
2. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
3. any benefit reductions/benefit penalties;
4. charges for Health Care Services which are non-Covered Services or excluded; and
5. the Premium applicable to your Contract.

SECTION 15: 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 Contract, responsible for providing, authorizing and coordinating all medical services for the Member.

2. Except as may otherwise be set forth in this Contract, 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 Contract. 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 Contract, 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 Member has obtained the referral, the Member may make an appointment with the Specialist.

When the Specialist suggests additional services, 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 Capital Health Plan authorizes coverage. 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 that results from an Emergency Medical Condition. **Follow-up care must be received, prescribed, directed or authorized by the Member's Primary Care Physician.** If a physician other than the Member's Primary Care Physician provides the follow-up care, coverage may be denied. If a determination is made that an Emergency Medical Condition does not exist, payment for any services provided other than Emergency Services and Care will be the responsibility of the Member.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges or the charge mutually agreed to by Capital Health Plan and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is the responsibility of the Member to furnish 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), 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 Contract 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.

Physician Assistant: Members have access to surgical assistant services rendered by a Physician Assistant. Licensed Physician Assistants, Nurse Practitioners or other individuals who are not Physicians, may render certain types of medical procedures and other services covered hereunder.

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 Contract.

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

If the member is actively receiving treatment for a Condition when Capital 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 Contract, 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 Contract 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. The Medical Director must authorize covered Services provided by a Non-Contracting Provider under this provision.

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 Contract. 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 Schedule of Benefits.

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 arrangements 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 Contract. 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 nonparticipating providers provide services, 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 16: PAYMENT OF PREMIUMS

This Contract is not enforceable, and your coverage is not effective until we receive and accept the Contract holder's application and the first Premium payment, in full. All future Premium payments are due, in full, in advance or within the Grace Period. The amount of your initial monthly Premium is printed on the front page of this Contract. If we do not, for any reason, provide you with a notice of payment due, you, as the Contract holder, are still obligated under this Contract to pay Premiums on time, even if you do not receive a bill from us. You, as the Contract holder, are solely responsible for submitting the Premium to the address indicated on the bill by the end of the Grace Period.

If we accept Premium for a Covered Dependent for a period of time after such dependent no longer meets the eligibility rules, coverage for such dependent will continue during the Grace Period for which an identifiable Premium was accepted, unless such acceptance resulted from a misstatement of age or residence.

Premium payments from third-party payors, except those required by law and indicated below, may not be accepted:

1. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. An Indian tribe, tribal organization, or urban Indian organization;
3. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf;
4. Private, not-for-profit foundations if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status, do not consider enrollees' health status and are determined acceptable to us; or
5. From a designated representative acceptable to us. This includes, but is not limited to, immediate family members, domestic partners, or individuals holding a properly executed power of attorney (POA) who make payments out of your accumulated funds on your behalf.

Premium Payment Due Date

The first Premium payment is due before the Effective Date of this Contract.

For applications received on or before the 15th calendar day of the month, the initial Premium payment must be received, in full, by the last calendar day of the month of application, in order for the Contract Effective Date to be the first calendar day of the following month.

For applications received after the 15th calendar day of the month, the initial Premium payment must be received, in full, by the last calendar day of the month following the month of application, in order for the contract Effective Date to be the first calendar day of the second month following the month of application.

In the event that the initial Premium payment is dishonored, your coverage will not be effective and we will not enroll you in coverage.

Each recurring monthly Premium payment, following the initial Premium payment, is due in full on or before the due date as stated on your monthly bill.

Grace Period

This Contract has a Premium payment Grace Period that begins on the date the Premium payment is due. If any required Premium payment is not received by us on or before the due date, it may be paid during this Grace Period. The length of the Grace Period depends on whether or not you are receiving Advanced Payments of the Premium Tax Credit (APTC) as determined by the Marketplace.

If you DO receive APTC

The Grace Period is three months, as long as you have paid at least one month's Premium. We will pay all claims for Covered Services during the first month of the Grace Period. During months two and three of your Grace Period we may pend any claims incurred and received during months two and three. If we do not receive your Premium payments in full by the end of the Grace Period, your coverage will terminate as of the last day of the first month of the Grace Period. Any pended claims will be denied and you will be responsible for payment.

If you DO NOT receive APTC

The Grace Period is 31 days. Coverage will stay in force during the Grace Period, however; if Premium payments are not received by the end of the Grace Period, coverage will terminate as of the Premium due date.

Partial Payments

When we bill you for different kinds of coverage, products and/or services on the same bill (such as health insurance and dental insurance) and you pay less than the total amount of the bill, the way we credit your partial payment may affect your coverage.

We have established the order in which your partial payment will be applied to the different kinds of coverage, products and/or services, which is outlined on your bill. By accepting this coverage, you agree that partial payments will be applied in the order indicated on your bill.

Changes in Premiums

The Premium may be modified each year on the Anniversary Date due to changes in the Rates. We will provide at least 45 days prior notice to the Contract holder. If you send us any payments after you receive the notice of change to your Premium, this means you, as the Contract holder, agree to the Premium changes.

In addition to the Anniversary Date changes discussed above, your Premium may change if the Risk Class of any Covered Dependent changes, or if the number of individuals covered under this Contract changes. For example, the Premium may change if you move to a different geographical area.

Defaults in Payments

If all Premiums required under this Contract are not paid in full when they are due, this Contract will terminate as described in this section. However, even if your coverage is terminated for non-payment, you, as the Contract holder are still obligated under this Contract to pay us any prorated portion of the Premium for the period of time during which we provided benefits, or for any amounts otherwise due us.

Any person who meets and continues to meet the eligibility rules described in this Contract, is entitled to apply for coverage with us under this Contract. These eligibility rules are binding upon you and your eligible dependents. We may require acceptable documents proving that a person meets and continues to meet the eligibility requirements, such as a court order naming the Contract holder as the legal guardian or appropriate Adoption documents described in this section.

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.

Contract holder Eligibility

In order to be eligible to apply for coverage as a Contract holder, you must:

1. maintain your primary residence in the Service Area;
2. be a bona fide resident of the state of Florida;
3. apply for coverage under, and be named on, the application for this Contract; and
4. pay the required Premiums.

Dependent Eligibility

A person who meets the eligibility criteria specified below is eligible to apply for coverage under this Contract as an Eligible Dependent only if the person: 1) was named on the initial application for, or properly enrolled under, this Contract; 2) pays the required Premium; and is:

1. The Contract holder's spouse under a legally valid existing marriage, who maintains their primary residence in the Service Area;
2. The Contract holder's present Domestic Partner, who maintains their primary residence in the Service Area;
3. The Contract holder's or Covered Domestic Partner's 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:
    - under 26 years of age (eligibility automatically terminates at the end of the month in which the Dependent has their 26th birthday); or
    - in the case of a Foster Child, is no longer eligible under the Foster Child Program; or
    - 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 his or her eligibility for this coverage. 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.

- 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.

  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 must provide written certification. 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.

- 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 that 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.

4. The newborn child of a Covered Dependent child. Coverage for such newborn child will end 18 months after the birth of the newborn child.

Note: You are solely responsible, as the Contract holder, to establish that a child meets the eligibility rules. Eligibility will end when the child no longer meets the eligibility rules required to be an Eligible Dependent described above.

Other Eligibility Rules

1. No person whose coverage with us has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll with us.
2. No person shall be refused enrollment or re-enrollment because of race, color, national origin, disability, sex, age, creed, marital status, gender, gender identity or sexual orientation (except as provided in this section).
3. The Contract holder must notify us as soon as possible when a Covered Dependent is no longer eligible for coverage. If a Covered Dependent fails to continue to meet each of the eligibility requirements, and the Contract holder does not provide timely notice to us, we shall have the right to:
   a. retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met; and
   b. to recover an amount equal to the Allowed Amount for Health Care Services and/or supplies provided after such date, less any Premium received for such dependent for coverage after such date.

   Upon our request, the Contract holder shall provide proof, which is acceptable to us, of a Covered Dependent's continuing eligibility for coverage.

General Rules for Enrollment

1. Any person who is not properly enrolled with us will not be covered under this Contract. We will have no obligation whatsoever to any person who is not properly enrolled.
2. All factual representations made by you to us in writing in connection with the issuance of this Contract and enrollment hereunder must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right we may have, we may terminate or Rescind your coverage.
3. We will not provide coverage or benefits to any person who would not have been eligible to enroll with us, had accurate and complete information been provided to us on a timely basis. In such cases, we may require you or a person legally responsible for you, to reimburse us for any payments we made on your behalf.

4. Risk Class applicable to you and your dependents determines eligibility for coverage under this Contract. In determining eligibility for coverage under this Contract, we rely on the information provided by you prior to your enrollment.

5. If, in applying for this Contract or in enrolling yourself or dependents, you commit fraud or make an intentional misrepresentation of material fact, we may Rescind your coverage. After two years from your Effective Date, your Contract may only be Rescinded for fraudulent misstatements. If, in applying for this Contract or in enrolling yourself or dependents, you make a fraudulent statement or intentional misrepresentation of a material fact, including but not limited to, your demographic information including your geographical area, your age, or the age of your dependents we may elect to cancel the Contract with 45 days prior written notice. We may also elect to continue this Contract if the Contract holder pays us for the full amount of the Premium that would have been in effect if you had stated the true facts.

How to Enroll in Coverage

To enroll in coverage, you must:

1. complete and submit, and we must receive and accept, an application;
2. provide any other information we may need to determine eligibility, at our request;
3. agree to pay the required Premium; and
4. complete and submit the required Enrollment Forms to add Eligible Dependents or delete Covered Dependents.

Your Effective Date depends on the date we receive your Enrollment Forms. If we receive the Enrollment Forms between the 1st and 15th of any month, the Contract holder and/or the Dependent's Effective Date is the first day of the following month. If we receive the Enrollment Forms between the 16th and the last day of any month, the Contract holder and/or Dependent's Effective Date is the first day of the second following month.

Annual Open Enrollment Period

The Annual Open Enrollment Period is the period of time each year, as designated by the Marketplace, when you can change coverage or enroll in a new QHP. Capital Health Plan may decide to offer a longer Annual Open Enrollment Period outside the Marketplace as indicated on the applicable Enrollment Form. Any changes made to your coverage during the Annual Open Enrollment Period can be effective as early as January 1st. If you do not enroll or change coverage during the Annual Open Enrollment Period you will need to wait until the next Annual Open Enrollment Period unless you or your Eligible Dependents are eligible for a Special Enrollment Period.

Special Enrollment Periods

Additional Rules for Dependent Enrollment

An Eligible Person who has a Qualifying Event may apply for coverage due to certain Special Enrollment circumstances as outlined below. Capital Health Plan must receive the request for enrollment within the timeframes specified below, or the request may be denied:

1. Loss of health coverage
    a. You may qualify for a Special Enrollment Period if you or anyone in your household lost qualifying health coverage **in the past 60 days** OR expects to lose coverage **in the next 60 days**.
2. Changes in household
    a. Got married. Pick a plan by the last day of the month and your coverage can start the first day of the next month.
    b. Had a baby, adopted a child, or placed a child for foster care. Your coverage can start the day of the event — even if you enroll in the plan up to 60 days afterward.
    c. Were divorced or legally separated and lost health insurance. Note: Divorce or legal separation without losing coverage does not qualify you for a Special Enrollment Period.
    d. Died. You will be eligible for a Special Enrollment Period if someone on your Marketplace plan dies and as a result you are no longer eligible for your current health plan.
3. Change in residence
    a. Household moves that qualify you for a Special Enrollment Period:
        i. Moving to a new home in a new ZIP code or county
        ii. Moving to the U.S. from a foreign country or United States territory
        iii. If you're a student, moving to or from the place you attend school
        iv. If you're a seasonal worker, moving to or from the place you both live and work
        v. Moving to or from a shelter or other transitional housing

Note: Moving only for medical treatment or staying somewhere for vacation does not qualify you for a Special Enrollment Period.

Important: You must prove you had qualifying health coverage for one or more days during the 60 days before your move. You do not need to provide proof if you are moving from a foreign country or United States territory.

4. An employer offer to help with the cost of coverage

a. You may qualify for a Special Enrollment Period if you or anyone in your household newly gained access to an individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) in the past 60 days OR expects to in the next 60 days.

5. Other qualifying changes.

Additional Rules for Adopted Newborn Children

In addition to the above, in order for an Adopted newborn's Effective Date to be the date of birth, a written agreement to Adopt such child must have been entered into by the Contract holder or Covered Domestic Partner prior to the birth of such child, whether or not such an agreement is enforceable. We may require the Contract holder to provide any information and/or documents that we deem necessary in order to administer this provision. Proof of final Adoption must be submitted to us. If the Adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the Adopted newborn child. You are responsible, as the Contract holder, to notify us that the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Contract holder. If a child is born before the Effective Date of the Contract holder, the newborn must be added during the application process.

Adopted/Foster Children (other than newborns) – To enroll an Adopted child (other than a newborn child) or Foster Child, you must complete and submit any required Enrollment Forms to us prior to or within 60 days after the date of placement and pay the additional Premium, if any. The Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Contract holder or Domestic Partner. We may need you to provide additional information and/or documents deemed necessary by us in order to properly administer this provision.

If the Adopted or Foster Child is enrolled within 30 days after the date of placement, no additional Premium will be charged for their coverage for the first 30 days. If the Adopted or Foster Child is enrolled within 31 to 60 days after the date of placement, additional Premium will be charged for their coverage from the date of placement.

Adopted Children – For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for such Adopted child. You are responsible, as the Contract holder, to notify us if the Adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

Foster Children – If your status as a foster parent is terminated, coverage will end for any Foster Child. You are responsible, as the Contract holder, to notify us in writing that the Foster Child is no longer in your care. Upon receipt of this notification, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

Other Dependents -- If other Eligible Dependents were not named on the application for this Contract (such as a new spouse or a court order to provide coverage for a minor child), you may still apply for coverage for such dependents during a Special Enrollment Period. An Eligible Dependent can become covered when you submit the required Enrollment Forms and pay the required Premiums.

The Effective Date of coverage for other dependents will be determined based on the type of special enrollment event and when we receive the Enrollment Forms.

Continuing Coverage on Termination of Eligibility

If coverage ceases because of termination of eligibility under this Contract, you shall be entitled to be issued a Contract in your name without evidence of insurability, provided that application is made and Premiums are paid within 31 days after termination. There will be continuous coverage during the 31-day period, if such coverage is selected and the Premiums are paid. See also the Notice of Ineligible Dependent subsection of the TERMINATION OF COVERAGE section.

SECTION 18: TERMINATION OF INDIVIDUAL COVERAGE

Introduction

This section describes the rules for termination of coverage. We have divided this section into two subsections: Termination of an Individual; and Termination of the Contract.

Termination of an Individual

If your coverage is terminated by us for any reason, we will provide you with written notice at least 45 days prior to your last day of coverage under this Contract.

Contract holder

A Contract holder's coverage will end at 12:01 a.m. on the date:

1. this Contract terminates in accordance with the Termination of the Contract subsection;
2. the Contract holder's coverage is terminated for cause (see Termination for Cause below); or
3. the Contract holder no longer meets any of the eligibility requirements.

If you, as the Contract holder, wish to terminate your coverage, you must provide notice to us. Termination will be effective no earlier than the date you notify us.

Covered Dependent

A Covered Dependent's coverage will end:

1. at 12:01 a.m. on the date the Contract holder's coverage terminates for any reason;
2. if the Covered Dependent no longer meets any of the eligibility requirements;
3. on the date 18 months after the birth of a newborn child who is the child of a Covered Dependent child;
4. on the date we specify that the Covered Dependent's coverage is terminated by us for cause.

If you, as the Contract holder, wish to delete a Covered Dependent from coverage, you must complete any required Enrollment Form and submit it to us, prior to the termination date requested.

If you wish to delete your spouse from coverage, in the case of divorce, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Domestic Partner and/or Domestic Partner's Dependent Child

In addition to the rules listed under Covered Dependent above, a covered Domestic Partner and their Covered Dependent child's coverage under the Contract will end at 12:01 a.m. on the date that the Domestic Partnership ends or the date of death of the covered Domestic Partner.

Termination for Cause

If, in our opinion, any of the following events occur, we may terminate a person's coverage for cause:

1. fraud, intentional misrepresentation of material fact or omission in applying for coverage or benefits;

2. you intentionally misrepresent, omit or give false information on Enrollment Forms or other forms completed for us for the purpose of obtaining coverage under this Contract, by you or on your behalf; or
3. fraudulent misuse of the ID Card.

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

Rescission of Coverage

We reserve the right to Rescind coverage under this Contract or coverage for any person covered under this Contract as permitted by law.

We may only Rescind the Contract or coverage of a person covered under the Contract if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits. Only fraudulent misstatements on the Enrollment Form may be used by us to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

We will provide at least 45 days advance written notice to the Contract holder 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 COMPLAINT AND GRIEVANCE PROCESS section.

Notice of Ineligible Dependent

If a Covered Dependent no longer meets all of the applicable eligibility requirements specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section of this Contract, the Contract holder must notify us in writing immediately and no later than 31 days after the date the Covered Dependent ceases to be eligible for coverage. If we receive notification after the 31-day period, the change will be effective as of a current date and we will not refund any Premiums.

Our Responsibilities Upon Termination of Your Coverage

Upon termination of coverage for you or any of your Covered Dependents for any reason, we will have no further liability or responsibility with respect to such person, except as otherwise specifically described in this Contract.

Certification of Creditable Coverage

In the event coverage ends for any reason, we will issue a written certification of Creditable Coverage to you.

The certification of Creditable Coverage will indicate the period of time you were enrolled with us.

Upon request, we will send you another certification of Creditable Coverage within a 24-month period after termination of coverage. You may call the customer service phone number on your ID Card to request the certification.

The succeeding carrier will be responsible for determining if our coverage meets their qualifying Creditable Coverage guidelines.

Termination of the Contract

Discontinuation of Form

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

1. we provide notice to each Contract holder under this policy form in the individual market at least 90 days before the date the coverage under this policy form will end;
2. we offer the option to each Covered Person to purchase any other individual health care coverage we currently offer to individuals in such market in the state; and
3. we act uniformly without regard to any health-status-related factor of Covered Persons or individuals who may become eligible for such coverage.

Discontinuation of all Policies in Individual Market

We may decide to discontinue all of the policies that we have issued in the individual market in this state (including this Contract), but may do so only if:

1. we provide notice to the Office of Insurance Regulation and each Contract holder at least 180 days before the date the coverage under such policy will end; and
2. we return any unused Premium to the Contract holder

Defaults in Payments

If all Premiums required under this Contract are not paid in full when they are due, this Contract will terminate at the end of the Grace Period, as described in the PAYMENT OF PREMIUMS section.

Notice of Termination

If the entire Contract is terminated by us, a written notice of any termination will be mailed to the Contract holder. This notice will state the reason the Contract is being terminated.

Reinstatement of the Contract

This Contract may be reinstated upon receipt of payment to us of the applicable Premiums due. We must approve any reinstatement request. If we approve the request for reinstatement, the Contract will be reinstated as of the last paid to date of the Contract. If we do not approve the request for reinstatement, we will provide the Contract holder with notice of our disapproval.

Conditions of Renewal and Termination

This Contract is guaranteed renewable. This means that it automatically renews each year on the Anniversary Date unless terminated earlier in accordance with the terms of this Contract. We may terminate this Contract or not renew it if:

1. Premiums are not paid in accordance with the terms of this Contract or we have not received timely Premium payments;
2. the Contract holder no longer meets any of the eligibility requirements;
3. you perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact; or
4. you fail to comply with a material provision of the Contract.

If we decide to terminate the Contract or not renew it, based on one or more of the actions listed above, we will provide at least 45 days advance written notice.

Introduction

This section is intended to:

1. help you understand what your treating Providers must do, under the terms of this Contract, in order to obtain payment for Covered Services that have been rendered or will be rendered to you; and
2. provide you with a general description of the applicable procedures we will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying you when we deny benefits.

Types of Claims

For purposes of this Contract, there are three types of claims: (1) Post-Service Claims; (2) Pre-Service Claims; and (3) Claims Involving Urgent Care. It is important that you become familiar with the types of claims that can be submitted to us 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 Contract.

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) Capital Health Plan receives that 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 Contract 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 Contract, 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 CHP 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 Contract 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 Contract. 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 Contract 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. Capital Health Plan may extend this 15-day determination period 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 Capital Health Plan took an extension of time.

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 Contract or termination of the Member's coverage as provided by this Contract.

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 Contract. 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 Contract 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 Contract 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 Contract 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 20: 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 duplication of payment for Covered Services and/or supplies. We shall coordinate payment of Covered Services to the maximum extent allowed by law, provided you 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 group or non-group insurance, group-type self-insurance, or HMO plan;
2. any group plans issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
4. Medicare; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of payment by us, if any, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to your coverage under other plans. When we are not primary, our payment may be reduced so that total benefits under all plans will not exceed 100 percent of the total reasonable expenses actually incurred for the Covered Services. In the event an In-Network Provider rendered the Covered Services, total reasonable expenses, for purposes of this section, shall be equal to the amount we are obligated to pay such In-Network Provider based on the Provider's 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 that 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 that 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 Contract 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.

Access to Information

We shall have the right to receive, from any health care Provider rendering Services to you, information that is reasonably necessary, as determined by us, in order to administer the coverage and/or benefits we provide, subject to all applicable confidentiality requirements set forth in this section. By accepting coverage under this Contract, you authorize every health care Provider who renders Services or furnishes supplies to you, to disclose to us or to entities affiliated with us, upon request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit us to copy any such records and reports so obtained.

Amendment

The terms of coverage and benefits to be provided by us under this Contract may be amended, without your consent or that of any other person, upon 45 days prior written notice to the Contract holder. In the event the amendment is unacceptable to the Contract holder, the Contract holder may terminate this Contract upon at least 14 days prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to benefits and coverage under this Contract prior to the date of such amendment. No agent or other person, except our duly authorized officer, has the authority to modify the terms of this Contract, or to bind us in any manner not expressly set forth herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The Contract holder may not amend the terms of coverage and benefits to be provided by us under this Contract unless such amendment is evidenced in writing and signed by our duly authorized officer.

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 we may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without your consent, at any time. Any assignment, delegation, or transfer made in violation of this provision shall be void.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under this Contract 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 you or us.

Exiting the Marketplace

If the QHP Issuer Agreement between Capital Health Plan and the Centers for Medicare and Medicaid Services (CMS) is terminated for any reason, we will provide you notice that Capital Health Plan will no longer offer its plans on-Marketplace. These plans will only be available off-Marketplace. This means you will no longer receive advance premium tax credits (APTCs) or Cost Share reductions (CSRs), if applicable. If you were eligible for a silver variant plan, you will be responsible for the full cost-sharing amounts of the base silver plan.

Confidentiality

Except as otherwise specifically provided in this Contract, and except as may be required in order for Capital Health Plan to administer coverage and/or benefits under the Contract, 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 Contract, 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 that 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.

Cooperation Required of Covered Persons

You must cooperate with us, and must execute and submit to us such consents, releases, assignments, and other documents as may be requested by us in order to administer, and exercise our rights under this Contract. Failure to do so may result in the denial of claims.

Enrollment Records

Reporting Changes

You, as the Contract holder must provide any information required for the purpose of recording changes in family status or other information relative to eligibility or coverage status. You shall make all records relevant to eligibility or coverage status under this Contract available.

Errors or Delays

Clerical errors or delays by us in keeping or reporting enrollment records will not make any coverage invalid if it would otherwise be validly in force, or continue coverage which would otherwise be validly terminated. If you intentionally omit information that you should have provided, or provided incorrect information, it may be corrected if it is determined that any such correction will not be prejudicial to us. You agree that you will be liable to us for any claims payments we make on behalf of any individual who was not eligible for coverage at the time the Service or supply was rendered.

Entire Agreement

This Contract, including the application for coverage and any Enrollment Forms, sets forth the exclusive and entire understanding and agreement between you and Capital Health Plan and shall be binding upon all Covered Persons, Capital Health Plan, and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this Contract, which includes the terms of coverage and/or benefits set forth herein, your Schedule of Benefits and/or any Endorsements.

Evidence of Coverage

You have been provided with this Contract and an Identification Card as evidence of coverage.

Florida Agency for Health Care Administration (AHCA) Performance Data

The performance outcome and financial data published by AHCA, per Florida Statutes, or any successor statute, can be located at www.floridahealthfinder.gov.

Governing Law

The terms of coverage and benefits to be provided hereunder 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.

Identification Cards

The Identification Cards issued to you in no way create, or serve to verify eligibility to receive coverage and benefits under this Contract. ID cards are our property and must be destroyed or returned to us immediately following termination of your coverage.

Indemnification

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

Misstatement of, Age, Residence, or Tobacco Use

If you have misstated any written information relevant to determining your Premium, the Premium amount you owe under this Contract will be changed based on the corrected information provided to us. Other than for a misstatement related to tobacco use, if we accepted Premiums based on such misstatement that we would not have accepted Premium for if the correct information had been stated, our only liability will be the return of any unearned Premium. We will not provide any coverage for that time period. This right is in addition to any other rights we may have under this Contract and applicable laws.

Modification of Provider Network

Our Provider network is subject to change at any time without prior notice to you, or your approval. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to you, or your approval. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered. Under this Contract, your financial responsibility may vary depending on a Provider's participation status.

Non-Waiver of Defaults

Any failure by us 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 our right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law, or this Contract.

Notices

Any notice required or permitted hereunder will 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 us:

To the address printed on the ID Card.

If to you:

To the latest address provided by you according to our records.

You must notify us immediately of any address change.

Our Obligations Upon Termination

Upon termination of your coverage for any reason, we shall have no further liability or responsibility under this Contract with respect to you, 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 Contract.

Relationships Between the Parties

Capital Health Plan and Health Care Providers

Neither Capital Health Plan nor any of its officers, directors or employees provides health care Services to you. By accepting this coverage and benefits, you agree that health care Providers rendering Health Care Services are not our employees or agents. In this regard, we hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider. We do 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 us concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for the purpose of determining whether such Services are covered, and not for the purpose of recommending any treatment or non-treatment. We assume no liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

Capital Health Plan and the Contract holder

You are not our agent or representative and shall not be liable for any acts or omissions of Capital Health Plan, its agents, servants, or employees. Additionally, neither you 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 your agent, servant, or representative, and shall not be liable for any acts or omissions of yours or any person or organization with which you have entered into any agreement or arrangement. By acceptance of Covered Services hereunder, you agree to the foregoing.

Medical Treatment Decisions

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 you, your family and your treating Physician in accordance with the patient/Physician relationship. It is possible that you or your treating Physician will conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Reservation of Right to Contract

We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities for assistance with the servicing of coverage and benefits to be provided by us or obligations due, under this Contract.

Right of Recovery

Whenever we have made payments in excess of the maximum provided for under this Contract, we will have the right to recover any such payments, to the extent of such excess, from you or any other person, plan, or organization that received such payments.

Right to Receive and Release Necessary Information

In order to administer coverage and benefits, we 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 person covered under this Contract or an applicant for enrollment which we deem to be necessary.

Service Mark

You hereby expressly acknowledge that this Contract constitutes a contract solely between you and us. Capital Health Plan is an independent corporation operating an affiliate of Blue Cross and Blue Shield of Florida, Inc. CHP is a Florida-based Health Maintenance Organization (“HMO”) providing comprehensive HMO coverage under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans (the "Association"), permitting us to use the Blue Cross and Blue Shield Service Mark in the State of Florida and that we are not contracting as the agent for the Association. You further acknowledge and agree that you have not entered into this Contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Contract.

Subrogation and Right of Reimbursement

As used herein, the term "Third Party," means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries.

If benefits are paid under this Contract for expenses incurred due to Third Party Injuries, then we retain the right to repayment of the full cost of all benefits provided under this Contract on your behalf that are associated with the Third Party Injuries. Our subrogation and reimbursement rights of recovery apply to any claim or potential claim made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

By accepting benefits under this Contract, you specifically acknowledge our right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an accident), and we pay benefits under this Contract as a result of those injuries, we will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits we have paid. This means that we have the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits we have paid. In order to secure our recovery rights, you agree to assign to us any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of our subrogation and reimbursement claims. This assignment allows us to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this Contract, you also specifically acknowledge our right of reimbursement. This right of reimbursement attaches when we have paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Contract, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided under this Contract. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

By accepting benefits under this Contract, you or your representatives further agree to:

- Notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
- Cooperate with us and do whatever is necessary to secure our right of subrogation and reimbursement under this Contract;

- Give us a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided under this Contract (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due to us as reimbursement for the full cost of all benefits associated with Third Party Injuries paid under this Contract (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing;
- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid under this Contract; and
- Serve as a constructive trustee for the benefits under this Contract over any settlement.

We may recover the full cost of all benefits paid by us under this Contract without regard to any claim of fault on your part, whether by comparative negligence or otherwise. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits provided by us under this Contract in addition to costs and attorney's fees incurred by us in obtaining repayment.

Third Party Beneficiary

This Contract was issued by Capital Health Plan to the Contract holder, and was entered into solely and specifically for the benefit of Capital Health Plan and the Contract holder. The terms and provisions of this Contract shall be binding solely upon, and inure solely to the benefit of, Capital Health Plan and the Contract holder, and no other person shall have any rights, interest or claims hereunder, or be entitled to sue for a breach hereof as a third-party beneficiary or otherwise. Capital Health Plan HMO and the Contract holder hereby specifically express their intent that health care Providers that have not entered into contracts with us to participate in our Provider networks shall not be third-party beneficiaries under this Contract.

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that provides either directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

Types of HMOs

Staff and Group Model HMOs

In a staff model HMO, the doctors and other Providers rendering care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract services with additional doctors and Providers. Unlike the staff or group model HMOs, the IPA model HMO does not provide Health Care Services itself. Instead, it pays independent, qualified Providers to render health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

MIXED Model HMOs

Capital Health Plan is a MIXED Model HMO. This means that the doctors and other providers with whom we contract may be a combination of independent contractors and as well as the employees and staff of Capital Health Plan. A key component of CHP's delivery system is its employed medical staff who practice in three state-of-the art health centers CHP has developed to exclusively serve its membership. These health centers are equipped with electronic medical records and can accommodate a broad range of preventive, primary and specialty care services including evening and weekend urgent care, lab, x-ray and digital mammography, colon screening, an eye care service, wound care, and centers focused on the needs of seniors and the chronically ill.

The following definitions will help you understand the terms that are used in this Contract, including the Schedule of Benefits and any Endorsements that are part of this Contract. As you read through this Contract you can refer to this section; we have identified defined terms in the Contract, the Schedule of Benefits and any Endorsements by capitalizing the first letter(s) of the term.

A

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to Sound Natural Teeth 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 injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Adoption or Adopt(ed) means the act of creating a legal parent/child relationship where it did not exist, declaring that the child is legally the child of the adoptive parents and their heir-at-law and is entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as defined by Florida law or a similar applicable law of another state.

Advanced Payments of the Premium Tax Credit (APTC) means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a QHP through the Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Contract in connection with:

1. a Pre-Service Claim or a Post-Service Claim;
2. a Concurrent Care Decision, as described in the CLAIMS PROCESSING section; or
3. Rescission of coverage, as described in the TERMINATION OF COVERAGE section

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The allowed amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and Capital Health Plan HMO.
2. In the case of Out-of-Network Providers located outside of the Service Area who participate in the BlueCard® Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BLUECARD® PROGRAM section for more details.
3. In the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Provider for the specific Covered

Services provided to you, the allowed amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to: (i) payment for such Covered Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Covered Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that we determine are comparable to the Out-of-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating Providers in other Provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by us, with our Provider network strategies (e.g., does not result in payment that encourages Providers participating in an Florida Blue network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the allowed amount for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating providers in its geographic area for such Services.

In no event will the allowed amount be greater than the amount the Provider actually charges.

You may obtain an estimate of the allowed amount for particular Services by calling the customer service phone number on your ID Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Contract apply. You should refer to the WHAT IS COVERED? section of this Contract and your Schedule of Benefits to determine what is covered and how much we will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Provider, the allowed amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or similar applicable laws of another state, 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.

Anniversary Date means the first day of January (January 1st) following your initial Effective Date and each January 1st thereafter.

Annual Open Enrollment Period means the period of time each year as designated by the Marketplace or on Enrollment Forms when you can change coverage or enroll in a new plan. The exact time period may change each year.

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. A cooperative group or center of any of the entities described in clauses (a) through (d) 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.
    g. Any of the following if the conditions described in paragraph (2) are met:
        1) The Department of Veterans Affairs.
        2) The Department of Defense.
        3) 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 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.

Applied Behavioral Analysis, meaning 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.

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.

B

Biosimilar Prescription Drug means a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (known as a reference product). A Biosimilar Prescription Drug has no clinically meaningful difference in terms of safety and effectiveness

from the reference product it is compared to.

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 patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the 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 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, such as Hospital room and board and ancillary Services.

Brand Name Prescription Drug means a Prescription Drug that is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

Breast Reconstructive Surgery means surgery to reestablish symmetry between the two breasts.

C

Calendar Year begins January 1st and ends December 31st of the same year.

Cardiac Therapy means Health Care 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.

Certified Nurse Midwife means a person who is licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

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 you with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed without the proposed Services being rendered.

Coinsurance means the sharing of health care expenses for Covered Services between you and us. After your Deductible is met, we will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your coinsurance. Not all plans include coinsurance.

Complaint means an oral (non-written) expression of dissatisfaction, whether or not such dissatisfaction is made in person, by telephone, or by another person acting on your behalf.

Concurrent Care Decision means a decision by us 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 we had previously approved or authorized coverage, benefits, or payment for that course of treatment or number of treatments in writing.

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 of the COVERAGE ACCESS RULES section.

Condition means a disease, illness, ailment, injury, or pregnancy.

Contract includes this document, your application for this contract, any Enrollment Forms signed by the Contract holder and any amendments and/or Endorsements.

Contract holder means an individual who meets and continues to meet all applicable eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under Contract other than as a Covered Dependent.

Convenience Kits are prepackaged kits that may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band-aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

Convenient Care Center means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one master's level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

Copayment or Copay means, when applicable, the dollar amount established solely by us that you must pay to a health care Provider at the time Covered Services are rendered by that Provider. In the case of Prescription Drugs, the amount you must pay to an In-Network Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you 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 your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility

requirements, described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under the Contract other than as a Contract holder.

Covered OTC Drug means an Over-the-Counter Drug that is designated in the Medication Guide as a covered OTC Drug.

Covered Person means a Contract holder or Covered Dependent.

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under the Pharmacy Program.

Covered Prescription Drug(s) and Supply(ies) means Covered Prescription Drugs and Covered Prescription Supplies.

Covered Prescription Supply(ies) means only the following Supplies, which are covered under the Pharmacy Program:

1. Prescription diaphragms indicated as covered in the Medication Guide;
2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage by us;
3. syringes and needles prescribed with a Prescription Drug authorized for coverage by us;
4. syringes and needles contained in anaphylactic kits; and
5. Prescription Supplies used in the treatment of diabetes, limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

Covered Services means those Health Care Services that meet the criteria listed in the WHAT IS COVERED? section.

Creditable Coverage means health care coverage that is continuous to a date within 63 days of your Enrollment Date. Such health care coverage may include any of the following:

1. a group health plan;
2. individual health insurance;
3. Medicare Part A and Part B;
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;
10. a health benefit plan of the Peace Corps;
11. Children's Health Insurance Program (CHIP);
12. public health plans established by the federal government; or

13. public health plans established by foreign governments.

Custodial or Custodial Care means care that serves to assist a person 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 frequency, intensity and 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.

D

Daily Living means age appropriate basic tasks of everyday life such as bathing, dressing, eating, toileting, transferring and walking.

Day Supply means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services that you must actually pay each Calendar Year to an appropriate licensed health care Provider who is recognized for payment under this Contract, before our payment for Covered Services begins. Not all plans include a deductible.

Dentist means a person who is properly licensed by the state of Florida, or a similar applicable law of another state, as a doctor of Dental Surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the Service is rendered, and acting within the scope of their license.

Designated Transplant Facility is a licensed facility that is designated by us and has a contract with us to provide covered transplant Services at the time the Services are rendered. Designated transplant facilities may or may not be located in the Service Area. The fact that a Hospital is an In-Network Hospital does not mean that it is a designated facility.

Detoxification means a process whereby an alcohol or drug intoxicated or alcohol or drug dependent person 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 Physician, while keeping the physiological risk to the person at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or similar applicable laws of another state, to supervise diabetes outpatient self-management training and educational Services.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of

another state to provide nutrition counseling for diabetes outpatient self-management Services.

Domestic Partner means a person of the same or opposite gender with whom the Contract holder has established a Domestic Partnership.

Domestic Partnership means a relationship between the Contract holder and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole domestic partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. the Contract holder has submitted to us acceptable proof of evidence of common residence and joint financial responsibility; and
5. the Contract holder has completed and submitted any required forms to us and we have determined the Domestic Partnership eligibility requirements have been met.

Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is not for comfort or convenience; (d) generally is not useful to an individual in the absence of a Condition; and (e) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law (or a similar applicable law of another state) to provide Durable Medical Equipment in the patient's home under a Physician's Prescription.

E

Effective Date means, with respect to eligible individuals properly enrolled, when coverage first becomes effective, 12:01 a.m. on the date printed on the first page of this Contract; and with respect to eligible individuals who are subsequently enrolled, means 12:01 a.m. on the date coverage will begin as specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may reasonably be expected to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

Emergency Services means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient.

Endorsement means a document issued by us that changes or modifies language in this Contract. Endorsements may also be referred to as amendments.

Enrollment Date means the date of enrollment of the individual under this Contract.

Enrollment Forms means those forms, electronic or paper, used to maintain accurate enrollment files under the Contract and which are approved for use by us or if you enrolled in this plan through the Marketplace; approved by the Marketplace.

Essential Health Benefits (EHB) means Health Care Services included in the Affordable Care Act's definition and includes Services in the following ten categories:

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental Health and substance use disorder Services, including behavioral health treatment
6. Prescription Drugs
7. Rehabilitative and Habilitative Services and devices
8. Laboratory Services
9. Preventive and wellness Services and chronic disease management
10. Pediatric Services including oral and vision care

Essential health benefits provided within this contract are not subject to lifetime or annual dollar maximums.

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 us:

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 you;

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 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 us):

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative Medical Literature and scientific literature;
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 that are determined by us to be experimental or investigational are excluded as described in the WHAT IS NOT COVERED? section. In making benefit determinations, we

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.

F

FDA means the United States Food and Drug Administration.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Capital Health Plan HMO is an HMO affiliate of Blue Cross and Blue Shield of Florida, Inc. D/B/A Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.

Formulary List means a list of Brand Name Prescription Drugs then in effect, for which we provide coverage and benefits, subject to the exclusions in the PRESCRIPTION DRUG PROGRAM section. The Formulary List is contained within the Closed Formulary Medication Guide.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health and Rehabilitative Services in compliance with Florida Statutes or by a similar applicable law in another state.

G

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care Provider. Fertilization takes place inside the tube.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either 1) has been approved by the United States Food and Drug Administration (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 2) 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 HMO, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All generic Prescription 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.

Grace Period means the period immediately following the Premium due date as indicated on the Contract holder's billing statement.

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 his or her behalf, another person designated by the Member, or a state agency may submit a grievance.

H

Habilitative Services means Health Care Services that help a person keep, learn or improve skills and functioning for Daily Living.

Health Care Services or Services 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, a licensed Provider.

Home Health Agency means a properly licensed agency or organization that provides health Services in the home pursuant to Chapter 400 of the Florida Statutes, or similar applicable laws of another state.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization duly licensed pursuant to Florida Statutes, or a similar applicable law of another 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 persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, 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 Birth Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility that primarily provides Custodial, educational, or rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital that is accredited by The Joint Commission, 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.

I

Identification (ID) Card means the cards we issue to Contract holders. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Contract.

Independent Clinical Laboratory means a laboratory, independent of a Hospital or Physician's office, which is a fixed location, properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Center means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An independent diagnostic testing center must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida laws or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an independent diagnostic testing center.

In-Network Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the ValueScript Pharmacy Program. Specialty Pharmacies and the Mail Order Pharmacy are also In-Network Pharmacies.

In-Network Pharmacy Allowance means the maximum amount allowed to be charged by an In-Network Pharmacy per Prescription for a Covered Prescription Drug, Covered OTC Drug or Covered Prescription Supply under the ValueScript Pharmacy Program.

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to provide Covered Services described in this Contract.

Intensive Outpatient Treatment means treatment in which an individual receives at least 3 clinical hours of institutional care per day (24-hour period) for at least 3 days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Internal Review Panel means a panel established by us to review Grievances related to Adverse Benefit Determinations that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet our 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 previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

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 a woman's uterus.

L

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statues, or a similar applicable law of another state.

M

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

Marketplace means the Health Insurance Marketplace, which is a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and implementing regulations and makes QHPs available to qualified individuals and qualified employers.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Contract, the term massage or massage therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Massage Therapist means a person properly licensed to practice Massage pursuant to Chapter 480 of the Florida Statutes, or similar applicable laws of another state.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Material Misrepresentation means the omission, concealment of facts or incorrect statements made on any application or Enrollment Forms by an applicant, Covered Person or Contract holder which would have affected your eligibility under this Contract, issuance of different benefits, or issuance of this Contract at a different Premium rate had they been known.

Maximum means the amount designated in the Medication Guide as the Maximum, including, but not limited to, frequency, dosage and duration of therapy.

Medical Literature means peer reviewed literature included in the PubMed/Medline database of the National Library of Medicine.

Medically Necessary or Medical Necessity means that, with respect to a Health Care Service, a Provider, exercising prudent clinical judgment, provided, or is proposing or recommending to provide, the Health Care Service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was/is:

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury disease or symptoms;
3. not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider; and
4. not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

   When determining whether a Service is not more costly than the same or similar Service as referenced above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

   a. the Allowed Amount for Service at the location for the delivery of the Service versus an alternate setting;

b. the amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or,

c. an analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

Note: The distance you have to travel to receive a Health Care Service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

Reviews we perform of medical necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular Service. In performing medical necessity reviews, we may take into consideration and use cost data which may be proprietary.

It is important to remember that any review of medical necessity by us is solely for the purpose of determining coverage or benefits under this Contract and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of medical necessity in this Contract as determined by us. In applying the definition of medical necessity in this Contract, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not medically necessary; however, you will be solely responsible for paying for the Service.

Medically Necessary Orthodontic Treatment means treatment as a result of a handicapping malocclusion and congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip.

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.

Mental Health Professional means a person properly licensed to provide mental health Services pursuant to Chapter 491 of the Florida Statutes, or a similar applicable law of another state. 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 who provide counseling Services.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD-10 CM), or their equivalents in the most recently published version 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 a similar applicable law of another state.

N

National Drug Code (NDC) means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Non-Formulary Drug means a Brand Name Prescription Drug that is not included on the Formulary List then in effect.

O

Occupational Therapist means a person properly licensed to practice occupational therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Occupational Therapy means Habilitative Services or 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.

One-Month Supply means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's daily dosing recommendations. Certain Drugs (such as Specialty Drugs) may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network Pharmacy means a Pharmacy that has not agreed to participate in our ValueScript Pharmacy Program and is not a Specialty Pharmacy or the Mail Order Pharmacy.

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to provide Covered Services described in this Contract.

Outpatient Facility for Habilitative and Rehabilitative Therapy (Outpatient Hab/Rehab Facility)

means an entity which renders, through Providers properly licensed pursuant to Florida law or a similar applicable law of another state: outpatient Physical Therapy; Speech Therapy; Occupational Therapy; Cardiac Therapy; and Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition or to keep, learn or improve skills and functioning for Daily Living. Further, such an entity must meet our criteria for eligibility as an outpatient facility for habilitative and rehabilitative therapy. The term outpatient facility for habilitative and rehabilitative therapy, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical habilitative or rehabilitative inpatient Services, or habilitative or rehabilitative outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

Over-the-Counter (OTC) Drug means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

P

Pain Management includes, but is not limited to, Services for pain assessment, medication, Physical Therapy, biofeedback, and/or counseling. Pain management programs feature multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 6 clinical hours of institutional care per day (24-hour period) for at least 5 days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Per Admission Deductible (PAD) means the amount of charges, up to the Allowed Amount, for inpatient Covered Services, which you must actually pay, for each Hospital admission to an appropriately licensed Hospital recognized for payment under this Contract, before our payment for any inpatient Covered Services begins. The Hospital PAD applies, when indicated on the Schedule of Benefits regardless of the reason for the admission and is in addition to the Deductible requirement, if applicable.

Per Visit Deductible (PVD) means the amount of charges, up to the Allowed Amount, for Covered Services rendered in an outpatient facility, which you must actually pay, for each visit to an appropriately licensed outpatient facility recognized for payment under this Contract, before our payment begins. The PVD applies, when indicated on the Schedule of Benefits regardless of the reason for the visit and is in addition to the Deductible requirement, if applicable.

Pharmacist means a person properly licensed to practice the profession of Pharmacy per Chapter 465 of the Florida Statutes, or a similar law of another state that regulates the profession of Pharmacy.

Pharmacy means an establishment licensed as a pharmacy per Chapter 465 of the Florida Statutes, or a similar law of another state, where a Pharmacist dispenses Prescription Drugs.

Pharmacy Benefit Manager means an organization that has established, and manages, a Pharmacy network and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

Pharmacy Deductible means the amount of charges, up to the In-Network Pharmacy Allowance for Covered Prescription Drugs and Supplies that you must actually pay per Calendar Year, in addition to any

applicable Copayment or Coinsurance, to a Pharmacy, who is recognized for payment under this Contract, before our payment for Covered Prescription Drugs and Supplies begins.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the Florida Statutes, or a similar applicable law of another state.

Physical Therapy means Habilitative Services or the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or hot or cold therapy.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

Physician Specialty Society means a United States medical specialty society that represents diplomates certified by a board recognized by the American Board of Medical Specialties.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) we receive that on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

Premium means the total amount required to be paid by the Contract holder to us in order to be covered under this Contract. The Premium is determined on the basis of the applicable Rates, Risk Class and certain demographics of individuals covered under this Contract.

Prescription means an order for Drugs, Services or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs, Services or Supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of the Pharmacy Program, insulin and emergency contraceptives are considered prescription Drugs because, in order to be covered, we require that they be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of their license.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Contract condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. 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 us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Contract do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Services covered under your plan. Note: The Preventive Services Guide is subject to change. Please refer to our website at https://capitalhealth.com/preventative-health-guidelines for the most current guide.

Primary Care Physician (PCP) means the Physician who, or in certain circumstances a clinic as specifically designated in the provider directory at the time Covered Services are rendered, is the assigned primary care Physician for the Covered Person, according to our records and who provides primary care medical Services to Covered Persons under a primary care physician Provider contract with us. 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 us as a primary care physician.

Prosthetic Device means a device that 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 nonfunctional body part or organ.

Prosthetist/Orthotist means a person or entity that is properly licensed or registered, if applicable, under Florida law, or a similar applicable law of another state, to provide Services consisting of the design and fabrication of medical devices such as braces, splints and artificial limbs prescribed by a Physician.

Provider means any facility, person or entity recognized for payment by us under this Contract.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Contract, a psychiatric facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state.

Q

Qualified Health Plan (QHP) means a health plan that is certified by the Marketplace.

R

Rate means the amount we charge for coverage. The rate will vary depending on the Risk Class of each covered individual.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse First Assistant means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

Rehabilitative Services means Services rendered for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to Cardiac Therapy, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage.

Repackaged Drug(s) means a pharmaceutical product that is removed from the original manufacturer container (brand originator) and repackaged by another manufacturer with a different NDC.

Rescission or Rescind refers to Capital Health Plan HMO's action to retroactively cancel or discontinue coverage under this Contract. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

Residential Treatment Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide care and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

- has Mental Health Professionals on-site 24 hours per day and 7 days per week;
- provides access to necessary medical services 24 hours per day and 7 days per week;
- provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- provides a level of skilled intervention consistent with patient risk;
- is not a wilderness treatment program or any such related or similar program, school and/or education service;

With regard to Substance Dependency treatment, in addition to the above, must meet the following:

- if Detoxification Services are necessary, provides access to necessary on-site medical services 24 hours per day and 7 days per week, which must be actively supervised by an attending Physician;
- ability to assess and recognize withdrawal complications that threaten life or bodily function and to obtain needed Services either on site or externally;
- is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation;

Residential Treatment Services means treatment in which an individual is admitted by a Physician overnight to a Hospital, Psychiatric Hospital or Residential Treatment Facility and receives daily face to face treatment by a Mental Health Professional for at least 8 hours per day, each day. The Physician must perform the admission evaluation with documentation and treatment orders within 48 hours and provide evaluations at least weekly with documentation. A multidisciplinary treatment plan must be developed within 3 days of admission and must be updated weekly.

Risk Class is a grouping of Covered Persons who have similar characteristics. For example, Covered Persons who: are the same age; use tobacco products; live in the same geographical area; and who have elected the same benefit plan may be grouped into a risk class. Capital Health Plan HMO determines the risk class of each Covered Person.

S

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, (except insulin). Covered self-administered injectable Prescription Drugs are denoted with a special symbol in the Medication Guide.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Service Area means either 1) the geographic area certified by the Marketplace through QHP Certification; or 2) if not a QHP, the geographic area approved by the Agency for Health Care Administration (AHCA); and in which rates have been approved by the Florida Office of Insurance Regulation (OIR). A listing of the applicable service area is available at: https://capitalhealth.com/agents/service-area-and-eligibility.

Skilled Nursing Facility means an institution or part thereof which meets our criteria for eligibility as a skilled nursing facility and which: 1) is licensed as a skilled nursing facility by the state of Florida, or a similar applicable law of another state; 2) is accredited as a skilled nursing facility by The Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless we have waived such accreditation or recognition requirement.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not sound natural teeth.

Special Enrollment Period means the period of time immediately before or after a life or special event.

Specialist means a Physician who limits practice to specific Services or procedures such as surgery, radiology, pathology, certain age categories of patients such as pediatrics, geriatrics, certain body systems such as dermatology, orthopedics, cardiology, internal medicine or types of diseases such as 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.

Specialty Drug means an FDA-approved Prescription Drug that has been designated solely by us, as a specialty drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. In-Network specialty pharmacies are listed in the Medication Guide. The fact that a Pharmacy is a participating Pharmacy does not mean that it is a specialty Pharmacy.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Speech Therapy means Health Care Services provided for the treatment of speech and language disorders by a Physician, Speech Therapist or licensed audiologist, including language assessment and language restorative therapy Services.

Stabilize shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act.

Standard Reference Compendium means (a) the United States Pharmacopoeia Drug Information; (b) the American Medical Association Drug Evaluation; and/or (c) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For purposes of this Contract, a substance abuse facility is not a Hospital or a Psychiatric Facility, as defined herein.

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.

Supply(ies) means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, bandages, cotton swabs, and similar items and any birth control device.

T

Telehealth, for purposes of this Contract, means the lawful practice of medicine by a Capital Health Plan contracted provider, including Amwell (for urgent care) where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications.

Three-Month Supply means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer's dosing recommendations.

U

Urgent Care Center means a properly licensed facility that: 1) is available to provide Services to patients at least 60 hours per week with at least 25 of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the urgent care center is closed; 3) employs or contracts with at least one or more board certified or board eligible Physician and Registered Nurse (RN) who are physically present during all hours of operation. (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and 1) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations. For purposes of this Contract, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Hab/Rehab Facility.

Z

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the result zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.