CAPITAL HEALTH PLAN

Basic HMO
Option I For Small Groups

Member Handbook

2009.15.BasicIHB.CoP

TABLE OF CONTENTS

Section 1: Introduction to the Member Handbook

This is your Member Handbook, which includes the Schedule of Copayments and any Endorsement(s). You should read it carefully before you need Health Care Services. It contains valuable information about:

- your Capital Health Plan Basic HMO benefits;
- what is covered;
- what is excluded or limited;
- our coverage and payment rules;
- how to access your benefits;
- how and when to file a claim;
- how to resolve a complaint or grievance;
- how much, 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.

If you did not receive, or cannot find, the Schedule of Copayments, which is a part of your Member Handbook, it is important that you call the customer service number on your Membership Card and another one will be mailed to you. You will need the Schedule of Copayments to determine how much you have to pay for particular Health Care Services.

When Reading Your Member Handbook, Please Remember That:

- You should read this Member Handbook in its entirety in order to determine if a particular Health Care Service is covered.
- The headings of sections contained in this Member Handbook are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- References to “you” or “your” throughout refer to you as the Subscriber 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 that refer solely to your Covered Dependent(s) will be noted as such.
- References to “we”, “us”, and “our” throughout refer to Capital Health Plan. We may also refer to ourselves as “CHP”.
- 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 defined within the particular section where it is used.

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that either provides 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, a network model, or a mixed model. Refer to the Types of HMOs subsection of the

General Provisions section for further information.

Where do you find information on…

- **What particular types of Health Care Services are covered?**

  Read the Covered Services and Exclusions and Limitations sections.

- **How much does CHP pay and how much do you have to pay?**

  Read the Financial Obligations of the Member section.

- **How do I add or remove a Covered Dependent?**

  Read the Enrollment and Effective Date of Coverage section.

- **How do I know what doctor or provider is in the CHP network in my Service Area?**

  Read the Coverage Access Rules section and refer to your *Directory of Physicians and Service Providers.*.

- **What can you do if you do not like your PCP?**

  Read the Choosing a PCP subsection of the Coverage Access Rules section.

- **What can you do if you have a concern about a coverage or payment decision?**

  Read the Complaint and Grievance section.

- **What happens if you are covered under Capital Health Plan Standard HMO and another health plan?**

  Read the Duplication of Coverage section.

- **What happens when your coverage ends?**

  Read the Termination of Coverage section.

- **What do the terms used throughout this Member Handbook mean?**

  Read the Definitions section.

- **Where do you find information on Contracting Providers' financial incentives?**

  Read the Coverage Access Rules section.

Section 2: Member's Rights and Responsibilities

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

Rights

- Receive information about CHP, the services, benefits, member rights and responsibilities, and affiliated practitioners who provide care.
- Receive medical care and treatment from practitioners and providers who have met the credentialing standards of CHP.
- Expect CHP affiliated practitioners to permit you to participate in decision-making about your health care consistent with legal, ethical, and relevant patient-practitioner relationship requirements. If you are unable to fully participate in treatment decisions you have a right to be represented by your parents, guardians, family members, health care surrogates or other conservators to the extent permitted by applicable laws.
- Expect health care practitioners who participate with CHP to provide treatment with courtesy, respect, and with recognition of your dignity and right to privacy.
- Communicate complaints or appeals about CHP or the care provided through the established appeal or grievance procedures found in your Member Handbook and the master policy or contract provided to your employer.
- Have candid discussion with practitioners about the best treatment options for you no matter what the cost of the treatment or your benefit coverage.
- Refuse treatment if you are willing to accept the responsibility and consequences of that decision**.**
- Have access to your medical records, request amendments to your records, and have confidentiality of these records and member information protected and maintained in accordance with State and Federal law and CHP policies.
- Call or write us anytime with helpful comments, questions and observations, whether concerning something you like about our plan, or something you feel is a problem area**.**

Responsibilities

- Seek all non-emergency care through your primary care physician (PCP), obtain a referral from your PCP for medical services by a specialist, and cooperate with those providing care and treatment.
- Respect the rights, needs and privacy of other patients, office staff and providers of care.
- Provide accurate and complete information related to your health problems and medical history. Answer all questions truthfully and completely.
- Follow the plans and instructions for care that you have agreed to with your practitioners. Ask questions and seek clarification as necessary.
- Pay copayments and provide current information concerning your CHP membership status to any CHP affiliated practitioner or provider.
- Follow established procedures for filing a complaint, appeal or grievance concerning medical or administrative decisions that you feel are in error.
- Review and understand the benefit structure, both covered benefits and exclusions, as outlined in the Member Handbook*. Cooperate and provide information that may be required to administer benefits.
- Seek access to medical and member information through your Primary Care Physician or through CHP Member Services.
- Follow the coverage access rules in your Member Handbook**.**

Section 3: Financial Obligations of the Member

Copayments

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

Non-Covered Services

You are responsible for the payment of charges for Health Care Services that are not covered and for the payment of charges in excess of any maximum benefit limitation set forth in the Schedule of Copayments.

Contributions

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

Maximum Copayments

Total Copayments in any Calendar Year shall not exceed the amount indicated in the Schedule of Copayments, which in no event will exceed twice the total annual Premium costs that you would be required to pay if you were enrolled under an option with no Copayments. After you reach the out-of-pocket maximum expense limit for a Member or a family listed on the Schedule of Copayments, Covered Services will be provided for that Member or family with no Copayment charge for the remainder of the Calendar Year.

It is your responsibility to submit a receipt to us for each Copayment you pay after either of these Copayment limits has been reached. When we receive the appropriate documentation, we will reimburse you for each Copayment you have paid.

Benefit Maximum Carryover

If immediately before the Effective Date of the Small Employer you were covered under a prior group policy issued by CHP to the Small Employer, amounts applied to your Calendar Year benefit maximums under the prior CHP policy will be applied toward your Calendar Year benefit maximums under this Member Handbook.

Section 4: Coverage Access Rules

It is important that you become familiar with the rules for accessing health care coverage through CHP. The following subsections explain our role and the role of your Primary Care Physician (PCP), how to access specialty care coverage through CHP and your PCP, and what to do if Emergency Services and Care is needed.

Choosing a Primary Care Physician

The first and most important decision you must make when joining a health maintenance organization is the selection of your PCP. This decision is important since it is through this Physician that all other Health Care Services, particularly those of Specialists, are obtained. You are free to choose any PCP listed in our published list of PCPs whose practice is open to additional Members. This choice should be made when you enroll. The Subscriber is responsible for choosing a PCP for all minor Covered Dependents including a newborn child or an adopted newborn child. If you fail to choose a PCP when enrolling, we will assign you one and notify you of that assignment. Some important rules apply to your PCP relationship:

1. The PCP you select will maintain a Physician-patient relationship with you, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for providing, authorizing and coordinating all your Health Care Services.
2. Except as specified in the Coverage Access Rules set forth in the provider directory, if any, you must look to your PCP to provide or coordinate your care.
3. Except in an emergency, all Services must be received from your PCP, from Contracting Providers on referral from or authorization of your PCP, or through another health care provider designated by your PCP and CHP. See the Access to Other Contracting Providers subsection of this section for exceptions to this rule.
4. We want you and your PCP to have a good relationship. To be certain this relationship is conducive to effective health care, both you and your PCP may request a change in the PCP assignment:
   a) You may request a transfer to another PCP whose practice is open to enrollment of additional Members. The transfer of care to the newly selected PCP shall be effective the first day of the following calendar month provided we receive the request before the 15th of the month.
   b) Instances may occur where your PCP, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with you. In such circumstances, the PCP may request that we assist you in the selection of another PCP.
5. If the PCP you selected terminates his or her contract with us, or is unable to perform his or her duties, or is on a leave of absence, we may assist you in selecting, or we may assign, another PCP to you.

Specialist Care

Except as specified in the Coverage Access Rules set forth in the provider directory, if any, the PCP you selected is responsible for referring you to Specialists when Medically Necessary, using the referral procedure authorized by us. The referral will identify the course of treatment

or specify the number of visits authorized for the diagnosis or treatment of your Condition.

Once you have obtained the referral, you or your PCP may make an appointment with the Specialist. You must see the Specialist within 60 days from the date of issue of the referral. Your referral will indicate the number of visits or treatments.

When the Specialist suggests additional Services or visits, you must first consult with your PCP to obtain additional authorization/referrals.

Your PCP may consult with us regarding coverage or benefits and with the Specialist in order to coordinate your care. This procedure provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

If a Specialist who is a Non-Contracting Provider is required, your PCP may refer you but payment for such Services will only be made if we authorize coverage. An agreed-upon treatment plan will then be implemented.

Continuity of Coverage and Care upon Termination of a Provider Contract

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

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

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

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

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

Emergency Services and Care

When necessary, you should seek Emergency Services and Care and then contact your PCP as soon as possible. Prior authorization is not required for Emergency Services and Care. It is your responsibility to notify us as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. **Follow-up care must be received, prescribed, directed or authorized by your PCP.** If the follow-up care is provided by a provider other than your PCP, coverage may be denied. If a determination is made that an Emergency Medical Condition does not exist, payment for Services other than Emergency Services and Care will be your responsibility.

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 the provider and us within 60 days of the submittal of the claim for

such Emergency Services and Care. It is your responsibility to furnish to us written proof of loss in accordance with the Claims Processing section.

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

Service Area

All non-emergency services must be received in the Service Area, from your PCP or from participating providers on referral from your PCP. Refer to Attachment A for the counties in your Service Area. Refer to the *Directory of Physicians and Services Providers* for the providers in the CHP network.

Verifying Provider Participation

You are responsible for verifying the participation status of a Physician, Hospital, or other provider prior to receiving Health Care Services. To determine if a particular health care provider is in the CHP provider network, review the most recent *Directory of Physicians and Service Providers.* You may also check provider participation on the CHP website, at www.capitalhealth.com. To verify a specific health care provider's participation status, contact the CHP's Member Services Department.

Case Management

Case management focuses on Members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, we may, in our sole discretion, assign a case manager to you to help coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the case management program, we may elect to offer alternative benefits or payment for cost-effective Health Care Services. We may make these alternative benefits or payments available on a case-by-case basis when you meet our case management criteria then in effect. Such alternative benefits or payments, if any will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing.

The fact that we may offer to cover or pay for certain Health Care Services under the case management program in no way obligates us to cover or pay for similar Services in the future. Nothing contained in this section shall be deemed a waiver of our right to enforce this Member Handbook in strict accordance with its terms. The terms of this Member Handbook will continue to apply, except as specifically modified in writing by us in accordance with the case management program rules then in effect.

Access to Osteopathic Hospitals

You may obtain inpatient and outpatient Services similar to inpatient and outpatient Services by allopathic hospitals 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 us 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 we have with allopathic Hospitals within the Service Area. It is your responsibility to contact us to obtain the documents necessary to comply with this provision.

Special Access Rules for Other Providers

Chiropractors and Podiatrists: Upon your request, you will be assigned a Doctor of Chiropractic or a Doctor of Podiatry who is a

Contracting Provider for the purpose of providing chiropractic Services and podiatric Services, respectively. You shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need of referrals from the PCP who is licensed as a Doctor of Medicine or Doctor of Osteopathy.

Dermatologists: You have access to dermatologists who are Contracting Providers for a maximum of five visits within a Calendar Year without an authorization or referral from your PCP. Any Services rendered above these five visits require an authorization from your PCP. If you do not get an authorization, visits over five within a Calendar Year will not be covered.

Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant and licensed to perform surgical first assisting Services. Certain types of medical procedures and other Covered Services may be rendered by Physician Assistants, nurse practitioners or other individuals who are not Physicians.

Certified Registered Nurse Anesthetist: You have access to anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if you request such Services, provided such Services are available, as determined by us, and are Covered Services.

Services Not Available from Contracting Providers

Except as provided in the Covered Services section, if a particular Covered Service is not available from any Contracting Provider, as determined by us, we may authorize coverage for such Service to be rendered by a Non-Contracting Provider. We must authorize Covered Services provided by a Non-Contracting Provider under this provision.

Contracting Provider Financial Incentive Disclosure

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

Section 5: Medical Necessity

Except for any preventive care benefits specifically described in the Covered Services sections, in order for Health Care Services to be covered under the Group Master Policy, such Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as defined by us.

Any review of Medical Necessity by us is solely for the purposes of determining coverage or benefits under this Member Handbook 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 Member Handbook as determined by us. In applying the definition of Medical Necessity in this Member Handbook, 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.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Physicians and health care providers. You and your Physicians are responsible for deciding what Health Care Services should be rendered or received and when that care should be provided. We are solely responsible for determining whether expenses incurred for Health Care Services are covered. In making coverage decisions, we will not be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care providers.

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to:

1. staying in the Hospital because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;
3. staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department); or
4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other service primarily for the convenience of the patient or his or her family members or a provider.

Note: Whether or not a Health Care Service is specifically listed as an exclusion, the fact that a provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by us) or a Covered Service. Please refer to the Definitions section for the definitions of "Medically Necessary" or "Medical Necessity".

Section 6: Covered Services

Introduction

This section describes the Health Care Services that are Covered Services. In determining whether a Health Care Service is a Covered Service, we will apply the criteria listed below.

Expenses for the Health Care Services described in this section are subject to the following and will be covered under the Group Master Policy only if the Services are:

1. within the Service categories in this Covered Services section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care provider who is recognized for payment by us and for which we receive an itemized statement or description of the procedure or Service which was rendered including any applicable procedure code, diagnosis code and other information we require in order to process a claim for the Service;
3. Medically Necessary, as defined in this Member Handbook and determined by us in accordance with our Medical Necessity coverage criteria then in effect, except as specified in this section;
4. rendered while coverage is in force;
5. not specifically or generally limited or excluded; and
6. received in accordance with the Coverage Access Rules (e.g., receipt of services from your PCP, or other Contracting Providers except in an emergency or approved by CHP). (See the Coverage Access Rules section.)

All benefits for Covered Services are subject to the Copayment amounts and benefit maximums listed herein or on your Schedule of Copayments.

Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the Exclusions and Limitations section. More than one limitation or exclusion may apply to a specific Service or a particular situation.

Benefit Guidelines

In addition to the above, our payment for a Service is subject to all of the other provisions of the Member Handbook and any Endorsements thereto. Our payment for a Service includes payment for all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service.

In determining whether Health Care Services are Covered Services, no written or verbal representation by any employee or agent of CHP, or by any other person shall waive or otherwise modify the terms of the Member Handbook and, therefore, neither you, nor the Small Employer, nor any health care provider or other person should rely on any such written or verbal representation.

Covered Services Categories

Accident Care

Health Care Services to treat an injury resulting from an Accident not related to your job or employment.

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded except for Services

(not otherwise excluded) when you are not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by you.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum.

Ambulance Services

1. All Ambulance or other transportation Services must be authorized by us in advance and ordered by your PCP.
2. Transportation by Ambulance to the nearest medical facility capable of providing required Emergency Services and Care to determine if an Emergency Medical Condition exists does not require authorization in advance.

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center include:

1. use of operating and recovery rooms;
2. respiratory therapy (e.g., oxygen);
3. drugs and medicines administered at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products;
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
10. chemotherapy treatment for proven malignant disease; and
11. other Medically Necessary services and supplies.

Anesthesia Administration Services

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA").

Exclusion:

Coverage does not include anesthesia Services by an operating Physician, his or her partner or associate.

Breast Reconstructive Surgery

Surgery to reestablish symmetry between two breasts and implanted prostheses, incident to Mastectomy following treatment for breast cancer. In order to be covered, such surgery must be in a manner chosen by your Contracting Physician, consistent with prevailing medical standards, and in consultation with you. See also Mastectomy Services.

Child Cleft Lip and Cleft Palate Treatment Services

Medical, dental, Speech Therapy, audiology, and nutrition Services for the treatment of a child under the age of 18 who has cleft lip or cleft palate. In order for such Services to be covered, your PCP, or a Contracting Provider on referral from your PCP, 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 Physician-delivered or Physician-supervised Services provided to a Covered Dependent from the moment of birth up to the 17th birthday as follows:

1. Periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory

guidance necessary to monitor the normal growth and development of a child;

2. Oral and/or injectable immunizations; and
3. Laboratory tests normally performed for a well child.

In order to be covered, Services will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Dental

Dental care is limited to the following:

1. Care and treatment rendered within 6 months of an Accidental Dental Injury provided such Services are for the treatment of damage to sound natural teeth. This Benefit does not include coverage for expenses for services related to an injury occurring while, and as a result of, biting or chewing.
2. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
    a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that;
        1) dental treatment is necessary due to a dental Condition that is significantly complex; or
        2) the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
    b) you have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Dermatology Services

Dermatology Services are limited to the following: minor surgery, tests, and office visits provided by a dermatologist who is a Contracting Provider for a maximum of five visits within a Calendar Year without an authorization or referral from your PCP. Any Services rendered above these five visits require an authorization from your PCP.

Diabetes Treatment Services

Diabetes outpatient self-management training and educational Services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes, if your PCP, or a Contracting Provider on referral from the PCP who specializes in the treatment of diabetes, certifies that such Services are Medically Necessary.

Insulin and syringes will be covered under the prescription drug benefit. You must file a claim for the cost of insulin and syringes and all other certified equipment and supplies purchased through a pharmacy. All other certified equipment and supplies will be covered under the Durable Medical Equipment provision subject to the amount, if any, on the Schedule of Copayments.

In order to be covered, 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. Additionally, in order to be covered, nutrition counseling must be provided by a licensed

Dietitian. Covered Services for the treatment of severe diabetic foot disease may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications).

Diagnostic Services

Diagnostic Services when ordered by your PCP, or a Contracting Provider on referral from the PCP, are limited to the following:

1. radiology;
2. laboratory and pathology Services;
3. Services involving bones or joints of the jaw (e.g., Services to treat temporomandibular joint [TMJ] dysfunction) or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. approved machine testing (e.g., electrocardiogram [EKG], electroencephalograph [EEG], and other electronic diagnostic medical procedures); and
5. Imagery Services, including ultrasound, nuclear medicine, and Magnetic Resonance Imaging (MRI).

Dialysis Services

Dialysis Services including equipment, training, and medical supplies, when provided at any location by a Contracting Provider licensed to perform dialysis including a Dialysis Center.

Durable Medical Equipment

Durable Medical Equipment that is specifically listed below and when determined by CHP and the Member's Primary Care Physician to be Medically Necessary for care and treatment of a Condition covered under this Group Plan. The specified Durable Medical Equipment will not, in whole or in part, serve as a comfort or convenience item for the Member. Supplies and services to repair medical equipment may be a covered Benefit only if the Member owns the equipment or is purchasing the equipment. CHP's allowance for Durable Medical Equipment is based on the most cost effective durable medical equipment which meets the Member's needs, as determined by CHP. At CHP's option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service.

The only equipment that is covered is as follows: Canes/crutches, walkers, hospital beds, commode chairs, bedpans/urinals, decubitus-care equipment, ostomy and urinary products, LSO and TLSO braces, traction equipment and standard wheelchairs.

Exclusions:

Equipment that is for convenience, comfort, and/or environmental control or equipment that has not been authorized by us is not covered. 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 and purifiers/cleaners/filters, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers.

The replacement of Durable Medical Equipment solely because it is old or used is not covered. Also excluded is coverage for repair or replacement except when authorized by us.

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 in or out of the Service Area without prior notification to us, subject to the Copayment amount set forth in the Schedule of Copayments. It is your responsibility, however, to notify us as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission that results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for Services rendered subsequent to that determination would be your responsibility.

Follow-up care must be received, prescribed, directed or authorized by your PCP. If the follow-up care is provided by other than your PCP, coverage may be denied.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges or the charge mutually agreed to by us and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is your responsibility to furnish to us written proof of loss in accordance with the Claims Processing section.

Enteral Formulas

Prescription and non-prescription enteral formulas for home use which are prescribed by a PCP 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 up to your 25th birthday includes food products modified to be low protein in an amount not to exceed $2,500 annually.

Eye Care

Eye care including the following Services:

1. Physician Services, soft lenses or scleral shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician Services to treat an injury to or disease of the eyes.

Exclusion:

Health Care Services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercise or visual training; eye glasses and contact lenses and their fitting. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK) is also excluded.

Home Health Care

The Home Health Care Services listed below when the following criteria are met:

1. You are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;
2. The Home Health Care Services rendered have been prescribed by your PCP or a Contracting Provider when on referral from the PCP by way of a formal written treatment plan that has been reviewed and renewed by the prescribing Physician every 30 days. We reserve the right to request a copy of any written treatment plan in order to

determine whether such Services are Covered Services.

3. We approve the formal written treatment plan;
4. The Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency within the Service Area; and
5. You are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Coverage for Home Health Care Services is limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., one visit per day of up to, but not exceeding, 2 hours) Services by a Registered Nurse, Licensed Practical Nurse and/or home health aide;
2. medical social Services;
3. nutritional guidance;
4. respiratory or inhalation therapy (e.g., oxygen); and
5. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist.

Note: In order to be covered, home health aide Services must be consistent with the plan of treatment and rendered under the supervision of a Registered Nurse.

Exclusion:

1. homemaker or domestic maid services;
2. sitter or companion services;
3. 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;
4. Speech Therapy provided for a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program approved by us. We reserve the right to request that your Physician certify in writing your life expectancy.

Exclusion:

Any Service that is not approved by us as part of the Hospice program.

Hospital Services

Hospital Services provided at Contracting Hospitals when you are an outpatient or inpatient admitted upon the instruction, written authorization, or referral by a PCP. 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, Speech Therapy, Occupational Therapy, and Cardiac Therapy (in connection with a covered Condition);
15. other Medically Necessary Services and supplies; and
16. transplants as described in the Transplant Services subsection.

Exclusion:

Expenses for the following Hospital Services are excluded when such Services **could have been provided without admitting you** to the Hospital:

1. room and board provided during the admission;
2. Physician visits provided while you were an inpatient;
3. Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and
4. other Services provided while you were an inpatient.

In addition, expenses for the following and similar items are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening. Benefits are not subject to the Copayment. This plan shall provide coverage for at least the following:

1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
2. 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 recommendation.
3. A mammogram every year for any woman who is 50 years of age or older.
4. One or more mammograms a year based upon a physician's recommendation for any woman who is at risk of 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.

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards in a manner determined in

consultation with you and the attending Physician. Outpatient post-surgical follow-up care for Mastectomy Services will 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 your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Care

Health Care Services provided to a Member for pregnancy, delivery, miscarriage, and pregnancy complications, including the following:

1. routine office visits for prenatal and postnatal care;
2. delivery services; and
3. postpartum care for the mother including the following: a postpartum assessment provided at the Hospital, the attending Physician's office, at a Birth Center, or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife. The postpartum assessment Services include:
   a) the physical assessment of the mother; and,
   b) performance of clinical tests in keeping with prevailing medical standards.

Note: A referral is required from your PCP for prenatal and postnatal care by another Contracting Provider.

Exclusion:

Prenatal care 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.

Note: For newborn child Health Care Services, please refer to the Newborn Child Care subsection.

Mental Health Services

1. Inpatient:

   Inpatient Services for short-term evaluation, diagnosis or Crisis Intervention of a Mental and Nervous Disorder if authorized in accordance with criteria established by us. These Services must be provided by a licensed Physician, Psychologist, or Mental Health Professional while confined in a Hospital or a Psychiatric Facility for treatment.

   Partial Hospitalization for mental health Services when provided in lieu of inpatient hospitalization and combined with the inpatient hospital benefit. Two days of Partial Hospitalization will count as one day toward the inpatient Mental and Nervous Disorder benefit.

   Note: To be covered, Partial Hospitalization Services must be provided under the direction of a Physician who is a Contracting Provider.

2. Outpatient:

   Outpatient treatment of a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy if authorized in accordance with criteria established by us. Treatment must be provided by a licensed Physician, Psychiatrist, Psychologist, or Mental Health Professional.

Exclusion:

Mental health Services that are:

1. rendered in connection with a Condition not classified in the most recently published version of the Diagnostic and Statistical

Manual of Mental Disorders of the American Psychiatric Association;

2. extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;
3. for marriage and juvenile counseling;
4. court ordered care or testing, or required as a condition of parole or probation;
5. testing for aptitude, ability, intelligence or interest;
6. testing and evaluation for the purpose of maintaining employment; or
7. cognitive remediation.

Newborn Child Care

Health Care Services provided to a newborn child of a Member from the moment of birth, provided that the newborn child is properly enrolled, including the following:

1. Services for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth;
2. postnatal care for the newborn including the following: a postnatal assessment provided at the Hospital, the attending Physician's office, at a Birth Center, or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife. The postnatal assessment Services include:
   a) the physical assessment of the newborn; and
   b) performance of clinical tests and immunizations in keeping with prevailing medical standards.
3. 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 us and certified by the PCP or a Contracting Physician as Medically Necessary to protect the health and safety of the newborn child.

Notes:

A referral is required from your PCP for provision of care by another Contracting Provider (e.g., routine office visits for postnatal care).

Coverage for a newborn child of a Member other than the Subscriber or the Subscriber's Covered Dependent spouse will automatically terminate 18 months after the birth of the newborn child.

Orthotic Devices

Orthotic devices designed and fitted by an Orthotist including braces and trusses for the leg, arm, neck and back, and special surgical corsets when authorized in advance by CHP and arranged by a PCP or a Contracting Provider on referral from the PCP or CHP.

Benefits may be provided for replacement of an Orthotic Device when due to irreparable damage, wear, a change in Condition, or when necessitated due to growth of a child.

Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device that meets your medical needs as determined by us.

Exclusion:

Expenses for arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, inserts, or similar type devices/ appliances regardless of intended use, except for therapeutic shoes (including inserts, and/or modifications) for the treatment of severe diabetic foot disease.

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;
3. individuals who are receiving long-term glucocorticoid (steroid) therapy,
4. individuals who have primary hyperparathyroidism; and
5. individuals who have a family history of osteoporosis.

Outpatient Rehabilitation Services

Outpatient rehabilitation Services are limited to the therapy categories listed below:

1. 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.

2. Physical/Occupational Therapy:

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

3. Cardiac Therapy:

   Services provided for cardiac rehabilitation for the purpose of aiding in the restoration of normal heart function lost due to illness, injury, stroke, or a surgical procedure.

Benefit Guidelines for Outpatient Rehabilitation Services

In order to be covered:

1. we must review, for coverage purposes only, a Rehabilitation Plan submitted or authorized by your PCP or a Contracting Provider on referral from the PCP;
2. we must agree that your Condition is likely to improve significantly with therapy;
3. such Services must be provided to treat functional defects which remain after an illness or injury; and
4. such Services must be Medically Necessary for the treatment of a Condition.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of rehabilitation Services to be provided to you with rehabilitation potential. The Rehabilitation Plan is required and must be renewed periodically as requested by CHP. Such a plan must have realistic goals that are attainable by you within a reasonable length of time.

Exclusion:

Rehabilitation Services, including physical, speech, occupational and other rehabilitation therapies that meet one or more of the following:

1. Services or supplies provided to you as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, where the admission is primarily to provide rehabilitative Services;
2. Services that maintain rather than improve a level of physical function; or
3. Services for treatment of abuse of or addiction to alcohol and drugs.

Oxygen

Expenses for oxygen, the equipment necessary to administer it, and the administration of oxygen.

Physician Services

Health Care Services provided by a Physician.

Prescription Drugs

Prescription Drugs, including syringes and needles are covered when prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of his or her license, and is received by you. The Copayments paid by you for Covered Prescription Drugs and/or covered syringes and needles will not be applied to the out-of-pocket maximum expense limit set forth in the Schedule of Benefits.

Prescription Drugs purchased from a Participating or Non-Participating Pharmacy are subject to the following provisions. Unless otherwise specified, in order to be covered, Prescription Drugs and/or syringes and needles must be:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;
2. dispensed by a Pharmacist;
3. be Medically Necessary; and
4. not otherwise limited or excluded.

Pharmacy Alternatives and Payment Rules

The Prescription Drug Copayment is set forth in the Schedule of Benefits and is printed on your identification card. Your identification card must be presented to a Participating Pharmacy each time a prescription is filled or refilled. The applicable Prescription Drug Copayment must be paid by you each time a prescription is filled or refilled at a Participating Pharmacy.

When Prescription Drugs are purchased from a Non-Participating Pharmacy due to an Emergency Medical Condition or at the direction of your Primary Care Physician, you are required to pay the full cost of the prescription and then obtain an itemized paid receipt and submit a claim to us. We will reimburse you for the Allowable amount for such Prescription Drug less the applicable Copayment. If you do not have an Emergency Medical Condition or do not have authorization from your Primary Care Physician, prescriptions filled or refilled at a Non-Participating Pharmacy are not covered.

The amount which must be paid by you for Covered Prescription Drugs and/or covered syringes and needles may vary depending on:

1. the participation status of the Pharmacy selected (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. whether the Prescription Drug is a Brand Name Prescription Drug or a Generic Prescription Drug; and
3. whether the Prescription Drug is on the Preferred Medication list.

Prescription Drugs may be either Generic Prescription Drugs or Preferred Brand Prescription Drugs each having a separate Copayment amount as outlined on the Schedule of Benefits. Prescription Drugs not identified as a Preferred Brand Prescription Drug on the Preferred Medication List of Covered Prescription Drugs are also covered, unless specifically excluded by this Group Plan. Non-Preferred Drugs are subject to the same requirements specified herein for Prescription Drugs and subject to the Non-Preferred Prescription Drug Copayment specified in the Schedule of Benefits.

Covered Prescription Drugs

1. Includes any drug, medicine or medication or oral contraceptive that, under Federal or

state law, may be dispensed only by Prescription from a Physician, or any compounded Prescription containing such drug medicine or medication;

2. Includes covered syringes and needles dispensed only by Prescription from a Physician;
3. Includes insulin, hypodermic needles and syringes with insulin on Prescription;
4. Must be prescribed by a Physician or Health Care Provider for the treatment of a Condition;
5. Must be dispensed by a Pharmacist;
6. Are limited to the lesser of a 31-day or 100 unit dose supply per Prescription per month;
7. Includes Prescription refills, but will not be covered until at least 75% of the previous Prescription has been used by you, (based on the dosage schedule prescribed by the Physician); and
8. Injectable drugs and biologicals only if:
    a) They are furnished incidental to a Health Care Provider's covered professional services;
    b) The are reasonable and necessary for the diagnosis or treatment of the covered illness or injury for which they are administered according to our accepted standard;
    c) They have not been determined by the FDA to be "less-than-effective";
    d) The injection is considered the indicated effective method of administration according to the accepted standards of medical practice for the covered Condition;
    e) The frequency, amount, and duration of the course of injectable drug or biological meets accepted standards of medical practice as an appropriate level of care for a specific Condition unless there are extenuating circumstances which justify the need for additional injections;
    f) They are a cost-effective alternative for an otherwise Covered Service as determined by us.

"Incidental to a Health Care Provider's professional service" means that the injectables are furnished as an effective integral, although incidental part of the Health Care Provider's personal professional services in the course of diagnosis or treatment of a specific injury or illness. In addition, the injection must be given by the Physician or under the Physician's supervision if it is the indicated effective method of administration. This does not mean, however, that to be considered "incidental to", each injection must always be at the occasion of the actual rendition of a personal professional service of the Health Care Provider. Such injections could be considered to be "incidental to" when furnished during a course of treatment where the Health Care Provider performs the initial service and subsequent services of a frequency which reflect his active participation in and the management of the course of treatment. Infusions of cancer chemotherapy drugs are considered to be procedures and not injections.

When a Health Care Provider gives you a subcutaneous, intramuscular, intravenous or intra-arterial injection, no additional payment will be made for the administration of the injection. Payment is made separately for the drug or biological injected, but the cost of the other supplies and the administration of the drug or biological is included in the payment for the visit or other services rendered.

9. Home administration and self-injectable drugs and biologicals only if:

a) Injection is considered the indicated effective method of administration for which the drug or biological is prescribed according to our accepted standards for the covered Condition;

b) The drug or biological can be safely self-administered based upon accepted standards of medical practice;

c) They are not immunizing agents;

d) They are reasonable and necessary for the specific or effective treatment for the covered Condition according to accepted standards of medical practice for the covered Condition;

e) They have not been determined by the FDA to be "less than effective";

f) The frequency, amount and duration of the prescribed course of injectable drug or biologicals meet accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections;

g) They are cost-effective alternative for an otherwise Covered Service as determined by us.

No coverage is provided for:

1. Any drug, medicine or medication that is consumed at the place where the Prescription is given or that is dispensed by a Health Care Provider;
2. Any portion of a Prescription or refill that exceeds a 31-Day Supply or a 100 unit dose per month; whichever is less;
3. Prescription refills in excess of the number specified by the Health Care Provider or dispensed more than 6 months from the date of the Physician's original order;
4. The administration of covered medication unless otherwise covered herein;
5. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a Hospital, Skilled Nursing Facility, convalescent Hospital, inpatient hospice facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis;
6. Prescriptions that are paid or received without charge under local, state or federal programs, including Worker's Compensation;
7. Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision of this Group Plan;
8. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use." Prescription Drugs which have not been approved by the FDA, as required by federal law, for distribution and delivery into interstate commerce;
9. Immunizing agents, biological serums or allergy serums;
10. Any drug or medicine that is lawfully obtainable without a Prescription, with the exception of insulin;
11. Any appetite suppressant and/or other Prescription Drug indicated, or used, for purposes of weight reduction or control;
12. Prescription Drugs used for cosmetic purposes including but not limited to Minoxidil, Rogaine, and Renova. (Retin-A is excluded after age 26);
13. Drugs listed in the Homeopathic Pharmacopoeia;
14. Drugs prescribed for uses other than the 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 cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;

15. Any costs related to the mailing, sending or delivery of Prescription drugs.

16. Mineral supplements, or vitamins, except Prescription prenatal vitamins, oral single product fluoride (non-vitamin supplementation), Prescription sustained release niacin, Prescription folic acid, Prescription oral hematinic agents, dihydrotachysterol and calcitriol.

17. Smoking cessation Drugs (e.g., Zyban).

18. Drugs prescribed by a Pharmacist.

19. Drugs purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized by us.

20. Prescription Drugs that do not have a valid National Drug Code.

21. Any Prescription Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Prescription Drug. This exclusion does not apply if:

    a) the dosages, frequency of use, or duration of administration of a Prescription Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

    b) the dosages, frequency of use, or duration of administration of a Prescription Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or

    c) we, in our sole discretion, waive this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs.

22. Any Prescription Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Prescription Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research unless we, in our sole discretion, decide to waive this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs.

23. Fertility Drugs.

24. Prescription Drugs approved for sexual dysfunction (e.g., Viagra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine) prescribed for any Member.

Preventive Health Services

Preventive health Services according to standards established by our Medical Directors after periodic review of major scientific publications, for health maintenance and the prevention and detection of disease. Preventive health Services includes:

1. periodic health assessments;
2. instruction in personal health care measures;
3. routine immunizations and inoculations, including flu shots;
4. eye and ear screening examinations in the office of a PCP to determine the need for vision and hearing correction;
5. prostate specific antigen (PSA) screening for men;
6. family planning counseling and information on birth control, sex education, including prevention of venereal disease, and fitting of diaphragms;
7. health education programs organized, sponsored, or offered by us, including nutrition education and counseling; instruction in personal health care and the appropriate use of Services; information regarding the coverage and benefits offered by us and the generally accepted medical standards for the use and frequency of each; and
8. one annual routine preventive gynecological examination per Calendar Year including Medically Necessary covered follow-up care to treat a Condition detected at that visit without a referral from the PCP. The annual examination may include a manual breast exam, a pelvic exam, and a pap smear. This examination must be provided by a Contracting Provider who is an obstetrician or gynecologist. In order for there to be coverage under this provision, follow-up care to treat a Condition detected during the annual examination may be provided by the same obstetrician or gynecologist who performed the annual examination. If you receive Services from the obstetrician or gynecologist for any Condition not detected during the annual routine preventive gynecological examination, a referral from the PCP will be required. **Reminder:** Any referral to another Specialist requires a referral from the PCP.

Prosthetic Devices

The following Prosthetic Devices designed and fitted by a Prosthetist who is a Contracting Provider when authorized in advance by CHP and arranged by a PCP or a Contracting Provider on referral from the PCP or CHP:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery;
2. appliances needed to effectively use artificial limbs or corrective braces; or
3. penile prosthesis and surgery to insert a penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of:
   a) prostate cancer;
   b) diabetes mellitus;
   c) peripheral neuropathy;
   d) medical endocrine causes of impotence;
   e) arteriosclerosis/postoperative bilateral sympathectomy;
   f) spinal cord injury;
   g) pelvic-perineal injury;
   h) post-prostatectomy;
   i) post-priapism;

j) epispadias; and

k) exstrophy.

Covered Prosthetic Devices are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition, except

1. cardiac pacemakers; and
2. prosthetic devices incident to Mastectomy

Coverage for Prosthetic Devices is based on the most cost-effective Prosthetic Device that meets your medical needs as determined by us.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessitated due to growth of a child.

Second Medical Opinion

Each Member is entitled to request a second medical opinion by a Physician of his or her choice subject to the following conditions:

1. The Member feels that he/she is not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the condition being treated. The PCP must be so informed by the Member and a request for a consultation is initiated. Such a consultation shall be provided upon authorization by the Medical Director;
2. The Member disagrees with our opinion or a Physician's, regarding the reasonableness or necessity of a surgical procedure; or, the treatment is for a serious injury or illness;
3. The Physician chosen by the Member for the second opinion is located in CHP's Service Area;
4. CHP retains the right to have any tests that may be required by a Non-Participating Physician administered by a Participating Provider;
5. Reimbursement for second medical opinions by Non-Participating Physicians may be limited to a maximum of three in a Calendar Year and is subject to the Allowed Charges applicable to the Plan's Service Area;
6. The Member is responsible for the Co-payment listed in the Health Services Agreement which is part of the Certificate of Coverage;
7. The Member's Participating Physician or our Medical Director's judgment concerning the treatment shall be controlling, after review of the second opinion, as to the obligations of CHP;
8. Any treatment, including follow-up treatment pursuant to the second opinion is authorized by CHP; and
9. CHP will reimburse the Member 60% of the Allowed Charge for the second opinion services performed by a Non-Participating Physician. The Member shall be responsible for the balance of such charges.

Furthermore, second medical opinions and consultations from a Physician who is listed in CHP's *Directory of Physicians and Service Providers* or any Physician located in the same geographical service after a Member has received a recommendation to have surgery includes the physical examination, laboratory work and x-rays not previously performed by the original Physician. The consulting physician must not be affiliated in practice with the surgeon who first recommended the surgery.

CHP will cover the second surgical opinion services for a Member in obtaining a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under this contract, if in addition to

the conditions listed above, the following conditions are also met:

1. The consulting Physician must personally examine the Member and CHP and the Member's PCP must receive a copy of the written opinion; and
2. The consulting Physician must not perform the surgery to correct the Condition for which the original recommendation was given.

Skilled Nursing Facilities

The following Skilled Nursing Facility Services when: a) authorized in writing by a PCP or Contracting Provider when on referral from the PCP, and for which coverage is approved by our Medical Director; and b) you are an inpatient in a Skilled Nursing Facility:

1. room and board;
2. respiratory therapy (e.g., oxygen);
3. drugs and medicines administered while an inpatient (except take home drugs);
4. intravenous solutions;
5. administration of, including the cost of, whole blood or blood products;
6. dressings, including ordinary casts;
7. anesthetics and their administration;
8 transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
10. chemotherapy treatment for proven malignant disease; and
11. Physical, Speech and Occupational Therapy.

We reserve the right to request a treatment plan for determining coverage and payment.

Limitation:

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

Spinal Manipulations

Non-surgical spine and back disorder treatments consisting of manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray. Benefits for Covered Services are limited to the number of visits per Member per Calendar Year set forth in the Schedule of Copayments.

Substance Dependency Treatment Services

Detoxification Services limited to the time necessary for the removal of toxic substances from the blood and outpatient follow-up care. Inpatient Detoxification coverage must be authorized in accordance with criteria established by us for this benefit to be a Covered Service.

Outpatient visits for the care and treatment of Substance Dependency. Consultations may be provided by Specialists or Psychologists who are Contracting Providers, and authorized in accordance with criteria established by us for this benefit to be a Covered Service.

Exclusions:

Expenses for the care and treatment of Substance Dependency in excess of the maximum amount set forth on the Schedule of Copayments for treatment of alcoholism or drug addiction, including prolonged treatment in a specialized inpatient or residential facility.

Expenses for non-medical ancillary Services such as vocational rehabilitation or employment counseling even if you are referred for such Services.

Surgical Assistant Services

Services rendered by a Physician or Physician Assistant licensed to perform surgical first assisting Services when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary.

Surgical Procedures

Surgical procedures performed by a Physician are covered including the following:

1. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
2. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth; and
3. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint [TMJ]) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury. We reserve the right to request medical review to determine if the Service is Medically Necessary as defined herein.

Transplant Services

Transplants as described below, if coverage is pre-determined by us and if performed at a facility acceptable to us, subject to the conditions and limitations listed below.

Transplant Services include Health Care Services related to the donation or acquisition of an organ or tissue for you once the donor has been identified and has agreed to donate the organ, and treatment of complications after transplantation in connection with the following transplants:

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate 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;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. pancreas transplant alone or after a kidney transplant.

We will cover donor expenses and organ acquisition for transplants, other than Bone Marrow Transplants, provided such expenses are not covered in whole or in part by any other insurance carrier, organization or person other than the donor’s family or estate.

We will cover transportation costs for the Member to and from the approved facility where the approved transplant is to be performed if the facility is more than 100 miles from the Member's home.

Direct, non-medical costs for one Member of the Subscriber's immediate family (two Members if the patient is under age 18) for (a) transportation to and from the approved facility where the transplant is performed, but no more than one round trip per person per transplant and (b) temporary lodging at a prearranged location during the Member's confinement in the approved transplant facility, not to exceed $75 per day. Direct, non-medical costs are only payable if the Member lives more than 100 miles from the approved transplant facility. There is a $5,000 maximum for these direct, non-medical expenses, subject to the $75.00 per day maximum stated above.

Benefit Guidelines

For a transplant to be covered, a written prior benefit determination from our Medical Director is required in advance of the procedure. You or your Physician must notify our Medical Director prior to your initial evaluation for the transplant in order for us to determine if the transplant Services are covered. Our Medical Director must be given the opportunity to evaluate the clinical results of the Member's evaluation. Our benefit determination will be based on the terms of this Member Handbook as well as written criteria and procedures established by our Medical Director. If prior benefit determination is not given, the transplant will not be covered.

Once a coverage decision is made, our Medical Director will advise you or your 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 us.

For covered transplants and all related complications, we will cover Hospital expenses and Physician expenses provided that such Services will be paid under Hospital Services and Physician Services in accordance with the same terms and conditions for care and treatment of any other covered Condition.

Exclusion:

No benefit is payable for, or in connection with, the following:

1. transplant procedures not included in the list above, or otherwise excluded herein (e.g., Experimental or Investigational transplant procedures);
2. our Medical Director and your PCP are not contacted for authorization prior to referral for evaluation of the transplant;
3. our Medical Director does not pre-authorize coverage for the transplant;
4. transplant procedures involving the transplantation of any non-human organ or tissue;
5. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us;
6. transplant procedures involving the implant of an artificial organ (e.g., artificial heart), including the artificial organ;
7. any organ, tissue, marrow, or stem cells that are sold rather than donated;
8. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published *Medicare Coverage Issues Manual;* or

9. any service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.

Section 7: Exclusions and Limitations

Exclusions

The following exclusions are in addition to any exclusions specified in the Covered Services section:

Abortions, including any Service or supply to an elective abortion. However, spontaneous abortions are not excluded nor are abortions performed for reasons when Medically Necessary.

Ambulance Services other than those specifically provided for in the Covered Services section.

Arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Autopsy or postmortem examination Services, unless specifically requested by us.

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 (except when used to treat metal toxicity and lead poisoning); thermography; mind-body interactions such as meditation, imagery, yoga, dance, music or art therapy; biofeedback; prayer and mental healing; massage which is not part of a Rehabilitation Plan approved by CHP; 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.

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

Contraceptive Appliances, except as specifically provided for in the Preventive Health Services or Prescription Drug benefit.

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

Cosmetic Services includes any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery subsection), including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

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

Custodial Care, and any service of a custodial nature, including without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; respite care; and provision of services which are for the sole purpose of allowing a family member or caregiver of a Member to return to work.

Dental care, care or treatment of the teeth or their supporting structures or gums, or dental

procedures, including, but not limited to: extraction of teeth (impacted or otherwise), restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to any non-surgical Phase II treatment (as defined by the American Dental Association) for TMJ dysfunction including, but not limited to, orthodontic treatment. This exclusion does not apply to Accidental Dental Care, Child Cleft Lip and Cleft Palate Treatment Services described in the Covered Services section.

Drugs

1. 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 your cancer in a Standard Reference Compendium or recommended for treatment of your cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All drugs dispensed to, or purchased by, you from a pharmacy, except as described in Prescription Drugs subsection of the Covered Services section. This exclusion does not apply to drugs dispensed to you when: a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility; b) you are in the outpatient department of a Hospital; c) dispensed by a pharmacy under contract with us to provide injectable medications to you at home for self-administration, or to provide injectable medications to your Physician for administration to you in the Physician's office; or d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs.
3. Any non-prescription medicine, remedy, vaccine, biological product (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, or over-the-counter drugs, supplies, products, or health foods.

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

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

Foot care, which is routine including any Health Care Service 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, or trimming of toenails.

General Exclusions include, but are not limited to, the following:

1. Any Health Care Services not specifically listed in the Covered Services section or in any Endorsement attached hereto, unless such expenses are specifically required to be covered by applicable law.

2. If you do not follow our Coverage Access Rules, any Health Care Services provided to, or received by, you are not covered. For further information, please refer to the Coverage Access Rules section.
3. Any Health Care Service, which in our opinion 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 CHP, does not in itself make such Service Medically Necessary or a Covered Service.
4. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services;
5. Any Health Care Services received prior to your Effective Date or received on or after the date your coverage terminates under the Group Master Policy, unless coverage is extended in accordance with the Extension of Benefits section;
6. Any Health Care Services provided by a Physician or other health care provider related to you by blood or marriage or any Health Care Services you provide to yourself;
7. Any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;
8. Any Health Care Service rendered at no charge;
9. Elective care, routine care, or any care other than Medically Necessary emergency care, you require while outside of the Service Area;
10. 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;
11. Any Health Care Services with respect to which CHP requests information from you regarding any other health plan coverage you had or have and you fail to provide the requested information; or
12. Any Health Care Services to diagnose or treat a Condition that, directly or indirectly, resulted from or is in connection with:
    a) war or an act of war, whether declared or not;
    b) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
    c) your engaging in an illegal occupation;
    d) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard.

Gene Therapy

Hearing aids and devices (external or implantable, including cochlear implants) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, maintenance agreements, repair or batteries.

Home Infusion Therapy, except for prescription drugs.

Hypnotism or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except immunizations necessary in the course of other medical treatments of an illness or injury or within the scope of, and coinciding with, periodic health assessments and/or state law requirements.

Infertility Diagnostic and Treatment Services including without limitation:

1. Office visits;
2. Diagnosis of infertility;
3. Diagnostic procedures to determine the cause of infertility;
4. Testing for the diagnosis or treatment of infertility;
5. Medications for the diagnosis or treatment of infertility;
6. Laboratory work; and
7. Procedures for the treatment of infertility, including, but not limited to, Artificial Insemination (AI), surgical procedures specifically related to correcting Conditions causing infertility (inpatient or outpatient), In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation.

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

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

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

Personal comfort, hygiene or convenience items, and Services deemed to be not Medically Necessary and not directly related to your care, including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses other than Medically Necessary Ambulance Services;
8. motel/hotel accommodations;
9. air conditioners and purifiers/cleaners/filters, furnaces, water purification systems, water softeners and/or purifiers, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, whirlpools, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment; and
13. hand rails and grab bars.

Private duty nursing care of any duration rendered at any location.

Remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used in conjunction with such activity.

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

Sexual reassignment, or modification Services, including but not limited to any Health Care Services related to such treatment, including psychiatric Services.

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

Sports-related devices used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding,

exercise, fitness, flexibility, and diversion or general motivation.

Training and educational programs, including programs primarily for pain management, or vocational rehabilitation or programs to improve grades, test scores or educational performance.

Travel or vacation expenses even if prescribed or ordered by a provider.

Transportation services that are non-emergency transportation between institutional care facilities, or to and from your temporary or permanent residence.

Voluntary sterilizations, including tubal ligations and vasectomies, unless Medically Necessary.

Volunteer services or Services which would normally be provided free of charge or services of a person who ordinarily resides in the home of the terminally ill Member, or is a member of your family, or of your spouse's family.

Weight control services including any Service to lose, gain, or maintain weight, including, but not limited to: any weight control/loss program; appetite suppressants; any drug indicated for weight reduction or control; dietary regimens; food or food supplements; exercise programs, equipment or memberships; or surgical procedures (e.g., gastric bypass and stomach stapling) unless Medically Necessary.

Wigs or cranial prosthesis, except when related to restoration after cancer or brain tumor treatment.

Work-Related Health Care Services to the extent the Covered Service is paid by Workers' Compensation.

Limitations

The rights of Members and obligations of CHP hereunder are subject to the limitations set forth on the Schedule of Copayments and the following limitations.

Circumstances Beyond the Control of CHP:

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of CHP, results in facilities, personnel or financial resources of CHP being unable to arrange for provision of the Covered Services, we 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 we will 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 our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section 8: Pre-existing Conditions Exclusion Period

Definitions

The following definitions will be referred to for purposes of this Pre-existing Condition Exclusion Period section. You should pay particular attention to the definition of Pre-existing Condition because it will vary depending upon the size of the group and whether you have Creditable Coverage that will reduce the Pre-existing Condition exclusionary period.

For Small Employers with two or more employees or with one employee that has Creditable Coverage that will reduce the Pre-existing Condition exclusionary period:

> **Pre-existing Condition** means any Condition related to a physical or mental Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately preceding:
>
> 1. the first day of the your Waiting Period for initial enrollees; or
> 2. your Effective Date of coverage under the Group Master Policy for special and annual enrollees.

For a Small Employer with one employee who does not have Creditable Coverage that will reduce the Pre-existing Condition exclusionary period:

> **Pre-existing Condition,** means any Condition that during the 24-month period immediately preceding the Member's Effective Date of coverage, has manifested itself in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received for that Condition. Pregnancy is a Pre-existing Condition when inception of the pregnancy preceded the Effective Date of the pregnant Member's coverage regardless of whether the pregnant Member knew she was pregnant prior to the Effective Date.

Definition Applicable to All Small Employers:

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Pre-Existing Condition Exclusionary Period

The Pre-existing Condition exclusionary period will vary based upon the size of the Small Employer and whether you have Creditable Coverage.

For Small Employers with two or more employees or with one employee with Creditable Coverage that will reduce the Pre-existing Condition exclusionary period:

There is no coverage under this Group Master Policy for Health Care Services to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until you have been continuously covered under this Group Master Policy for a 12-month period. This 12-month Pre-existing Condition exclusionary period begins on the first day of the Waiting Period (your Enrollment Date) if you are an initial enrollee, or on your Effective Date of coverage if you are a special or annual enrollee. This

exclusionary period also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

For a Small Employer with one employee who does not have Creditable Coverage that will reduce the Pre-existing Condition exclusionary period:

There is no coverage under this Group Master Policy for Health Care Services to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until you have been continuously covered under this Group Master Policy for a 24-month period. This 24-month Pre-existing Condition exclusionary period begins on your Effective Date of coverage. This exclusionary period also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

Exceptions to the Pre-existing Condition Exclusionary Period

The Pre-existing Condition exclusionary period does not apply to:

1. a newborn child or an adopted newborn child;
2. an adopted child who is covered under Creditable Coverage;
3. Genetic Information in the absence of a diagnosis of the Condition;
4. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
5. Conditions arising from domestic violence;
6. you, if you were covered under the Small Employer's prior medical plan on the date immediately preceding the Effective Date of coverage under this Group Master Policy;

In addition to the above list, the Pre-existing Condition exclusionary period does not apply to pregnancy for:

1. a Small Employer with two or more employees or one employee who has Creditable Coverage; or
2. a Small Employer with one employee who has Creditable Coverage that will reduce the Pre-existing Condition exclusionary period.

Reducing the Pre-existing Conditions Exclusionary Period

You may be able to reduce or even eliminate the Pre-existing Conditions exclusionary period if you have prior Creditable Coverage.

If you are enrolling when you are first eligible for coverage, or during an Annual Enrollment Period or Special Enrollment Period, and you have no more than a 63-day break in Creditable Coverage as of your Enrollment Date under this Group Master Policy, your Pre-existing Conditions exclusionary period will be reduced by the amount of prior Creditable Coverage you have.

If you have no Creditable Coverage or if you have a break in coverage of 63 days or more between your Creditable Coverage and your Enrollment Date, then the full Pre-existing Condition exclusionary period will apply.

Proving Creditable Coverage

You may provide certification of Creditable Coverage or a Prior/Concurrent Coverage Affidavit to prove the amount of time you were covered under Creditable Coverage. Prior health insurers and/or group health plans are required to provide you with certification of Creditable Coverage upon termination of your coverage and at any time upon request up to 24 months after termination of your prior health coverage.

If you do not provide a certification, you must provide us some other evidence of Creditable Coverage such as a copy of an identification card or health insurance bill from a prior carrier and attest to the amount of time you were covered under the Creditable Coverage.

Section 9: Eligibility for Coverage

Each employee or other individual who meets and continues to meet the eligibility requirements (described in this Member Handbook) will be entitled to apply for coverage with us. These eligibility requirements are binding upon you and/or your eligible family members as well as the Small Employer. No changes in our eligibility requirements will be permitted unless we have been notified of and have agreed in writing to any such change in advance.

We may require acceptable documentation that an individual meets and continues to meet the eligibility requirements such as a court order naming the Subscriber as the legal guardian or appropriate “adoption” documentation described in the Enrollment and Effective Date of Coverage section.

Eligibility Requirements for Subscribers

In order to be eligible to enroll as a Subscriber, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. The employee must be a bona fide employee of the Group;
2. The employee's job must fall within a job classification identified on the Group Application;
3. The employee must maintain his/her primary residence in the Service Area or be regularly employed in the Service Area;
4. The employee must have completed any applicable Waiting Period identified on the Group Application; and
5. The employee must meet any additional eligibility requirement(s) identified on the Group Application.

The Subscriber eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Small Employer, provided such companies and the Small Employer are under common control; and
4. other individuals as determined by us and the Small Employer (e.g., members of associations or labor unions).

Any expansion of the Subscriber eligibility class must be approved in writing by the Small Employer and us prior to such expansion, and may be subject to different Rates.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under the Group Master Policy.

1. Spouse:

   The Subscriber’s spouse under a legally valid existing marriage.

2. Child(ren):

   A Subscriber's natural newborn, adopted, or step child(ren) (or a child for whom the Subscriber has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year in which the child reaches age 25 (or in the case of a foster child, until the end of the month in which the foster child reaches age 18 or the Covered Employee no longer has legal custody), and who is:

dependent upon the Subscriber for financial support and maintaining his/her primary residence in the Service Area; and

a) living in the household of the Subscriber or a full-time or part-time student;

b) not living in the household of the Subscriber and is not enrolled as a full or part-time student because the child has not met the age requirements to begin elementary school education; or

c) any child who lives with the employee in a normal parent child relationship if the child qualifies at all times for the dependent exemption as defined in Internal Revenue Code and the federal tax regulations.

3. Handicapped Child(ren):

   A handicapped Covered Dependent child, who maintains his/her primary residence in the Service Area, is eligible to continue coverage beyond the limiting age of 25 if such Covered Dependent is:

   a) otherwise eligible for coverage under this Group Master Policy;

   b) incapable of self-sustaining employment as a result of mental retardation or physical handicap; and

   c) chiefly dependent upon the Subscriber for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 25th birthday.

   This eligibility will terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

4. Newborn Child of a Covered Dependent:

   The newborn child of a Covered Dependent other than the Subscriber's Covered Dependent spouse is eligible for coverage. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility as the Subscriber to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Other Provisions Regarding Eligibility

1. No individual whose coverage has been terminated for cause (see the Termination of Individual Coverage for Cause subsection) shall be eligible to re-enroll with CHP.

2. No Eligible Employee or Eligible Dependent who meets the eligibility requirements described in this section will be refused enrollment or re-enrollment in CHP because of race, color, creed, marital status, sex, or age.

3. The Subscriber 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 our eligibility requirements, and we do not receive proper notification in a timely manner from the Subscriber, we shall have the right to retroactively terminate coverage of such Covered Dependent to the date any such eligibility requirement was not met. For Services provided after the termination date of your Covered Dependent, we may recover an amount equal to the Allowance less any Premium we received for the Covered Dependent's coverage. Upon our request, the Subscriber shall provide proof, which is acceptable to us, of a Covered Dependent's continuing eligibility for coverage.

4. If the Small Employer offers an alternative health benefit plan for Medicare eligibles or

retirees, and you elect to be covered under such plan, then you are not eligible for coverage.

Section 10: Enrollment and Effective Date of Coverage

Eligible Employees and Eligible Dependents may apply for coverage according to the provisions below.

Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under the Group Master Policy. We shall have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. Any Eligible Employee and/or Eligible Dependent may apply for coverage by completing and submitting the appropriate Enrollment Forms.
2. 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, might result, in addition to any other legal right(s) we may have, in disqualification for, termination of, or rescission of coverage. Eligible Employees are responsible for submitting completed Enrollment Forms in accordance with the applicable enrollment procedures established by the Small Employer or us.
3. We will not provide coverage and/or benefits to any individual who would not have been entitled to enrollment with us, had accurate and complete information been provided on a timely basis on the Enrollment Forms. In such cases, we may require such individual, or an individual legally responsible for that individual, to reimburse us for any payments we made on behalf of such individual.
4. If the Small Employer requires an individual to make a periodic financial contribution in order to be a Member, such individual shall have agreed in writing to make, and actually shall make, all required financial contributions.

Enrollment Forms/Electing Coverage

To apply for coverage, you as the Eligible Employee must:

1. complete and submit the Enrollment Forms, through your Small Employer;
2. provide, at our request, any additional information needed to determine eligibility;
3. agree to pay your portion of the required Premium; and
4. complete and submit, through your Small Employer, the Enrollment Forms to add Eligible Dependents or delete Covered Dependents.

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

1. Employee Only Coverage:

   This type of coverage provides coverage for the Eligible Employee only.

2. Employee/Spouse Coverage:

   This type of coverage provides coverage for the Eligible Employee and the employee's spouse under a legally valid existing marriage.

3. Employee/Child(ren) Coverage:

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

4. Employee/Family Coverage:

   This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

There may be an additional premium charge for each Covered Dependent based on the coverage selected by the Small Employer.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the 30-day period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the Small Employer's health benefit program. The period is established by us, occurs annually and will take place prior to the Anniversary Date.

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

Employee Enrollment

1. An Eligible Employee must submit completed Enrollment Forms to enroll during the Initial Enrollment Period in order to become covered as of the Small Employer's Effective Date as stated on the Group Application.
2. An individual who becomes an Eligible Employee after the Small Employer's Effective Date (for example, newly-hired employees) must submit completed Enrollments Forms to enroll before or within his or her Initial Enrollment Period. The Effective Date of coverage for such individual will be the first CHP billing date (e.g., 1st or 15th of each month) following receipt of the Enrollment Forms.

Dependent Enrollment

1. Eligible Dependents may be enrolled at the same time the Eligible Employee enrolls. The Eligible Employee must submit completed Enrollment Forms to enroll during the Initial Enrollment Period in order to become covered as of the Small Employer's Effective Date as stated on the Group Application.
2. For an individual who becomes an Eligible Dependent after the Small Employer's Effective Date, the Subscriber must submit completed Enrollments Forms to enroll Eligible Dependents before or within their Initial Enrollment Period. The Effective Date of coverage for such Eligible Dependent not otherwise described below will be the first CHP billing date (1st or 15th of each month) following receipt of the Enrollment Forms.

Described below are special rules for certain Eligible Dependents.

1. Newborn Child:

   To enroll a newborn child who is an Eligible Dependent, the Subscriber must submit Enrollment Forms during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

   We must be notified, in writing, within 30 days after the birth. If timely notice is given, no additional Premium will be charged for coverage of the newborn child for the first 30 days after the birth of the child. If timely notice is not received, we will charge the applicable Premium from the date of birth. The applicable Premium for the child will be charged after the initial 30-day period in either case.

Coverage will not be denied for a newborn child if you provide notice to the Small Employer, and we receive Enrollment Forms within the 60-day period following the birth of the child and any applicable Premium is paid back to the date of birth. If we are not notified within 60 days of the birth of the newborn child, you must make application during an Annual Open Enrollment Period in order for the newborn child to be covered.

Note: Coverage for a newborn child of a Member other than the Subscriber or the Subscriber's Covered Dependent spouse will automatically terminate 18 months after the birth of the newborn child.

2. Adopted Newborn Child:

   To enroll an adopted newborn child, the Subscriber must submit Enrollment Forms during the 30-day period immediately following the date of birth. The Effective Date of coverage for an adopted newborn child eligible for coverage will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Subscriber prior to the birth of such child, whether or not such agreement is enforceable.

   If timely notice is given, no additional Premium will be charged for coverage of the adopted newborn child for the duration of the notice period. If timely notice is not received, we will charge the applicable Premium from the date of birth of the adopted newborn. We may require the Subscriber to provide any information and/or documents, which we deem necessary in order to administer this provision.

   If we are not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Subscriber provides notice to the Small Employer, and we receive the Enrollment Forms within 60 days of the birth and any applicable Premium is paid back to the date of birth. If we are not notified within 60 days of the date of birth, you must make application during an Annual Open Enrollment Period in order for the adopted newborn child to be covered.

   If the adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the adopted newborn child. It is your responsibility to notify us within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

3. Adopted Child:

   To enroll an adopted child, the Subscriber must submit Enrollment Forms during the 30-day period immediately following the date of placement and pay the additional Premium, if any. The Effective Date for an adopted child (other than an adopted newborn child) will be the date such adopted child is placed in the residence of the Subscriber in compliance with Florida law. If timely notice is given, no additional Premium will be charged for coverage of the adopted child for the duration of the notice period. We may require the Subscriber to provide any information and/or documents we deem necessary in order to properly administer this provision.

   If we are not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as you provide notice to the Small Employer, and we receive the Enrollment Forms within 60 days of the placement, and any applicable Premium is paid back to the date of placement. If we are not notified within 60 days of the date of placement, the Subscriber must make application during an Annual Open Enrollment Period in order for the adopted child to be covered.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child. Proof of final adoption must be submitted to us. It is your responsibility to notify us if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child.

4. Foster Child:

   To enroll a foster child, the Subscriber must submit completed Enrollment Forms to us prior to or during the 30-day period immediately following the date of placement if on the date the Subscriber has Dependent Coverage and pays the additional Premium, if any. This coverage will be subject to the Pre-existing Condition exclusionary period. No coverage will be provided under this provision for the child who is not ultimately placed in the Subscriber's home. For children in the Subscriber's custody, coverage will terminate at the end of the month in which the foster child reaches age 18 or the date the Subscriber no longer has legal custody.

5. Marital Status:

   A Subscriber may apply for coverage of an Eligible Dependent due to a legally valid existing marriage. To apply for coverage, the Subscriber must submit completed Enrollment Forms. The Subscriber must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

6. Court Order:

   If a court has ordered coverage to be provided for a minor child under the Subscriber's plan, a Subscriber may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period. To apply for coverage, you must submit completed Enrollment Forms. The Subscriber must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Covered Dependent who is enrolled as a result of a court order is the date required by the court order or the next billing date.

Annual Open Enrollment

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by submitting completed Enrollment Forms during the Annual Open Enrollment Period.

The Effective Date of Coverage for an Eligible Employee and any Eligible Dependent(s) will be the first billing date following the Annual Open Enrollment Period.

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

Special Enrollment

An Eligible Employee and/or his or her Eligible Dependents may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Eligible Dependents must submit completed Enrollment Forms within 30 days of the special enrollment

event. For purposes of this subsection, the following are the special enrollment events:

1. Loss of Coverage:

   You lose your coverage under another group health benefit plan (as an employee or Covered Dependent), or coverage under other health insurance, or coverage under Healthy Kids, Medicare or Medicaid, or COBRA continuation coverage or Florida Health Insurance Continuation Coverage Act (FHICCA) that you were covered under at the time of initial enrollment provided that:

   a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

   b) you lost your other coverage under a group health benefit plan or health insurance coverage as a result of termination of employment, reduction in the number of hours you work, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage were terminated.

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

2. Special Circumstances:

   You get married or obtain a Covered Dependent through birth, adoption or placement in anticipation of adoption.

The Effective Date of coverage for you and your Eligible Dependent(s) who are enrolled as a result of one of the special events listed above is the date of the special enrollment event. Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period.

Other Provisions Regarding Enrollment and Effective Date of Coverage

1. Rehired Employees:

   Individuals who are rehired as employees of the Small Employer are considered newly-hired employees for purposes of this section. The provisions of the Group Master Policy which are applicable to newly-hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

2. Premium Payments:

   In those instances where an individual is to be added to coverage (e.g., a new Eligible Employee or a new Eligible Dependent, including a newborn or adopted child), that individual's coverage shall be effective, as described in this section, provided we receive the applicable additional Premium payment within 30 days of the date we notified the Small Employer of such amount. In no event shall an individual be covered under this Group Master Policy if we do not receive the applicable Premium payment within such time period.

3. Adding or Deleting Dependents:

   You are responsible for adding and deleting dependents by notifying the Small Employer in accordance with all requirements and on a timely basis. The Small Employer is responsible to notify us of the addition of, or the deletion of, employees or dependents. We are not responsible for providing

coverage for any individual who should not have been added or who should have been deleted.

Section 11: Termination of Coverage

Termination of Subscriber Coverage

A Subscriber's coverage will automatically terminate at 12:01 a.m. on the date the Group Master Policy terminates or on the Small Employer's next billing cycle date following the date:

1. the Subscriber becomes covered under an alternative health benefit plan which is offered through or in connection with the Small Employer;
2. the Subscriber otherwise fails to continue to meet each of the eligibility requirements specified by us or the Small Employer; or
3. the Subscriber's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

Termination of Covered Dependent Coverage

A Covered Dependent's coverage will automatically terminate at 12:01 a.m. on the date the Group Master Policy terminates or on the Small Employer's next billing cycle date following the date:

1. his or her Subscriber's coverage terminates for any reason;
2. the Covered Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Small Employer;
3. the Covered Dependent otherwise fails to continue to meet each of the eligibility requirements; or
4. the Covered Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

Termination of Individual Coverage for Cause

1. If, in our opinion, any of the following events occur, we may terminate an individual's coverage for cause:
   a) disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Member's continued coverage in CHP impairs our ability to provide coverage and/or benefits or to arrange for the delivery of Health Care Services to such Member or to other Members. Prior to disenrolling a Member for any of the above reasons, we will:
      1) make a reasonable effort to resolve the problem presented by the Member, including the use or attempted use of our Complaint and Grievance Process (refer to the Complaint and Grievance Process section of this Member Handbook); and
      2) determine, to the extent possible, that your behavior is not related to the use of medical Services or mental illness; and
      3) document the problems encountered, efforts made to resolve the problems, and any of your medical conditions involved.
   b) the knowing misrepresentation, omission, or the giving of false information on Enrollment Forms, or other forms completed for us, by or on behalf of the Member;
   c) fraud, material misrepresentation, or omission in applying for coverage or in requesting the receipt of Covered Services;

d) misuse of the Membership Card;

e) no longer lives, resides or works in the Service Area; or

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

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

Note: Relative to a misstatement on Enrollment Forms, after two years from your Effective Date, only fraudulent misstatements may be used to void coverage or deny any claim for loss incurred or disability starting after the two-year period.

Notice of Member Termination

If an individual's coverage terminates for reasons other than the termination of the Small Employer Master Policy, or for nonpayment of Premium, or as a result of termination of eligibility, we shall notify you and the Small Employer, in writing, at the respective addresses then on file with CHP, at least 45 days prior to the date of termination. Such notice to Members who are Covered Dependents may be made through such Covered Dependent's Subscriber. This notice will state the reason(s) and effective date of termination of coverage.

Responsibilities of CHP Upon Termination of an Individual's Coverage

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

Certification of Creditable Coverage

In the event coverage terminates 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. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time you had prior Creditable Coverage.

Upon request, we will send you another Certification of Creditable Coverage within a 24-month period after termination of coverage.

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

Section 12: Extension of Benefits

Extension of Benefits

In the event the entire Group Master Policy is terminated, coverage will end as of the termination date. We will not provide coverage or benefits for any Service rendered on or after the termination date, except as described below. The extension of benefits provisions described below only apply when the Group Master Policy is terminated, and the benefits provided under an extension of benefits is subject to all other provisions, including the limitations and exclusions, described in this Member Handbook.

Note: It is your responsibility to provide acceptable documentation to us that you are entitled to an extension of benefits.

1. If you are totally disabled on the termination date of the Group Master Policy as a result of a specific Accident or illness incurred while you were covered under the Group Master Policy, as determined by us, we will provide a limited extension of benefits for the disabled Member only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Master Policy.

   For purposes of this section, a person is totally disabled only if, in our opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. This would also apply to a Member who, although not engaged in an occupation (e.g., a student, non-working spouse, or children), is not able to perform the normal day-to-day activities that they would otherwise be able to perform.

2. In the event a Member is pregnant as of the termination date of the Group Master Policy, we will provide a limited extension of the maternity expense benefits, provided the pregnancy commenced while the pregnant Member was covered by us. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. This extension of benefits is not predicated upon the Member being totally disabled.

We are not required to provide an extension of benefits if this entire Group Master Policy is terminated by CHP based upon any event referred to in §641.3922(7)(a) (b) and (e) *Florida Statutes.*

Section 13: Continuing Coverage

Introduction

This section describes the federal and Florida laws that cover continuation of coverage for certain former employees of Small Employers. While both federal and Florida law provide for continuation of coverage for certain employees of Small Employers, they do not overlap. Therefore, if federal law applies to a Small Employer, state law will not and vice versa.

Whether federal or Florida law will apply to your Small Employer will depend upon many factors, including but not limited to, the size of the Small Employer and whether the Small Employer is a church group or a government plan.

This section provides a description of both federal and Florida law continuation of coverage requirements. Contact your Small Employer to determine what continuation law is applicable to you.

Federal Continuation of Coverage Law

A federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to the Small Employer. If COBRA applies to the Small Employer, you or your Covered Dependents may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

You must contact the Small Employer to determine if you or your Covered Dependent is entitled to COBRA continuation of coverage. The Small Employer is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Members of their rights under COBRA. If the Small Employer or you fail to meet your obligations under COBRA and this Group Master Policy, we will not be liable for any claims incurred by you or your Covered Dependent(s) after your termination of coverage.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Small Employer are met by the purchase of the Group Master Policy; the duty to meet such obligations remains with the Small Employer.

The following is a summary of what you may elect, if COBRA applies to the Small Employer and you are eligible for such coverage:

1. You may elect to continue your coverage for a period not to exceed 18 months* in the case of:

    a) termination of employment of the Subscriber other than for gross misconduct; or

    b) reduced hours of employment of the Subscriber.

    ***Note:** You and your Covered Dependents are eligible for an 11 month extension of the 18 month COBRA continuation option above (to a total of 29 months) if you or your Covered Dependent is totally disabled (as defined by the Social Security Administration [SSA]) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. You must supply notice of the disability determination to the Small Employer within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:

    a) the Subscriber's entitlement to Medicare;

    b) divorce or legal separation of the Subscriber;

    c) death of the Subscriber;

    d) the employer files bankruptcy (subject to Bankruptcy Court Approval); or

    e) a Covered Dependent child may elect the 36-month extension if the Covered Dependent child ceases to be an Eligible Dependent under the terms of the Small Employer's coverage.

Children born to or placed for adoption with the Subscriber during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

If you are eligible to continue group health insurance coverage pursuant to COBRA, the following conditions must be met:

1. The Small Employer must notify you of your continuation of coverage rights under COBRA within 14 days of the event that creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify the Small Employer, in writing, within 60 days of any of these events. The Small Employer's 14-day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue the coverage within 60 days of the later of:

    a) the date that the coverage terminates; or

    b) the date the notification of continuation of coverage rights is sent by the Small Employer.
3. COBRA coverage will terminate if you become covered under any other group health plan. However, COBRA coverage may continue if the new group health plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the SSA that you are no longer disabled. You must inform the Small Employer of the SSA determination within 30 days of such determination.
6. You must meet all Premium payment requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, as described in the Group Master Policy.
7. The Small Employer must continue to provide group health coverage to its employees.

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Group Master Policy shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA

and changes to COBRA that are mandatory with respect to the Small Employer.

Florida Continuation of Coverage Law

Section 627.6692, *Florida Statutes,* known as the Florida Health Insurance Coverage Continuation Act, requires that a Small Employer who does not qualify for COBRA coverage, offer you the opportunity for a temporary extension of health coverage (called "continuation of coverage") in certain instances where coverage under the Group Master Policy would otherwise end. The Small Employer may not qualify for COBRA coverage for many reasons, including but not limited to, the Small Employer employs fewer than 20 employees or is a state or local government plan, or church plan.

You have certain rights and obligations under the continuation of coverage provision of the law. These rights are outlined below.

Initial Notice to Choose Continuation of Coverage:

It is your responsibility to notify the designated administrator at the address listed below of any event that qualifies you to continue coverage under this Group Master Policy. Please refer to the Notice Requirements below.

Types of Qualifying Events:

If your Small Employer has fewer than 20 employees, you have the right to continue coverage under the Florida continuation of coverage law if:

1. you lose group health coverage because of a reduction in your hours of employment; or
2. your employment is terminated (for reasons other than gross misconduct on your part).

The Covered Dependent spouse of the Subscriber has the right to choose continuation of coverage if the group health coverage is lost for any of the following four reasons:

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

The Covered Dependent child of a Subscriber has the right to continuation of coverage if group health coverage is lost for any of the following five reasons:

1. the death of the Subscriber;
2. the termination of the Subscriber's employment (for reasons other than gross misconduct) or a reduction in the Subscriber's hours of employment;
3. parents' divorce or legal separation;
4. the Subscriber becomes entitled to Medicare; or
5. the dependent ceases to be a Covered Dependent under the terms of the Group Master Policy.

You also have a right to elect continuation of coverage if you are covered under the Group Master Policy as a retiree, or spouse or child of a retiree, and lose coverage within one year before or after the commencement of proceeding under Title 11 (bankruptcy), United States Code, by the Small Employer from whose employment the Subscriber retired.

You must inform Coverage Continuation Service (CCS) of any qualifying event under the Group Master Policy. **This notification must be postmarked no later than 30 days after the date of the qualifying event that would cause a loss of coverage.**

The notice must be in writing and include:

1. the name and address of the qualified beneficiary;
2. the social security number of the qualified beneficiary;
3. the name of the Small Employer;
4. the insurance carrier's name;
5. one of the types of qualifying events as listed above;
6. the date of the qualifying event;
7. the daytime telephone number;
8. the Subscriber's social security number;
9. the Group Master Policy number; and
10. the name and address of all other qualified beneficiaries.

When CCS receives the timely written notice as described above, CCS will send you by Certified Mail a premium notice and election form. You have 30 days from the date of receipt of the form to elect continuation of coverage. To elect continuation of coverage, complete and return the form with applicable premium payment to CCS. Continuation of coverage begins on the day after coverage would otherwise be terminated, only if CCS receives the form and full premium payment within the allotted time period and all other eligibility requirements are satisfied.

If you do not elect continuation of coverage and pay the premium, your group health coverage will terminate in accordance with the provisions outlined in the Member Handbook.

If you chose continuation of coverage, the coverage will be identical to the coverage provided under the Group Master Policy to similarly situated Members. The law requires that you be afforded the opportunity to maintain continuation coverage for 18 months. However, the law also provides that your continuation of coverage may be terminated for any of the following reasons:

1. the Small Employer no longer provides group health coverage to any of its employees;
2. the premium for your continuation of coverage is not paid within 30 days;
3. after electing continuation of coverage, you become covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any Pre-existing Condition; or
4. after electing continuation of coverage, you are approved for Medicare.

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

You do not have to show insurability to choose continuation of coverage. However, you may have to pay up to 115 percent of the applicable premium for continuation of coverage. The law also requires that, at the end of the 18-month or 29-month continuation of coverage period, you may enroll in an individual conversion health plan provided under the current group health plan.

Any questions regarding these provisions or notifications required by this section should be directed to the person or office shown below. If

your address or marital status has changed, please notify in writing, the person or office shown below:

Coverage Continuation Service (CCS)
P. O. Box 534088
St. Petersburg, Florida 33747-4088
Telephone: (888) 342-5888

Fax: (727) 865-3649

If any Member is at a different address, please notify CCS in writing so we may send a separate notice to the separate household.

Section 14: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for an CHP individual policy (hereinafter referred to as a "converted policy" or "conversion policy") if:

1. you were continuously covered for at least three months under the Group Master Policy, and/or under another group policy with your Small Employer, that provided similar benefits immediately prior to the Group Master Policy; and
2. your coverage was terminated for any reason, including discontinuance of the Group Master Policy in its entirety and termination of continued coverage under COBRA or FHICCA.

Notify us in writing or by telephone if you are interested in a conversion policy. Within 14 days of such notice, we will send you a conversion policy application, premium notice and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Copayments and payment provisions.

We must receive a completed application for a converted policy and the applicable premium payment within the 63-day period beginning on the date the coverage under the Small Employer terminated. If coverage has been terminated, due to the non-payment of Premium by the Small Employer, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Master Policy terminated.

In the event we do not receive the converted policy application and the initial Premium payment within such 63-day period, your converted policy application will be denied and you will not be entitled to a converted policy.

Additionally, you are not entitled to a converted policy if:

1. you are eligible for or covered under the Medicare program;
2. you failed to pay, on a timely basis, the contribution required by the Small Employer for coverage under this Group Master Policy;
3. the Group Master Policy was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under this Group Master Policy; or
4. you commit fraud or intentional misrepresentation in applying for Membership or for any Covered Services;
5. you are terminated for cause as set forth in the Termination of Individual Membership for Cause subsection;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. a) You fall under one of the following categories and meet the requirements of 7.b. below
    1) you are covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Member Handbook; or
    2) you are eligible, whether or not covered, under any arrangement of

coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Member Handbook; or

3) benefits similar to the benefits provided under this Member Handbook are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and

b) the benefits provided under the sources referred to in paragraph 7.a)1) or the benefits provided or available under the source referred to in paragraphs 7.a)2) and 3) above, together with the benefits provided by our converted policy would result in over insurance in accordance with our over insurance standards, as determined by us.

We have no obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a CHP converted policy application and the initial Premium payment to us on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under the Group Master Policy terminated.

Note: Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Member Handbook. When applying for our converted policy, you have two options: 1) a converted policy providing coverage meeting the requirements of 641.3922 *Florida Statutes* or 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) *Florida Statutes*. In any event, we will not be required to issue a converted policy unless required to do so by Florida law.

We may have other options available to you. Call the telephone number on your Membership Card for more information.

Section 15: The Effect of Medicare Coverage

When you become covered under Medicare and continue to be eligible and covered under the Group Master Policy, our coverage will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, our coverage will be secondary to any Medicare benefits. To the extent we are the primary payer, claims for Covered Services should be filed with us first.

Under Medicare, your Small Employer MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, your Small Employer MAY NOT induce you to decline or terminate your group health coverage and elect Medicare as primary payer.

Working Elderly

If you become 65 or become eligible for Medicare due to End Stage Renal Disease (ESRD), you must notify your Small Employer.

Individuals with End Stage Renal Disease

If you are entitled to Medicare coverage because of ESRD, we will provide group health coverage on a primary basis for 30 months beginning with the earlier of:

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

If Medicare was primary prior to the time you became eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if the group health coverage was primary prior to ESRD entitlement, then the group health coverage will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, we will provide group health coverage, as described in this Member Handbook, on a primary basis for 30 months.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Group Master Policy.
2. We will not be liable to the Small Employer or to any individual covered under the Group Master Policy due to any nonpayment of primary benefits resulting from any failure of performance of the Small Employer's obligations as described in this section or in the Group Master Policy.
3. If we should elect to make primary payments for Covered Services rendered to a Member as described in this section in a period prior to receipt of the information required by the terms of this section, we may require the Small Employer to reimburse us for such payments. Alternatively, we may require the Small Employer to pay the Rate differential that resulted from the Small Employer's failure to provide us with the required information in a timely manner.

Section 16: Duplication of Coverage

Coordination of Benefits

Coordination of benefits ("COB") is a limitation of coverage and/or benefits to be provided by us. This provision is required by and subject to applicable federal and/or Florida law concerning coordination of health benefits and will be modified to the extent necessary to enable us to comply with such laws.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. We will coordinate payment of Covered Services to the maximum extent allowed by law provided you follow the Coverage Access Rules described in the Coverage Access Rules section.

It is your responsibility to provide us and your Physician with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If we do not receive the information we request from you, we may deny your claims and you will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies which may be subject to COB 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 health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile personal injury protection ("PIP") insurance policy and/or medical payment coverage in which the law permits us to coordinate benefits;
4. Medicare, as described in The Effect of Medicare Coverage; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of our payment, if any, when we coordinate benefits under this section, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to coverage under other plans. When we are not primary, our payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, if you receive Covered Services from a Contracting Provider, "total reasonable expenses", will mean the amount we are obligated to pay the Contracting Provider pursuant to the applicable provider contract. **In the event that the primary payer's payment exceeds the maximum amount established by us, no payment will be made for such Services.**

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

1. When we cover you as a Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.

2. When we cover 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 year of birth, and the other plan has covered one of the parents longer than us, we will be secondary.

3. When we cover a dependent child whose parents are separated or divorced:

    a) if the parent with custody is not currently married, the plan of the parent with custody is primary;

    b) if the parent with custody is currently married, 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 we cover a dependent child and the dependent child is also covered under another plan:

    a) the plan of the parent who is neither laid off nor retired will be primary; or

    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 you the longest shall be primary.

    We 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.

6. If you are covered under a COBRA or FHICCA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, or FHICCA, as amended, and also under another group plan, the following order of benefits applies:

    a) first, the plan covering the person as an employee, or as the employee's Covered Dependent;

    b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Covered Dependent provided according to the provisions of COBRA.

7. If the other plan does not have rules that establish the same order of benefits as under this plan, the benefits under the other plan will be determined primary to the benefits under this plan.

Facility of Payment

Whenever payments which are payable by us under the Group Master Policy are made by any other person, plan, or organization, we will have the right, exercisable alone and in our sole discretion, to pay to any such person, plan, or organization making such other payments, any amounts we determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under the Group Master Policy and, to the extent of such payments, we will be fully discharged from liability.

Non-Duplication of Government Programs and Worker's Compensation

The benefits under the Group Master Policy shall not duplicate any benefits to which you or

your Covered Dependents are entitled to, or eligible for, under government programs (e.g., Medicare, Medicaid, Veterans Administration, TRICARE) or Worker's Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 17: Subrogation

Subrogation

If you are injured or become ill as a result of another person’s or entity’s intentional act, negligence or fault, you must notify us concerning the circumstances under which you were injured or became ill. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. If you recover money to compensate for the cost/expense of Health Care Services to treat your illness or injury, we are legally entitled to recover payments made on your behalf to the doctors, hospitals, or other providers who treated you. Our legal right to recover money we have paid in such cases is called "subrogation." We may recover the amount of any payments we made on your behalf minus our pro rata share for any costs and attorney fees incurred by you pursuing and recovering damages. We may subrogate against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although we may, but are not required to, take into consideration any special factors relating to your specific case in resolving our subrogation claim, we will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believe that you have not been made whole for your losses or damages by the amount of the recovery or settlement.

You must do nothing to prejudice our right of subrogation hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 18: Right of Reimbursement

If any payment is made to you or on your behalf with respect to any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, we will have a right to be reimbursed by you (out of any settlement or judgment proceeds you recover) one dollar ($1.00) for each dollar paid minus a pro rata share for any costs and attorney fees incurred in pursuing and recovering such proceeds.

Our right of reimbursement will be in addition to any subrogation right or claim available to us, and you must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement hereunder. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must do nothing to prejudice our right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 19: Claims Review

Introduction

This section is intended to:

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

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

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

Types of Claims

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

Definitions

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

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Member Handbook with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.

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.

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 in writing coverage, benefits, or payment for that course of treatment or number of treatments.

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

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

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) that is received by us in a format acceptable to us 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 you and with respect to which the terms of this Member Handbook condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive 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 us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Member Handbook do not require approval by us 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 us. Experience shows that the most common type of claim we will receive from you or your treating providers will likely be Post-Service Claims.

Contracting Providers have agreed to file Post-Service Claims for Services they render to you. If you receive a bill from a Contracting Provider, it should be forwarded to us. If you require Emergency Services and Care from a Non-Contracting Provider while inside or outside the Service Area or, if we refer you to a Non-Contracting Provider, we will pay for Covered Services provided to you. If you receive a bill from a Non-Contracting Provider for such Services, it should be forwarded to us. We rely on the information you provide when processing a claim.

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

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

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);
3. the amount actually charged by the provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the provider's name and address;

6. the name of the individual who received the Service; and

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

Note*:* Please refer to the Prescription Drug subsection of the Covered Services section for information on the processing of prescription drug claims.

The Processing of Post-Service Claims:

We will use our best efforts to pay, contest, or deny all Post-Service Claims for which we have all of the necessary information, as determined by us. Post-Service Claims will be paid, contested or denied within the timeframes described below.

1. Payment for Post-Service Claims:

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

2. Contested Post-Service Claims:

   In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a paper Post-Service Claim, or a portion of such a claim, we will use our 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 we reasonably expect to notify you of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of the request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our 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 we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within 20 days of receipt that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our 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 your responsibility to ensure that we receive all information that we determine is necessary to adjudicate a Post-Service Claim. For claims submitted directly by participating providers, we will use our best efforts to obtain all information necessary to adjudicate the claim directly from the provider. **If we do not receive the necessary information, the claim or a**

portion of the claim may be denied.

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

4. Additional Processing Information for Post Service Claims:

   In any event, we will use our 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 us or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by us within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

Pre-Service Claims

How to file a Pre-Service Claim:

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

We are 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 you unless the terms of this Member Handbook require approval by us (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, we will use our 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, we will use our best efforts to provide notice within 24 hours of: (1) the need for additional information; (2) the specific information that you or the provider may need to provide; and (3) the date that we reasonably expect to provide notice of the decision. If we request additional information, we must receive it within 48 hours of the request. We will use our 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 you were afforded to provide the specified additional information as described above.

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

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

If additional information is necessary to make a determination, we will use our 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 you or the provider may need to provide; and (3) inform you of the date that we reasonably expect to notify you of the decision. If we request additional information, we must receive it within 45 days of the request for the information. We will use our best efforts to provide notice of the decision on the Pre-Service Claim within 15 days of receipt of the requested information.

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

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services:

A reduction or termination of coverage or benefits for Services will be considered an Adverse Benefit Determination when:

- We have 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 or 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 us was not due to an amendment to the Member Handbook or termination of your coverage as provided by this Member Handbook.

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Compliance and Grievance Process described in this Member Handbook. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services:

Your 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, we will use our best efforts to notify you 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 or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: (1) we need additional information; or (2) you, or your representative failed to follow proper procedures in the request for an extension. If we request additional information, you will have 48 hours to provide the requested information. we may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Member Handbook.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination:

We will use our 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 you free of charge upon request):

1. the specific reason or reasons for the Adverse Benefit Determination;

2. a reference to the specific Member Handbook provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

3. a description of any additional information that might change the determination and why that information is necessary;

4. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and,

5. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If the claim is a Claim Involving Urgent Care, we may notify you orally within the proper timeframes, provided we follow 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

1. Release of Information/Cooperation:

   In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

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

3. Legal Actions:

   No legal action arising out of or in connection with coverage under this Member Handbook may be brought against us within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

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

5. Communication of Claims Decisions:

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

   a) The specific reason or reasons for the Adverse Benefit Determination;

   b) Reference to the specific Member Handbook provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline,

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

c) a description of any additional information that would change the initial determination and why that information is necessary;

d) a description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

e) if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

4. Circumstances Beyond our Control:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we 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 our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section 20: Complaint and Grievance Process

Introduction

We have established a process for reviewing your Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, your dissatisfaction with us, our administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent Contracting Provider. The Complaint and Grievance Process also permits you, or your Physician, to expedite our review of certain types of Grievances. The process described below must be followed if you have a Complaint or Grievance.

Under the Complaint and Grievance Process, a Complaint will be handled informally in accordance with the Informal Review subsection set forth below. A Grievance will be handled formally in accordance with the Formal Review subsection described below. A request to review an Adverse Benefit Determination of a Pre-Service Claim, Post-Service Claim, or a Concurrent Care Decision will be handled in accordance with the terms of this section.

We encourage you to first attempt informal resolution of any dissatisfaction by calling us. If we are unable to resolve the matter on an informal basis, you may submit your formal request for review in writing.

Definitions

The following definitions will be referred to for purposes of this Complaint and Grievance Process section:

Ad Hoc Review Panel means a panel established by CHP to review Grievances related to Adverse Benefit Determinations made by CHP that an admission, availability or care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet CHP's 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.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Member Handbook with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.

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 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.

Complaint means an oral (i.e., non-written) expression of dissatisfaction, whether or not such dissatisfaction was made in person, by telephone, or 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 in writing coverage, benefits, or payment for that course of treatment or number of treatments.

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

Grievance means a written expression of dissatisfaction. You, a provider acting on your behalf, 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.

Informal Review - Complaints

To advise us of a Complaint, you should first contact a CHP Member Services Representative at CHP, either by telephone or in person. The telephone number is listed on the Membership Card, and the address of CHP 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 your satisfaction. If you remain dissatisfied with our resolution of the Complaint, you may submit a Grievance in accordance with the Formal Review subsection below.

Important Note:

You must provide to the Member Services Representative all of the facts relevant to the Complaint. Your failure to provide any requested or relevant information may delay our review of the Complaint. Consequently, you are obliged to cooperate with us in our review of the matter.

Formal Review - Grievances

You, a provider acting on your behalf, a state agency, or another person designated by you, may submit a Grievance. To submit or pursue a Grievance on your behalf, a healthcare provider must previously have been directly involved in your treatment or diagnosis. The form or letter must be mailed to the address listed in the Telephone Numbers and Addresses subsection.

How To Obtain Forms: We will provide you the form necessary to initiate a Grievance. You may obtain the necessary form by contacting a Member Services Representative at the number listed on the Membership Card. You are not required to use CHP's preprinted form.

If you need assistance in preparing the Grievance, you may contact us for such assistance. Hearing impaired Members may contact us via TDD (850/383-3534).

1. Level 1 Review:

    a) Standard Grievances

    In order to begin the formal review process, you must complete a form or write a letter explaining the facts and circumstances relating to the Grievance. You should provide as much detail as possible and attach copies of any relevant documentation. The Grievance Review Panel will review the Grievance in accordance with the standard Grievance procedure and advise you of its decision in writing. If the Grievance involves a Pre-Service Claim, our decision regarding the Grievance will be made within 15 days of receipt of the Grievance. If the Grievance involves a Post-Service Claim, our decision regarding the Grievance will be made within 30 days.

    If you remain dissatisfied with the decision of the Grievance Review Panel,

you may request a reconsideration of the decision by our Executive Grievance Panel as described in the Level 2 Review provision.

b) Ad Hoc Review Panel Grievance

In the event of a Grievance involving an Adverse Benefit Determination where a coverage determination by us 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 effectiveness, and coverage for the requested Service is therefore denied, reduced, or terminated, the Grievance will be reviewed by an Ad Hoc Review Panel. For you to have such an Adverse Benefit Determination Grievance reviewed by the Ad Hoc Review Panel, we must receive the review request within 30 calendar days from the date that you received a denial decision. To request this type of review, send a **written request and supporting documentation** within the 30-day time limit to the address listed in the Telephone Numbers and Addresses subsection.

If we do not receive the request for review by the Ad Hoc Panel within 30 calendar days, the denial decision will be reviewed by the Grievance Review Panel in accordance with the standard Grievance procedure. If the Grievance involves a Pre-Service Claim, our decision regarding the Grievance will be made within 15 days of receipt of the Grievance. If the Grievance involves a Post-Service Claim, our decision regarding the Grievance will be made within 30 days.

The Ad Hoc Review Panel will review the Grievance and may make a decision based on medical records, additional information, and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review. CHP will advise you of its decision in writing.

If you remain dissatisfied with the decision, you may request a reconsideration of the decision by the Executive Grievance Panel as described in the Level 2 provision.

c) Expedited Review of Urgent Grievances

In the event of a Grievance involving an Adverse Benefit Determination, you, or a person acting on your behalf, may request that the review of the Grievance be expedited. In order for a Grievance to be eligible for expedited review (i.e., a Claim Involving Urgent Care), it must meet the following criteria as determined by CHP:

You must be dissatisfied with an CHP Adverse Benefit Determination;

As determined by us, a delay in the provision of Health Care Services for the length of time permitted under the standard Grievance procedure time frames (approximately 30-60 working days) could seriously jeopardize your life or health, or your ability to regain maximum function, or in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed with the care

of treatment that is the subject of the claim; and

The health care provider involved has refused to or will not provide the needed medical Service without a guarantee of coverage or payment from you or us.

You, or a provider acting on your behalf, must specifically 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: (1) Pre-Service Claims; or (2) requests for extension of concurrent care Services made within 24 hours prior to the termination of authorization for such Services.

Information necessary to evaluate a Claim Involving Urgent Care may be transmitted by telephone, facsimile transmission, or such other expeditious method as is appropriate under the circumstances.

A Claim Involving Urgent Care will be evaluated by a health care professional who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the Condition, process, or treatment which you or the provider are requesting be reviewed.

We will make a decision and notify you, or the provider acting on your behalf, as expeditiously as the Condition requires, but in no event longer than 72 hours after receipt of the request for expedited review.

If your request for expedited review arises out of a utilization review determination by us 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 you have been notified of the determination.

We will provide written confirmation of our decision concerning Claims Involving Urgent Care within two working days after providing notification of that decision. If you are not satisfied with the decision, you may submit the Grievance to the Statewide Provider and Subscriber Assistance Panel.

5. Level 2 Review: Executive Grievance Panel

   In order to appeal the decision of the Level 1 Grievance or Ad Hoc Review Panel to CHP's Executive Grievance Panel, we must receive, within 30 days of the Level 1 decision, a form or a letter explaining why you feel that the Level 1 decision was wrong or not appropriate and what you would like us to do to remedy the matter.

   CHP's Executive Grievance Panel will review the Level 1 decision as quickly as possible and advise you of our decision in writing.

Statewide Provider and Subscriber Assistance Panel

You always have the right, at any time, to have a Complaint or a Grievance reviewed by the Florida Department of Financial Services, Division of Insurance Consumer Services; or the Agency for Health Care Administration or the Statewide Provider and Subscriber Assistance Panel. You may submit the Grievance to the Statewide Provider and Subscriber Assistance Panel within 365 days of the Executive Grievance Panel decision. Telephone numbers and addresses are listed in the Telephone Numbers and Address subsection. You must complete the entire Complaint and Grievance

Process and receive a final disposition from us before pursuing review by the Statewide Provider and Subscriber Assistance Panel.

Time Frames for Resolution of a Grievance

We will resolve Grievances in a timely manner. In resolving Grievances, time frames may vary depending on the circumstances, between the Level 1 and Level 2 review. We will, however, resolve your Grievance within 30 days after receipt for Pre-Service Claims, or within 60 days for Post-Service Claims.

General Rules

General rules regarding our Complaint and Grievance Process include the following:

1. You must cooperate fully with us in our effort to promptly review and resolve a Complaint or Grievance. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the Complaint or Grievance processed within the time frames set forth above.
2. We will offer to meet with you if you believe that such a meeting will help us resolve the Complaint or Grievance to your satisfaction. For your convenience, and at your option, you may elect to meet with our representatives in person, or by telephone conference call. We will not reimburse you for travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing to be held at CHP's administrative offices within the Service Area. We will make these telephone arrangements with no additional charge to you. You must notify us that you wish to meet with our representatives concerning the Complaint or Grievance.
3. The time frames set forth herein may be modified by the mutual consent of CHP and you, however, any mutually agreed time frame extension does not preclude you from having our decisions reviewed by the Statewide Provider and Subscriber Assistance Panel at any time.
4. We will not honor a request for expedited review that relates to Services that have already been performed, rendered, or provided to you or a request that is not eligible for expedited review in accordance with the criteria set forth in the Expedited Review of a Claim Involving Urgent Care provision. We will process any such Grievance, however, in accordance with the standard Grievance procedure.
5. We must receive all Grievances within one year of the date of the occurrence that initiated the Grievance.
6. If the Grievance involves a determination that the Services did not meet CHP's Medical Necessity guidelines for coverage of a Service or that the Service is excluded because it meets the definition of an Experimental or Investigational Service or a similar exclusion or limitation, then you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Member Handbook to your medical circumstances.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. You may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Plan. If ERISA applies to the Group Plan, the Subscriber or the Subscriber's covered Dependents are entitled, after exhaustion of the appeal procedures provided for in the Complaint and Grievance Process section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Telephone Numbers and Addresses

You may contact a CHP Grievance Coordinator at the number listed on the Membership Card or the numbers listed below. If a Grievance is unresolved, you may, at any time, contact CHP at the telephone numbers and addresses listed below.

Capital Health Plan
Member Services
1545 Raymond Diehl Road, Suite 300
Tallahassee, FL 32308
(850) 383-3311
TDD: 850-383-3534

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

Web page: http://www.capitalhealth.com

Florida Department of Financial Services
Division of Insurance Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399-0322
1-800-342-2762

Statewide Provider and Subscriber Assistance Program
2727 Mahan Drive, Building 1, Room 301, Mail Stop-27A
Tallahassee, Florida 32308
1-850-921-5458
1-888-419-3456

Agency for Health Care Administration
2727 Mahan Drive, Building 1, Mail Stop 27
Tallahassee, FL 32308
1-888-419-3456

Section 21: Relationships Between the Parties

CHP and Health Care Providers

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 we make concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. Neither CHP nor the Small Employer will assume liability for any loss or damage arising as a result of acts or omissions of any health care provider.

Members and Providers

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

CHP and the Small Employer

Neither the Small Employer nor any Member is our agent or representative, and neither shall be liable for any acts or omissions by our agents, servants, employees or us. Additionally, we will not be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. We are not your agent, servant, or representative nor are we an agent, servant, or representative of the Small Employer and we will not be liable for any of your acts or omissions, or those of the Small Employer, its agents, servants, employees, or any person or organization with which the Small Employer has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Decisions--Responsibility of Member's Physician, Not CHP

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

Section 22: General Provisions

Access to Information

We have the right to receive, from you and any health care provider rendering Services to you, information that is reasonably necessary, as determined by us, in order to administer the coverage and benefits we provide, subject to all applicable confidentiality requirements described below. By accepting coverage, you authorize every health care provider who renders Services 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

We may amend the terms of coverage and benefits to be provided by us at renewal of the Group Master Policy, without your consent, or the consent of the Small Employer or any other person, upon 45 days prior written notice to the Small Employer. In the event the amendment is unacceptable to the Small Employer, the Small Employer may terminate the Group Master Policy upon at least ten days prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to Covered Services prior to the date of such amendment. No agent or other person, except a duly authorized officer of CHP, has the authority to modify the terms of the Group Master Policy, or to bind us in any manner not expressly described herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The Small Employer may not amend the terms of coverage and benefits to be provided by us unless such amendment is evidenced in writing and signed by a duly authorized officer of CHP. The Small Employer is required to notify you of any such amendment and/or to assist us in notifying you at our request.

Assignment and Delegation

Your obligations arising hereunder may not be assigned, delegated or otherwise transferred by you without our written consent. We may assign our coverage and benefit obligations to our successor in interest or an affiliated entity without the consent of you or the Small Employer at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Attorney Fees: Enforcement Costs

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

Changes in Premium

We may modify the Rates at any time, without your consent, upon at least 30 days prior notice to the Small Employer. It is the Small Employer’s responsibility to immediately notify you if your financial contribution requirement is changed due to a change in Rates.

Complaint and Grievance Process

We have established and will maintain a process for hearing and resolving your grievances as described in the Complaint and Grievance Process section of this Member Handbook. You are required to first bring grievances to the attention of a CHP Grievance Coordinator or Member Services Representative, at the CHP Office.

If you file any action or complaint regarding Services you received (including, without limitation, the filing of a lawsuit, administrative action, or grievance) against us or a Contracting Provider, we will have the right to receive from any health care provider rendering Services to you information and records reasonably necessary to investigate the allegations in such action or complaint. This right includes, without limitation, your authorization for us, or our legal representatives, to discuss your Condition with, and receive all relevant reports and records from, Contracting Providers and Non-Contracting Providers who provided Services to you, or consulted with you, as a result of injuries alleged in any action or complaint, even if such Services or consultations are provided subsequent to termination of coverage. The authorization described in this section survives the termination of our coverage.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under the Group Master Policy shall be deemed to have been modified 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.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received from providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties, and by accepting coverage you hereby authorize us to disclose such information, for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and utilization review activities. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist us in providing coverage, benefits or Services under this Group Master Policy. Further, 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.

Our arrangements with Contracting Providers may require that we release certain claims and medical information about you even if you have not sought treatment by or through that provider. By accepting coverage, you hereby authorize us to release to Contracting Providers claims information, including related medical information, pertaining to you in order for the Contracting Provider to evaluate financial responsibility under their contracts with us.

Cooperation Required of You and Your Covered Dependents

You must cooperate with us, and must execute and submit to us any consents, releases, assignments, and other documents we may request in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause by us. (See the

Termination of Individual Coverage for Cause subsection in the Termination of Coverage section.)

ERISA

We are not the plan sponsor or plan administrator, as defined by Employee Retirement Income Security Act (ERISA). If the group health plan under which you are covered is subject to ERISA, the Small Employer, as either plan sponsor or plan administrator of an employee welfare benefit plan subject to ERISA, is responsible for ensuring compliance with ERISA.

Evidence of Coverage

You have been provided with this Member Handbook and a Membership Card as evidence of coverage under the Group Master Policy issued by us to the Small Employer.

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.

Membership Cards

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

Modification of Provider Network

We may change our provider network at any time without prior approval of, or notice to, you or the Small Employer. 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, or approval of you or the Small Employer.

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 described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will 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, the Small Employer Master Policy, or this Member Handbook.

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 listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

If to us:

To the address printed on the Group Application and/or the Membership Card.

If to you:

To the latest address provided by you or to your latest address on the Enrollment Forms actually delivered to us.

You must notify us immediately of any address change.

If to Small Employer:

To the address indicated on the Group Application.

Our Obligations upon Termination

Upon termination of your coverage for any reason, we will have no further liability or responsibility to you under the Group Master

Policy with respect to such individual, except as specifically described herein.

Promissory Estoppel

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

Right of Recovery

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

Right to Receive Necessary Information

In order to administer coverage and benefits, we may, without the consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to you or any applicant for enrollment that we deem to be necessary.

Types of HMOs

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. Here are a few important ways these types of HMOs differ:

Staff and Group Model HMOs:

In a staff model HMO, the doctors and other providers providing 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 and Network 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 provide 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.

In a network model HMO, the HMO contracts with individual, independent doctors, IPAs, and/or medical groups to make up a health care network. Unlike the staff or group model HMOs, the network model HMO does not provide health care services itself. Instead, it pays independent, qualified providers to provide health care. The doctors in a network model HMO are not the employees of the HMO and typically practice in their own personal offices. Like the IPA model HMO, doctors under contract with a network model HMO usually continue to see patients covered by other third party payers or managed care organizations.

Mixed Model HMO's:

A mixed model HMO is a combination of two other types. This type of HMO provides care through HMO-employed physicians and other providers, and through contracts with

individual, independent physicians or groups of physicians to make up a provider network.

Note: This description is not intended to be an exhaustive listing of all HMO organization models in use in the United States.

Capital Health Plan is a mixed model HMO. This means that the physicians practicing in the CHP facilities are employees of CHP. The other doctors and providers with whom we contract are independent contractors and not the employees or agents, actual or ostensible, of Capital Health Plan. Rather these independent doctors and providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

Section 23: Statement on Advance Directives

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

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

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

There are three types of documents recognized in Florida commonly used to express an individual's advance directives: a Living Will, a Healthcare Surrogate Designation and a Durable Power of Attorney for Healthcare.

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

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

Finally, there is the Durable Power of Attorney for Healthcare. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical condition.

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 and your health care provider cannot condition treatment on whether or not you have

one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

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

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

It is our policy to recognize your right to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an advance directive to guide treatment decisions in the event you become unable to do so. We will not interfere with your decision. It is your responsibility to provide notification to your providers that an advance directive exists. If you have a written advance directive, we recommend that you furnish your providers with a copy so that it can be made a part of your medical record.

Pursuant to §765.308 of the *Florida Statutes*, Florida law does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a provider or facility in the CHP network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another provider or facility.

CHP providers have, in accordance with state law, varying practices regarding the implementation of an individual's advance directive. Therefore, we recommend that you have discussions about advance directives with your medical caregivers, family members and other friends and advisors. Your physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical condition or environment.

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

Agency for Health Care Administration
Bureau of Managed Health Care
Building 1, Room 311
2727 Mahan Drive
Tallahassee, Florida 32308

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law.

Section 24: Definitions

The following definitions are used in this Member Handbook. Other definitions may be found in the particular section or subsection where they are used.

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

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

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 a similar applicable law 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 date, one year after the Effective Date, stated on the Group Application, and subsequent annual anniversaries.

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

Birth Center means a facility or institution other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the *Florida Statutes*, or a similar applicable law of another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. 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 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 (e.g., 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.

Calendar Year means a period of time that begins January 1st and ends December 31st.

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 464 of the *Florida Statutes*, or a similar applicable law of another state, as an advanced registered nurse practitioner 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 registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

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

Contracting Provider means any health care institution, facility, pharmacy, Physician, or other health care provider who has entered into a contract with us for the provision of Health Care Services.

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

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Subscriber. (See the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section.)

Covered Prescription Drugs means all Drugs and supplies that, under federal or state law, require a Prescription and which are covered. Sometimes Covered Prescription Drugs and Supplies will be referred to in the singular as Covered Prescription Drug and/or Supply.

Covered Services means those Health Care Services which meet the criteria listed in the Coverage Access Rules and Covered Services sections.

Creditable Coverage means health care coverage that may include any of the following:

1. A group health plan;
2. Individual health insurance;
3. Part A and Part B Medicare;
4. Medicaid;
5. Benefits to members and certain former members of the uniformed services and their Covered Dependents;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of Title 5, United States Code;
9. A public health plan; or
10. A health benefit plan of the Peace Corps.

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

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the 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.

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

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

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law 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 (CMS) and the Florida Agency for Health Care Administration (AHCA) (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.

Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health

Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

Effective Date means, with respect to the Small Employer, 12:01 a.m. on the date specified on the Group Application. With respect to individuals covered under the Group Master Policy, Effective Date means 12:01 a.m. on the date the Small Employer specifies that the coverage will commence as described in the Enrollment and Effective Date of Coverage section of the Member Handbook.

Eligible Dependent means an individual other than the Subscriber who meets all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection.

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Subscribers subsection and is eligible to enroll as a Subscriber. Any individual who is an Eligible Employee is not a Subscriber until such individual has actually enrolled with, and been accepted for coverage as a Subscriber by us.

Emergency Medical Condition, as indicated in the Member's chart by a Physician or, to the extent permitted by law, by other appropriate licensed professional Hospital personnel under the supervision of a Hospital Physician, means

1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    a) serious jeopardy to the health of a patient, including a pregnant woman or fetus.
    b) serious impairment of bodily functions.
    c) serious dysfunction of any bodily organ or part.
2. With respect to a pregnant woman:
    a) that there is inadequate time to effect safe transfer to another hospital prior to delivery;
    b) that a transfer may pose a threat to the health and safety of the patient or fetus; or
    c) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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

Endorsement means an amendment to the Group Master Policy or the Member Handbook issued by us.

Enrollment Date means the date of enrollment of the individual or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those CHP forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under the Group Master Policy. Such forms may include the Small Employer Application/True Group Application and the Member Status Change Request Form.

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; or
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; or
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; or
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; or
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; or
6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or
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 and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution

studying substantially the same evaluation, treatment, therapy, or device;

5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services that are determined by us to be Experimental or Investigational are excluded. (See the Covered Services section.) In determining whether a Health Care Service is Experimental or Investigational, 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.

FDA means United States Food and Drug Administration.

Foster Child means a person who is placed in your residence and care under the Foster Care Programs by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state's applicable laws.

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 fallopian tube.

Gene Therapy means treating disease by replacing, manipulating, or supplementing nonfunctioning or malfunctioning genes.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Drug that either (i) has been approved by the United States Food and Drug Administration (FDA) for sale or distribution as the bioequivelant of a Brand Name 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 Drug, is legally marketed in the United States and, in the judgment of CHP, is marketed and sold as a generic competitor to its Brand Name 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 Drug.

Group Application means the CHP form, electronic (where available) or paper, including the underwriting questionnaire form, if any, that the Small Employer must submit to us when applying for coverage.

Group Master Policy means the written document, which is the agreement between the Small Employer and us, whereby coverage and benefits will be provided to you and your Covered Dependents. The Group Master Policy includes the Member Handbook (including the Schedule of Copayments), the Group Application, the Enrollment Forms, and any Endorsements to this Member Handbook or the Group Master Policy.

Group Plan means the employee welfare benefit plan established by the Small Employer.

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, providers.

CHP means Capital Health Plan, a Florida Corporation (and any successor corporation) operating as a health maintenance organization under applicable provisions of federal and/or state law.

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

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical Services and personal care 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, which is duly licensed by the State of Florida under applicable law, 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 which primarily provides Custodial educational, or rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities or 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.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

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

Lifetime Maximum means the total amount of Covered Services payable to you by us under the Group Master Policy and any renewals thereof. The Lifetime Maximum is set forth in the Schedule of Benefits.

Massage Therapist means a person properly licensed to practice massage therapy pursuant

to Chapter 480 of the *Florida Statutes*, or a similar applicable law of another state.

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

Medical Director means a Physician serving as Medical Director for CHP.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means, in accordance with our guidelines and criteria then in effect, for coverage and payment purposes, that a Health Care Service is required for the identification, treatment, or management of a Condition, and is, in the opinion of CHP:

1. consistent with the symptom, diagnosis, and treatment of the Member's Condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. universally accepted in clinical use such that omission of the Service in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not Experimental or Investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of the Member, the Member's family, the Physician or other provider, or solely for allowing you or a member of your family to return to work; and,
7. the most appropriate level of Service which can safely be provided to the Member; and
8. in the case of inpatient care, the Health Care Service(s) cannot be provided safely in an alternative setting.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Member means any Subscriber or Covered Dependent.

Membership means having the status of being a current Member.

Membership Card means the identification card(s) we issue to Subscribers. The card is our property, and is not transferable to another person. Possession of a card in no way verifies that a particular individual is eligible for, or covered, under the Group Master Policy.

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 or sect who are not licensed to provide counseling services pursuant to Chapter 491.

Mental and Nervous Disorders means any and all disorders listed in the diagnostic categories of the most recently published edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the *Florida Statutes*, or a similar applicable law of another state.

Non-Contracting Provider means any health care institution, facility, pharmacy, Physician, or other health care provider with whom we do not have a contract in effect at the time the Health Care Services are provided.

Non-Participating Pharmacy means a retail Pharmacy that has not signed an agreement with CHP to render services to Members.

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

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 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.

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

Orthotist means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide services consisting of the design, fabrication and fitting of Orthotic Devices.

Partial Hospitalization means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Participating Pharmacy means a retail Pharmacy that has signed an agreement with CHP to dispense Covered Prescription Drugs and/or Covered Supplies to Members.

Pharmacist means a person properly licensed to practice the profession of Pharmacy pursuant to Chapter 465 of the *Florida Statutes*, or other states' applicable laws.

Pharmacy means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the *Florida Statutes,* or other states' applicable laws.

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 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 heat 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 pursuant to Chapter 458 of the *Florida Statutes*, or a similar applicable law of another state.

Preferred Brand Name Prescription Drug means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect.

Preferred Medication List means a list of preferred Drugs for which CHP provides coverage and benefits.

Prescription means an order for medications or medicinal supplies by a Physician authorized by the laws of the state to prescribe such Drugs or supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed pursuant to 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."

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

Primary Care Physician (PCP) means the Physician who is the PCP for the Member, according to our records, and who provides primary care medical Services to Members under a PCP provider contract with us then in effect. A PCP 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 PCP. Refer to the PCPs who are listed as PCPs in the *Directory of Physicians and Service Providers* .

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 malfunctioning body part or organ.

Prosthetist means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide services consisting of the design, fabrication and fitting of Prosthetic Devices.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the care and treatment of Mental and Nervous Disorders. For purposes of this Member Handbook, 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.

Rate(s) means the amount CHP charges the Small Employer for each type of coverage under the Group Master Policy (e.g., Employee Only Coverage).

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.

Service Area means the geographic area(s) described in Attachment A.

Skilled Nursing Facility means an institution or part thereof which meets CHP's 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; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by CHP.

Small Employer means any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employs an average of at least one but not more than 50 Eligible Employees on business days during the preceding Calendar Year, and employs at least one employee on the first day of the plan year, through which coverage and/or benefits are issued by CHP, and through which Eligible Employees and Eligible Dependents become entitled to the Covered Services described herein.

Specialist means a Physician, who is a Contracting Provider, or a Physician who is a Non-Contracting Provider when authorized by us, who limits practice to specific Services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems

(e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board. (Refer to the Physicians who are listed as Specialty Physicians in the CHP *Directory of Physicians and Service Providers.)*

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 the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy Services.

Standard Reference Compendium means 1) *The United States Pharmacopoeia Drug Information*; 2) *The American Medical Association Drug Evaluation*; or 3) *The American Hospital Formulary Service Hospital Drug Information*.

Subscriber means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered under the Group Master Policy other than as a Covered Dependent. (See the Eligibility Requirements for Subscribers subsection of the Eligibility for Coverage section.)

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 the purposes of this Member Handbook, 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 his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Urgent Care means medical screening, examination, and evaluation received in an Urgent Care Center or rendered in your Primary Care Physician's office after-hours and the covered services for those conditions which (1) could seriously jeopardize the Member's 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.

Waiting Period means the period of time specified on the Group Application, if any, which must be met by an individual before that individual is eligible for coverage under the Group Master Policy.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the resulting 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.

Attachment A: Service Area

Capital Health Plan Service Area – includes only the following counties:

Gadsden
Jefferson
Leon
Wakulla