Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Conversion Option A

For Individuals Under 65

Non-Group Contract

Capital Health Plan
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SECTION 1: INTRODUCTION TO THE CONTRACT

Thank you for your application to convert to the CAPITAL GROUP HEALTH SERVICES OF FLORIDA, INC., Non-Group Membership Conversion Contract. This Contract provides coverage for certain Covered Services following conversion from Group to Non-Group Membership and is not intended to provide a continuation of coverage for the Covered Services provided by the Group Contract from which you converted.

We want you to understand and be satisfied with the terms of this Contract. The words "you" and "your" are used to mean you, the Subscriber and your Dependents.

CAPITAL GROUP HEALTH SERVICES OF FLORIDA, INC., D/B/A CAPITAL HEALTH PLAN (referred to as "CHP" in this Contract), in consideration of your application for coverage, payment of the first Prepayment Fee, or premium, and CHP's acceptance of the application, hereby agrees to provide coverage for health care services in accordance with and subject to the terms of this Contract. CHP undertakes to organize, provide, arrange for or otherwise make available to its Members, the health care services described in this Agreement. The interpretation of this Agreement shall be guided by the direct service nature of the CHP program and its objectives of promoting community health.

DISCRETIONARY AUTHORITY: CHP has the discretionary authority to determine Covered Services, and to construe the terms of this Contract.

SECTION 2: DEFINITIONS

For the purpose of this Contract and any attachments and endorsements, the following terms shall have the meanings set forth below:

Accidental Dental Injury means an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional, and unexpected event or force. It does not include injuries to natural teeth caused by biting or chewing.

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

Application means the Application for CHP Individual Conversion Coverage form provided by or acceptable to CHP, which an individual must complete and submit to CHP in order to apply for conversion to Non-Group Membership.

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

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative 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 or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all hospital, physician or other health care provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

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

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

Certified Registered Nurse Anesthetist means a 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 other states' applicable laws.

CHP means CAPITAL GROUP HEALTH SERVICES OF FLORIDA, INC., a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of Federal and/or State law.

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

Contract means this Non-Group Membership Conversion Contract, your application for coverage, any endorsement, and other attachments described herein and attached hereto.

Contract Year means that time period commencing on the Effective Date of this Contract and ending on the last day of the twelfth (12th) month immediately succeeding the Effective Date of this Contract.

Copayment means the dollar amount required to be paid by a Member in connection with certain Covered Services or supplies as set forth in the Covered Services Section and any endorsement attached hereto.

Covered Services means those health care services and supplies which are specifically set forth in the Covered Services Section of this Contract. Such services must be rendered by an appropriate licensed health care provider who is recognized for payment under this Contract and not otherwise excluded in this Contract.

Dependent means a person who meets and continues to meet all of the applicable eligibility requirements set forth in the *Eligibility Requirements for Dependents* subsection, is properly enrolled hereunder through submission of an Application or Member Status Change Request Form, as applicable, by his or her Subscriber, and for whom, or on whose behalf, Prepayment Fees and any Supplemental Charges have been received by CHP.

Diabetes Educator means a person who is properly certified pursuant to Florida law to supervise diabetes outpatient self-management training and educational services.

Effective Date with respect to this Contract and to Members properly enrolled when this Contract becomes effective means 12:01 a.m. on the first day subsequent to the termination date of the Member's coverage under the Group Contract, as determined by CHP; and with respect to Members subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section.

Emergency Medical Condition as defined in the Covered Services Section.

Emergency Services and Care as defined in the Covered Services Section.

Exclusions means those services and supplies that are not Covered Services, as set forth in the Exclusions and Limitations Section of this Contract.

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 CHP:

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

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

3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;

4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published medical literature in the United States, Canada or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or

8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by CHP):

1. records maintained by physicians or hospitals rendering care or treatment to the Insured or other patients with the same or similar Condition;

2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

4. the written protocol or protocols relied upon by the treating physician or institution or the protocols of another physician or institution studying substantially the same evaluation, treatment, therapy, or device;

5. the written informed consent used by the treating physician or institution or by another physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

   NOTE: Services or supplies which are determined by CHP to be Experimental or Investigational are excluded under this Contract (see Exclusions and Limitations Section). In making Covered Service determinations under this Contract, CHP 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.

Full-time Student means a student who is enrolled in an accredited school for a sufficient number of credit hours in a semester or other academic term to enable the student to complete the course of study within not more than the number of semesters or other academic terms normally required to complete that

course of study on a full-time basis at the school in which the student is enrolled. CHP determines if a child is a Full-time Student.

Group means the employer, labor union, trust, association, partnership, department, other organization or entity through which eligible Members become entitled to the Covered Services described herein.

Group Contract means the CHP Group Health Services Agreement under which you were a Member immediately preceding your conversion to this Contract.

Home Health Agency means a properly licensed agency or organization which provides health services in the home pursuant to Chapter 400 of the *Florida Statutes*, or other states' applicable laws.

Hospice means a public agency or private organization which is duly licensed by the State to provide hospice services, and with whom CHP has a current Participation Agreement. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital means an institution:

1. which is licensed by a State; and accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, American Osteopathic Association, or other accrediting organization acceptable to CHP, unless such accreditation requirement has been waived by CHP; and

2. which is operated pursuant to law, under the supervision of a staff of physicians with twenty-four (24) hour a day nursing service, and which is primarily engaged in providing:

    a. general inpatient medical care and treatment of sick or injured persons through medical, diagnostic and major surgical facilities on the premises or under its control; or

    b. specialized inpatient medical care and treatment of sick or injured persons through medical or diagnostic facilities (including x-ray and laboratory) on its premises and under its control or, through a written agreement with a hospital (as defined above) or specialized provider of those facilities; and

3. which is not a convalescent nursing home or an institution which:

    a. is used primarily as a convalescent facility, rest facility, or facility for the aged, or

    b. furnishes principally domiciliary or custodial care, or

    c. is operated primarily as a school.

Low-risk Pregnancy means a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the Department of Health and Rehabilitative Services, and which is accompanied by adequate pre-natal care.

Medical Director of CHP means a Physician serving as the Medical Director of Capital Health Plan.

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

Medically Necessary or Medical Necessity means a medical service or supply that is required for the identification, treatment, or management of a Condition if, in the opinion of the Medical Director of CHP, it is: (1) consistent with the symptom, diagnosis, and treatment of the Member's Condition; (2) widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence; (3) universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; (4) not Experimental or Investigational; (5) not for cosmetic purposes; (6) not primarily for the convenience of the Member, the Member's family, the Physician or other provider; and (7) the most appropriate level of service, care or supply which can safely be provided to the Member. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Member in an alternative setting.

Medical Services Agreement means a written agreement entered into by CHP and one or more Primary Care Physicians for the provision of Covered Services to Members.

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.

Member means any Subscriber or Dependent.

Membership means having the status of being a current Member.

Membership Card means the identification card issued by CHP to Members enrolled under this Contract. The Membership Card is the property of CHP, and is not transferable to another person. Possession of such Membership Card in no way verifies eligibility to receive Covered Services under this Contract.

Member Status Change Request Form means the form(s) provided by or acceptable to CHP, which a Subscriber must complete and submit to CHP when adding or deleting a Dependent.

Mental and Nervous Disorders means any and all mental illnesses, Conditions, or disorders, including but not limited to all disorders set forth 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, or the disorder. Examples include, but are not limited to: attention-deficit hyperactivity; anorexia nervosa; bulimia; bipolar affective disorder; autism; mental retardation; and Tourettes' disorder.

Midwife means any person not less than eighteen (18) years of age, other than a licensed Physician or Certified Nurse Midwife, who is licensed pursuant to Chapter 467 of the *Florida Statutes* to supervise the delivery of a child.

Non-Participating Provider means any health care institution, facility, agency, pharmacy, Physician, or other health care provider with whom CHP does not have a Participation Agreement or Medical Services Agreement in effect at the time the health care services or supplies are provided.

Participating Provider means any health care institution, facility, agency, pharmacy, Physician, or other health care provider properly licensed by the State and which provides health care services or supplies to Members under a Participation Agreement then in effect.

Participation Agreement means any written agreement entered into by CHP and a Hospital, health care institution, facility, agency, pharmacy, Physician, or other health care provider under which such person or entity provides Covered Services which are referral, institutional, or other non-primary care services to Members.

Physician means any individual who is licensed by the State as a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Chiropractic, or Doctor of Ophthalmology.

Prepayment Fee means the amount required to be paid periodically, as set forth in the Payments Section of this Contract.

Primary Care Physician means the Physician who is the Primary Care Physician of record for the Member and who provides primary care medical services to Members under a Medical Services Agreement with CHP then in effect.

Reasonable Charges means charges, rates, or fees which CHP deems appropriate, based upon many factors, including but not limited to the cost of providing the services or supplies; the charge(s) of the provider; the charge(s) of similar providers within a particular geographic area, as established by CHP; various pre-negotiated payment allowances; and pre-established fee schedule. In any event, Reasonable Charges will not be greater than the amount the provider actually charges the Member (i.e., the amount the Member is obligated to pay to the provider). The Reasonable Charge allowance for a particular service or supply may be modified by CHP at any time without the consent or notice to any Member.

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

Skilled Nursing Facility means an institution or part thereof which is licensed as a skilled nursing facility by the State, 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; and which provides Covered Services that are skilled nursing services, as determined by CHP, to Members under a Participation Agreement then in effect.

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

State means the State of Florida or any other state of the United States in which CHP is authorized and licensed to operate and in which a Service Area has been established.

Subscriber means a person who is not a Dependent, who meets all applicable eligibility requirements of the *Eligibility Requirements for Subscribers* subsection, who enrolls hereunder, and for whom the payment(s) required by this Contract has been received by CHP.

Supplemental Charges means amounts which must be paid for Covered Services provided under endorsements that are part of this Contract.

SECTION 3: TERM OF CONTRACT

This Contract shall become effective as of the Effective Date provided that CHP accepts the application, and that the individual pays the applicable initial Prepayment Fee not later than 63 days after termination of Membership. This Contract, as it may be modified from time to time, shall continue until terminated in accordance with the provisions of this Contract.

SECTION 4: ELIGIBILITY FOR MEMBERSHIP

Each individual who was a Member under a Group Contract for at least three (3) months immediately prior to termination, who is eligible to convert his or her Membership to non-group Membership pursuant to the terms of the Group Contract and this Contract, and who meets and continues to meet all of the eligibility requirements described in this Contract shall be entitled to non-group Membership. Additionally, newly-acquired dependents of Members may be eligible for Membership in accordance with the terms of this Contract.

Eligibility Requirements for Subscribers

To be eligible to become a Subscriber under this Contract, and to remain eligible to be a Subscriber, a person must:

1. no longer be eligible for CHP Group Coverage;

2. maintain his/her primary residence in the Service Area;

3. have continuous previous coverage under a Group Contract for at least three (3) months immediately prior to termination;

4. meet any other applicable eligibility requirement set forth in this Contract.

You shall not be eligible for coverage under this Contract for the following reasons:

1. if you had not been continuously covered under a Group Contract for at least three (3) months prior to your termination; or

2. if termination of your Group Contract occurred because of your failure to pay any required Prepayment Fee, Supplemental Charge, or Member contribution (e.g., Copayments) unless such nonpayment was due to acts of an employer or person other than the individual; or

3. because your discontinued Group coverage was replaced by similar Group coverage within thirty-one (31) days of termination; or

4. because you provided fraudulent information or material misrepresentation in applying for Membership under this Contract; or

5. if termination of your Group Contract occurred for cause as set forth in the *Termination of Individual Membership for Cause* subsection of the Group Contract; or

6. if you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or

7. if you are eligible for Medicare, Title XVIII of the Social Security Act of 1965.

Additionally:

1. if you are eligible for similar benefits, whether or not covered under any arrangement of coverage for individuals in a group, whether on an insured or non-insured basis; or

2. if you are eligible for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service insured contract or medical practice or other prepayment plan, or by any other plan or program; or

3. if similar benefits are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (i.e., COBRA); and

4. if the benefits provided or available to you, together with the benefits of this Contract, would result in excess of coverage, as determined by CHP.

Eligibility Requirements for Dependent(s)

To be eligible to become a Dependent, and to remain eligible to be a Dependent, a person must meet and continue to meet each of the eligibility requirements set forth in the ***Eligibility Criteria for Subscribers*** subsection of this Contract; and:

1. be the present spouse of a Subscriber; or

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

a. unmarried, and principally dependent upon the Subscriber for financial support as determined by CHP; and

b. (1) under nineteen (19) years of age and maintaining his/her primary residence in the Service Area (eligibility terminates at the end of the month in which the Dependent has his or her nineteenth (19th) birthday); or

(2) under twenty-three (23) years of age and enrolled in an accredited school as a Full-time Student and attends class on a regular basis. Semester breaks do not jeopardize a child's full-time status. However, if a child is not a Full-time Student for the entire semester immediately following such break, that child will not be considered a Dependent as of the first day of such following semester (eligibility will terminate on the last day of the month in which the child no longer meets any of the requirements for extended eligibility as a Dependent child); or

(3) a Dependent child, nineteen (19) years of age or older who is, in the opinion of CHP, incapable of self-sustaining employment as a result of mental retardation or physical handicap which commenced prior to the time such Dependent reached his or her 19th birthday, and who is principally dependent on the Subscriber for support and maintenance. If a child attains the limiting age for a Covered Dependent (see the Eligibility for Membership provision), Coverage will not terminate while that person is, and continues to be, both:

a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

b. Chiefly dependent on the Covered Employee for support and maintenance.

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

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

Other Requirements/Rules Regarding Eligibility

1. A foster child shall in no event be eligible to be a Member under this Contract.

2. No individual whose Membership in CHP has been terminated for cause (see the *Termination of Membership For Cause* subsection) shall be eligible to re-enroll in CHP.

3. No person shall be refused enrollment or re-enrollment in CHP because of race, color, creed, marital status, sex, age (except as provided in the *Eligibility Requirements for Dependents* subsection above), health status, requirements for health services or the prospective costs thereof, or the existence of a mental or physical Condition.

4. The Subscriber must notify CHP as soon as possible when a Dependent Member becomes no longer eligible for Membership (for example, no longer a Full-Time Student). If a Dependent fails to continue to meet each of the eligibility requirements under this Contract, and such proper notification is not timely provided by the Subscriber to CHP, CHP shall have the right to retroactively terminate Membership of such Dependent to the date any such eligibility requirement was not met, and to recover an amount equal to the Reasonable Charges for services and/or supplies provided following such date less any Prepayment Fees and Supplemental Charges received by CHP for such Dependent for coverage after such date. Upon CHP's request, the Subscriber shall provide proof, which is acceptable to CHP, of a Dependent's continuing eligibility for Membership.

SECTION 5: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Individuals who meet all of the eligibility requirements for conversion to Non-Group Membership under the Group Contract and under this Contract may apply for Membership, according to the provisions set forth below.

General Rules for Enrollment

1. All factual representations on the enrollment forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) CHP may have, in disqualification for, termination of, or rescission of Membership.

2. CHP shall not be required to provide Covered Services to any individual who would not have been entitled to Membership in CHP had accurate and complete information been provided on a timely basis on the Non-Group Membership Conversion Contract Application. In such cases, CHP may require such individual, or an individual legally responsible for that individual, to reimburse CHP for any such Covered Services provided or payments made by CHP on behalf of such individual.

3. Individuals, including Subscribers and Dependents, not enrolled when first eligible for Membership under this Contract may not be enrolled.

Enrollment of Members/Effective Date

To apply for coverage under this Contract, the individual must:

1. Complete and submit an Application to CHP within the sixty-three (63)-day period immediately following the termination date of Membership under the Group Contract;

2. Provide any additional information needed to determine eligibility, if requested by CHP; and

3. Pay the required Prepayment Fees or Supplemental Charges within sixty-three (63) days following the termination date of Membership under the Group Contract.

This Contract will provide coverage without evidence of insurability for Dependents only when: (1) the Dependents are named on the initial Application for coverage; and, (2) the Application is accepted by CHP.

The Effective Date of coverage under this Contract is the day following the termination of Membership under the Group Contract. There may be additional Prepayment Fees for each Dependent based on the coverage selected by the individual.

Additional Requirements for Enrollment of Dependents/Effective Date

Individuals eligible for Membership as dependents acquired after the Effective Date of this Contract may enroll as permitted below. Except as otherwise set forth in this Contract, the Effective Date for a Subscriber's Dependent(s) shall begin on that Subscriber's Effective Date.

1. Newborn Child -- The Effective Date of coverage for a newborn child shall be the moment of birth, provided CHP receives the Member Status Change Request form before or within thirty (30) days after the date of birth. If the form is received by CHP before or within this thirty (30)-day period, Prepayment Fee and/or Supplemental Charges will not be charged for the first thirty (30) days of coverage. In the event CHP does not receive the form before or within thirty (30) days after the date of birth, the newborn child will be added as of the date of birth as long as any applicable Prepayment Fee and/or Supplemental Charge is paid back to the date of birth.

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

2. Adopted Newborn Child -- The Effective Date of coverage for an adopted newborn child eligible for Membership shall be:

   (a) the moment of birth, provided that a written agreement to adopt such child has been entered into by the Member prior to the birth of such child, whether or not such agreement is enforceable; or,

   (b) the date such adopted newborn child is placed in the residence of the Member in compliance with Florida law, provided such adopted newborn child is properly enrolled.

   To enroll an adopted newborn child, the Subscriber must submit a Member Status Change Request Form to CHP prior to birth or placement or within thirty (30) days after the date of birth or placement and pay the additional Prepayment Fee and/or Supplemental Charge, if any. If the form is received by CHP before or within this thirty (30)-day period, Prepayment Fee and/or Supplemental Charges will not be charged for the first thirty (30) days of coverage. In the event CHP does not receive the form before or within thirty (30) days after the date of birth or placement, the adopted newborn child will be added as of the date of birth as long as any applicable Prepayment Fee and/or Supplemental Charge is paid back to the date of birth.

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

3. Adopted Child -- The Effective Date for an adopted child (other than an adopted newborn child) eligible for Membership shall be the date such adopted child is placed in the residence of the Member in compliance with Florida law; provided such adopted child is properly enrolled and provided that the adopted child is so placed in the residence of the Member. To enroll an adopted child, the Subscriber must submit a Member Status Change Request Form to CHP prior to, or within thirty (30) days after the date of placement. If the form is received by CHP before or within this thirty (30)-day period, Prepayment Fee and/or Supplemental Charges will not be charged for the first thirty (30) days of coverage. In the event CHP does not receive the form before or within thirty (30) days after the date of placement, the adopted child will be added as of the date of placement as long as any applicable Prepayment Fee and/or Supplemental Charge is paid back to the date of placement.

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

4. Court Order -- A Subscriber may request enrollment for a dependent under this Contract if a court has ordered coverage to be provided for a minor child under the Subscriber's plan and a request for enrollment is made within thirty (30) days after issuance of the court order. Child(ren) in court-ordered custody of the Subscriber may be covered to the end of the Calendar Year in which they reach the age of eighteen (18).

Any individual who is not properly enrolled will not be eligible for Covered Services hereunder and CHP shall have no obligation whatsoever under this Contract with respect to such individual. Any Dependent other than a newborn or adopted child, not indicated on the Application at initial enrollment will not be eligible for enrollment under this Contract.

Other Requirements/Rules Regarding Enrollment

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

1. The Subscriber has requested enrollment in CHP for himself/herself and any dependents in compliance with the provisions of this Contract.

2. Entitlement to Covered Services under this Contract is subject to the timely receipt by CHP of the monthly Prepayment Fees and any Supplemental Charges from or on behalf of Subscribers and their Dependents enrolled as Members of CHP. CHP is not obligated to provide any Covered Services to any individual for whom CHP has not received such fees and charges in advance.

3. Subscribers are responsible for adding and deleting Dependents in a manner consistent with this Contract on a timely basis. Subscribers must advise CHP immediately in the event a Dependent no longer meets the eligibility requirements by submitting a Member Status Change Request Form to CHP. CHP is not responsible for providing Covered Services for any individual who should not have been added or who should have been deleted. The Subscriber is liable to CHP for any such Covered Services provided by CHP.

SECTION 6: TERMINATION OF MEMBERSHIP

Termination of Subscriber Membership

Subscriber's Membership under this Contract will terminate, consistent with the provisions of this Contract, on the date:

1. this Contract terminates (see *Termination of Health Plan by CHP* subsection); or

2. the Subscriber otherwise fails to continue to meet each of the eligibility requirements under this Contract; or

3. the Subscriber's Membership is terminated for cause (see *Termination of Membership for Cause* subsection); or

4. the Subscriber becomes eligible for Group coverage; or

5. failure to timely pay Prepayment Fees required under this Contract.

Termination of Dependent Membership

A Dependent's Membership under this Contract will terminate on the date:

1. this Contract terminates (see *Termination of Health Plan by CHP* subsection); or

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

3. the Dependent fails to continue to meet each of the eligibility requirements under this Contract; or

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

5. the Dependent becomes eligible for Group coverage; or

6. failure to timely pay Prepayment Fees required under this Contract.

Termination of Membership for Cause

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

    a. disruptive, unruly, abusive, or uncooperative behavior to the extent that such Member's continued Membership in CHP seriously impairs CHP's ability to administer this Contract or to provide coverage for health care services to such Member or to other Members; or

    b. the knowing misrepresentation, omission, or the giving of false information on the Application or other forms completed for CHP, by or on behalf of the Member; or

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

d. misuse of the Membership Card; or

e. the Member has left the Service Area with the intent to relocate or establish a new residence outside the Service Area.

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

3. If a Member's Coverage is terminated for cause by CHP, CHP shall notify such Member, in writing, at the address then on file with CHP. Such written notice shall state the reason(s) and effective date for termination of the Member's Coverage.

Termination by Subscriber

This Contract may be terminated by the Subscriber by giving written notice to CHP at least thirty (30) days prior to the end of the last period for which a Prepayment Fee has been paid. In such event, termination of this entire Contract shall be effective at midnight on the last day of such period.

Termination of Health Plan by CHP

This Contract may be terminated by CHP at any time by giving written notice to the Subscriber at least ninety (90) days prior to the effective date of non-renewal, provided this Contract is cancelled for all Members in the Service Area.

Notice of Termination by CHP

CHP will provide the Subscriber with written notice of termination. The Subscriber shall immediately notify each of the Subscriber's Dependents of such termination. Such notice will specify the effective date of termination and the reason(s) for the termination. Except in those instances where termination is for non-payment of premium or failure to meet, or continue to meet an eligibility requirement, such notice shall be sent by CHP at least forty-five (45) days prior to the effective date of the termination.

Extension of Benefits

In the event CHP terminates this Contract, a Member who is totally disabled as of the date of such termination shall be entitled to an extension of benefits for any continuous loss which commenced while this Contract was in effect, but only for as long as such individual continues to be totally disabled. Such extension of benefits is limited to the occurrence of the earliest of the following events:

a. the expiration of twelve (12) months;
b. such time as the Member is no longer totally disabled;
c. a succeeding carrier elects to provide replacement coverage without limitation as to the disability Condition; or
d. the maximum benefits payable under the Contract have been paid.

Maternity coverage, when not covered by the succeeding carrier, will continue for a pregnancy that commenced while this Contract is in effect. This extension of benefits is limited to the period of that pregnancy and is not based upon total disability.

For purposes of this subsection, the term "totally disabled" means that, in the opinion of CHP, the Member is physically unable to work at any gainful job for which such Member is suited by education, training, or experience due to an illness or injury.

Certification of Creditable Coverage

In the event a Member's coverage under this Contract terminates for any reason, CHP will issue a written Certification of Creditable Coverage to the Member.

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

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

The subsequent insurer will be responsible for determining if the CHP coverage meets the qualifying creditable coverage guidelines (e.g., no more than a sixty-three (63)-day break in coverage).

Responsibilities of CHP Upon Termination of Membership

Upon termination of an individual's Membership for any reason, CHP shall have no further liability or responsibility under this Contract with respect to such individual, except as specifically set forth in this Contract. Prepayment Fees received on behalf of person(s) whose Coverage has terminated, and which are applicable to periods after the effective date of termination, may be refunded.

SECTION 7: PAYMENTS

Payment of Prepayment Fees

Subscribers are responsible for the payment of all Prepayment Fees due on behalf of him/herself and any Dependents. The initial Prepayment Fee must be paid by the Subscriber prior to the Effective Date of coverage. The payment of all Prepayment Fees is required to be made in advance, on a quarterly basis, on or before the due date as specified on the CHP billing form.

Modification of Prepayment Fees

The amount of Prepayment Fees to be paid to CHP by the Subscriber on behalf of the Subscriber and his/her Dependents may be modified by CHP at any time. As an example, but without limitation thereto, such fees and/or charges may be modified by CHP in the event the actual enrollment mix varies from the assumed enrollment mix that was utilized to calculate the rates then in effect. CHP shall provide at least forty-five (45)) days prior written notice of any such modification. Payments submitted to CHP following receipt of any such written notice of modification constitute acceptance by the Member of any such modification.

Grace Period

This Contract has a ten (10) day grace period for payments due from the Subscriber. If any required payment is not received by CHP on or before the date it is due, it may be paid during the grace period. During this grace period this Contract will stay in force. However, if such payment is not received by CHP by the end of this grace period, then this Contract shall automatically terminate, effective as of the end of the grace period.

Copayments by Members

Each Member shall be responsible for the payment of all Copayments for Covered Services, and for all other incurred charges for non-Covered Services or supplies provided to such Member. The Subscriber shall also be responsible for the payment of all Copayments for Covered Services and for all other incurred charges for non-Covered Services or supplies, with respect to every individual enrolled as his/her Dependent, but only to the extent that such Copayments and/or other charges are not paid by or on behalf of any such individual. All such payment obligations are due and payable as they are incurred, and shall be paid directly to the provider.

Maximum Copayments

Copayment charges for any single service shall not exceed fifty (50) percent of the total charge for providing such service. Additionally, total Copayment charges in any Calendar Year shall not exceed the amount indicated in the Schedule of Copayments, which in no event shall exceed twice the total annual premium costs which a Subscriber (or, if there are Dependents, the Subscriber and his or her Dependents) would be required to pay if such individual(s) were enrolled under an option with no Copayments. It is the Member's responsibility to retain receipts and to notify and document to the satisfaction of CHP when this Copayment limit has been reached. Thereafter, services will be provided with no Copayment charge for the remainder of the Calendar Year.

SECTION 8: DUPLICATION OF COVERAGE

Coordination of Benefits

Coordination of benefits is a limitation of the Covered Services provided under the Contract which is designed to avoid the costly duplication of payment for health care services and/or supplies. CHP shall coordinate payment of Covered Services to the maximum extent allowed by law. Contracts which may be subject to coordination of benefits include, but are not limited to, the following, which will be referred to as "Plan(s)" for purposes of this section:

- any group insurance, group-type self-insurance, or HMO plan;
- any group contract issued by any Blue Cross and/or Blue Shield plan(s);

- any plan, program or insurance policy, including an automobile insurance policy; or

- any plan, program, or insurance established pursuant to legislation or other legislation of similar purpose.

The amount of payment by CHP, if any, is based on whether or not CHP is the primary payer. When CHP is primary, CHP will provide Covered Services without regard to the Member's coverage under other Plans. When CHP is other than primary, Covered Services may be reduced so that total Covered Services under all such Plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services.

The following rules shall be used to establish the order in which Covered Services under the respective Plans will be determined:

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

2. When CHP covers a Dependent child whose parents are not separated or divorced:

   a. The Plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary;

   b. If both parents have the same birthday, excluding year of birth, and the other Plan has covered one of the parents longer than CHP, CHP will be secondary.

3. When CHP covers a Dependent child whose parents are separated or divorced:

   a. If the parent with custody is not remarried, the Plan of the parent with custody is primary;

   b. If the parent with custody has remarried, the Plan of the parent with custody is primary; the step-parent's Plan is secondary; and the Plan of the parent without custody pays last;

   c. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the Plan of that parent is primary.

4. When CHP covers the Member as a Dependent child and the other Plan covers the Member as a Dependent child:

   a. The Plan of the parent who is neither laid off nor retired will be primary;

   b. If the other Plan is not subject to this rule, and if, as a result, such Plan does not agree on the order of Covered Services, this paragraph shall not apply.

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

   CHP 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.

Reduction of Coverage Due to Medicare

This Contract may provide for a reduction of coverage on any Member upon his/her eligibility for coverage under Medicare or under any other State or federal law providing benefits similar to those provided by this Contract.

Subrogation

If you are injured or become ill as a result of another party's intentional act or negligence, you must notify CHP concerning the circumstances under which you were injured. Under *Florida Statutes Section* 768.76, you or your lawyer must notify CHP, by certified or registered mail, if you intend to claim damages from someone for your injuries or illness. If you recover money to compensate you for the cost/expense of health care services to treat your illness or injury, CHP is legally entitled to be reimbursed for payments made on your behalf to the doctors, hospitals, or other providers who treated you. CHP's legal right to be reimbursed in such cases is called "subrogation." Normally, CHP may recover the amount of any payments it made on your behalf minus its pro rata share for any costs and attorneys fees you incur in pursuing and recovering your damages. CHP may "subrogate" against all money you recover regardless of the source of the money including but not limited to uninsured motorists coverage.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of, and implementing the terms of, this Contract, including without limitation this Duplication of Coverage Section, CHP may, without the consent of or notice to any person, plan, or organization release to or obtain from any person, plan, or organization any information with respect to any Member or applicant for enrollment which CHP deems to be necessary.

Facility of Payment

Whenever payments which should have been made under this Contract are made by any other person, plan or organization, CHP shall have the right, exercisable alone and in its sole discretion, to pay over to any such person, plan or organization making such other payments, any amounts CHP shall determine to be required in order to satisfy the terms of this Contract. Amounts so paid shall be deemed to be benefits paid under this Contract, and, to the extent of such payments, CHP shall be fully discharged from liability under this Contract.

Right of Recovery

Whenever CHP has paid for Covered Services in excess of the maximum required under the rules stated in this Duplication of Coverage Section, CHP shall have the right to recover payment for such Covered Services, to the extent of such excess, from any Member, person, plan, or other organization that received payment for such excess Covered Services.

Non-Duplication of Government Programs

The Covered Services under this Contract shall not duplicate any benefits to which Members are entitled, or for which they are eligible, under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Worker's Compensation Act, to the extent allowed by law. In the event CHP has

duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to CHP to the extent of such duplication.

Non-Duplication of Other Extension of Coverage

The Covered Services under this Contract shall not duplicate any Covered Services to which Members are entitled by law, and/or for which they are eligible under any extension of benefits and/or coverage provisions of any other plan, policy, program, or contract, including any CHP Group Contract.

Cooperation Required of Members

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

SECTION 9: CLAIMS PROCESSING

How to File a Claim/Time Requirement

Participating Providers have agreed to file, where appropriate, claims for Covered Services with CHP on the Member's behalf. In the event the Member obtains services or supplies from a Non-Participating Provider who does not file the claim on the Member's behalf, it is the Member's responsibility to file the claim with CHP.

The Member shall ensure that a claim is received by CHP at the address set forth on the Membership Card within ninety (90) days of the date the service or supply was rendered, or if it is not reasonably possible to file the claim within such 90-day period, the Member shall ensure that the claim is filed as soon as possible. In any event no claim for services or supplies will be considered for payment by CHP if CHP does not receive the claim within one hundred twenty (120) days of the date the service or supply was rendered.

To file a claim, the Member must obtain an itemized statement from the health care provider and forward it to the address on the Membership Card. The itemized statement must contain the following information: the date the service or supply as provided, a description of the service or supply, the amount actually charged by the provider, the diagnosis, the provider's name and address, the patient's name, and the Subscriber's name.

Processing of the Claim

Once CHP has received the completed claim, CHP will promptly process it. CHP will process all claims for which it has all of the necessary information, as determined by CHP, within one hundred twenty (120) days of receipt of the completed claim for benefits (proof of claim). In the event CHP contests or denies the claim or a portion of the claim, or needs additional information, CHP will so notify the Member or the

Member's assignee, if any assignment of benefits is required to be honored by CHP under this Contract, within forty-five (45) days of receipt of the initial claim. The notice will identify the contested or denied portion of the claim and the reason(s) for contesting or denying the claim or portion of the claim. It is the Member's responsibility to ensure that CHP receives all information that CHP determines is necessary to complete processing of the claim. If CHP does not receive necessary information, a claim or portion of a claim may be denied. CHP will then complete the processing of the claim within sixty (60) days of receipt of the additional information requested by CHP . In any event, all claims will be paid or denied within one hundred twenty (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 processing decision is deposited in the mail by CHP.

CHP will investigate any claim of improper billing by a provider, upon written notification by a Member.

Review of Claims Which Are Denied

In the event CHP denies a claim, the Member may request CHP to review the decision to deny the claim. The Member must request such review within sixty (60) days of receipt of the notice of the claim denial. The Member should submit to CHP any additional information the Member wants CHP to consider during the review. CHP will promptly notify the Member of its review decision. The Member may designate, in writing, an individual to represent the Member during the review process.

Additional Claims Processing Provisions

1. Release of Information/Cooperation

   In order to process claims, CHP may need information, including medical information, from the health care provider who rendered the service or supply. Members shall cooperate with CHP in its effort to obtain such information by, among other ways, signing any release of information form as requested by CHP. Failure by a Member to fully cooperate with CHP will result in the denial of the pending claim and CHP shall have not liability for such claim.

2. Physical Examination

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

3. Legal Actions

   No legal action arising out of or in connection with this Contract may be brought against CHP within the sixty (60)-day period following CHP's receipt of the completed claim as required by this Contract. Additionally, no such action may be brought after expiration of the applicable statute of limitations period from the time CHP receives the completed claim as required by this Contract.

4. Fraud, Misrepresentation or Omission in Applying for Benefits

   CHP relies on the information provided on the itemized statement when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement,

omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy CHP may have, in denial of the claim or cancellation or rescission of the Member's coverage under this Contract.

5. Explanation of Claims Decisions

All claims decisions, including denial and claims review decisions, will be communicated to the Member in writing. The explanation may indicate:

- the reason(s) the claim was denied;
- a reference to the Contract provision upon which the denial is based;
- a description of additional material or information necessary to make the claim payable and why such material or information is necessary; and
- an explanation of the steps to be taken if a Member wants a claim denial decision reviewed.

SECTION 10: GENERAL PROVISIONS

Access to Information

CHP shall have the right to receive from any health care provider rendering services to a Member, information that is reasonably necessary, as determined by CHP, in order to administer this Contract, subject to all applicable confidentiality requirements set forth in the *Confidentiality* subsection. By accepting Membership each Member authorizes every health care provider who renders services, or furnishes supplies, to such Member, to disclose to CHP or to entities affiliated with CHP, upon request, all facts, records, and reports pertaining to such Member's care, treatment, and physical condition, and to permit CHP to copy any such records and reports so obtained.

Amendment

This Agreement may be amended at the time of annual coverage renewal so long as such modification is consistent with the laws of this state, approved by the Department of Insurance and effective on a uniform basis among all individuals with this Agreement. In the event the amendment is unacceptable to the Subscriber, the Subscriber may terminate this Agreement upon at least ten (10) days prior written notice to CHP. Any such amendment shall be without prejudice to claims filed with CHP prior to the date of such amendment. No agent or other person, except a duly authorized officer of CHP, has the authority to modify this Agreement, or to bind CHP in any manner not expressly set forth in this Agreement in any way, including but not limited to the making of any promise or representation, or by giving or receiving any information. This Agreement may not be amended by the Subscriber unless such amendment is evidenced in writing and signed by a duly authorized representative of the Subscriber and a duly authorized officer of CHP. The Subscriber shall immediately notify each Member of any such amendment.

Assignment and Delegation

This Contract and the obligations hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that CHP may assign this Contract to its successor in interest or an affiliated entity without the consent of the Member at any time. Any assignment, delegation, or transfer made in violation of this provision shall be void.

Attorney Fees: Enforcement Costs

Unless the parties otherwise agree in writing, if any legal action or other proceeding is brought for the enforcement of this Contract, or because of an alleged dispute concerning, or breach of, this Contract, 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.

Authorization

Where this Contract requires that an act involving the administration of this Contract be authorized or approved by CHP, such authorization or approval shall be considered given when provided by an officer of CHP or his/her designee.

Compliance With State and Federal Laws

The provisions of this Contract shall be deemed to have been modified by the parties, and shall be interpreted so as to comply with applicable state or federal laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of a Member or CHP.

Confidentiality

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

Entire Contract: Binding Effect

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

Evidence of Coverage

Each Subscriber will be provided with a copy of the Non-Group Membership Conversion Contract and a Membership Card for enrolled Members.

Governing Law

This Contract 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.

Grievance Procedure

CHP has established and will maintain a process for hearing and resolving grievances raised by Members. Members are required to first bring grievances to the attention of CHP's Member Services at the CHP Office in Tallahassee, Florida. Details regarding the grievance resolution process are provided in the Complaint and Grievance Process Section of this Contract.

Indemnification

The Member shall hold harmless and indemnify CHP against all claims, demands, liabilities, or expenses (including reasonable attorney's fees and court costs), which are related to, arise out of, or are in connection with any acts or omissions of the Member, or the Member's agents, in the performance of the obligations of the Member under this Contract; provided, however, this subsection shall not apply if, and to the extent that any applicable liability insurance policy provides for the non-coverage or the reduction of coverage, if this subsection were applicable.

Liability of Member for Non-Covered Services

The Member shall be responsible for payment for all goods and services which are not Covered Services or otherwise not provided in accordance with the provisions of this Contract.

Membership Cards

The Membership Cards issued to CHP Members in no way create or serve to verify eligibility to receive Covered Services under this Contract. Membership Cards remain the property of CHP, and must be returned to CHP within thirty-one (31) days of the termination of a Member's Membership.

Modification of Provider Network

The CHP provider network is subject to change at any time without prior notice to, or approval of, any Member. Additionally, CHP may, at any time, terminate or modify the terms of any Participation Agreement and may enter into additional Participation Agreements without prior notice to, or approval of, any Member.

Non-Waiver of Defaults

Any failure by CHP at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions of this Contract, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect the right of CHP at any time to enforce or avail itself of any such remedies as it may have under this Contract or otherwise.

Notices

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

If to CHP:

To the address printed on the Non-Group Membership Conversion Contract Application and/or the Membership Card.

If to Member:

To the latest address provided by the Member on the Non-Group Membership Conversion Contract Application or change of address form actually delivered to CHP.

Records

1. Reporting Changes of Member Status

The Subscriber shall furnish to CHP such information as may reasonably be required for the purpose of recording changes in family status or other information, including information relative to eligibility, regarding Members. All information which has a bearing on Membership under this Contract shall be made available to CHP by the Subscriber.

2. Errors or Delays

Clerical errors or delays by CHP in keeping or reporting information regarding Membership will not invalidate coverage which would otherwise be validly in force, or continue coverage which would otherwise be validly terminated. An omission of information which should have been provided, or the furnishing of incorrect information to CHP, may be corrected, provided that CHP determines that any such correction will not be prejudicial to CHP.

Relationships Between the Parties

1. CHP and Providers

CHP Physicians, other CHP Staff and other persons rendering services authorized by CHP Staff shall be solely responsible for the performance of all health services rendered to a member. The relationship between members and Participating Providers shall be solely that of a health care provider-patient relationship, in accordance with any applicable professional and ethical standards.

The relationship between CHP and any Participating Provider, Non-Participating Provider, or other associated institution, organization, or practitioner, sometimes collectively referred to hereinafter as "Independent Contractor(s)", is solely that of an independent contractor. Neither CHP nor any of its agents, servants or employees shall be deemed to be an agent, servant, or employee of any such Independent Contractor and neither such Independent Contractor nor any of its agents, servants, or employees shall be deemed to be an agent, servant, or employee of CHP. CHP shall be deemed not to be a healthcare provider with respect to any services performed or provided by any such Independent Contractor. Any decisions made by CHP concerning appropriateness of setting, or whether any service or supply is Medically Necessary, pursuant to this Contract shall be deemed to be made solely for purposes of determining whether Covered Services are due under this Contract and not for purposes of recommending any treatment or non-treatment. CHP will not assume liability for any loss or damage arising as a result of acts or omissions of any Independent Contractor.

2. Members and Healthcare Providers

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

3. CHP and the Member

No Member is the agent or representative of CHP. Additionally, neither any Member, nor CHP shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which CHP has made or hereafter makes arrangements for the provision of services under this Contract. CHP shall not be liable for any acts or omissions of any Member, any Member's agents, or any person or organization with which the Member has entered into any agreement or arrangement.

Reservation of Right to Contract

CHP reserves the right to contract with any individuals, corporations, associations, partnerships, or other entities for the delivery of any of the medical services described in this Contract.

Service Mark

The Member hereby expressly acknowledges understanding that this Contract constitutes a contract solely between the Subscriber and CHP, that CHP is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting CHP to use the Blue Cross and Blue Shield Service Mark in the State of Florida and that CHP is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than CHP and that no person, entity, or organization other than CHP shall be held accountable or liable to the Member for any of CHP's obligations to the Member created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of CHP other than those obligations created under other provisions of this Contract.

Services by Non-Participating Providers

Except as provided in the Covered Services Section, if Participating Providers are unable to provide to a Member Covered Services, as determined by the Medical Director of CHP, then CHP agrees to pay for equivalent services rendered by Non-Participating Providers chosen or approved by CHP.

SECTION 11: COVERED SERVICES

Introduction

The Covered Services herein are subject to the Copayments set forth in the Schedule of Copayments (Attachment B) and will be limited to the maximum amounts specified on the Schedule of Copayments which is included with this Contract.

1. Entitlement of a Member to any of the Covered Services described in this Covered Services Section is subject to all terms and conditions of this Contract, including without limitation any

and all exclusions, limitations, restrictions, and requirements that are set forth in this Contract. This Contract does not limit coverage for pre-existing conditions.

2. The Covered Services set forth below will be paid for only if the Covered Services are Medically Necessary and have been prescribed, directed, or authorized by, and rendered by a Participating Provider, except in cases of Emergency Services and Care (see *the Emergency Services and Care* subsection of this Covered Services Section).

3. Additionally, the Covered Services set forth below will be paid for only if they are Medically Necessary Covered Services which are the most appropriate supply or level of services which can safely be provided to the Member, as determined by CHP. With respect to services or supplies that may be provided as inpatient services or supplies, payment by CHP will be made only when the Condition of the Member is such that the services or supplies cannot be safely provided to the Member as an outpatient, as determined by CHP.

4. The Member is responsible for verifying the participation status of the Physician, Hospital, or other provider prior to receiving the service or supply. To determine if a particular health care provider is in the CHP provider network, review the most recent provider directory listing those Primary Care Physicians and Participating Providers under this Contract. To verify a specific health care provider's participation status, the Member may contact the local CHP office. When failure to verify participation status or to show the Membership Card results in non-compliance with required CHP procedures, coverage may be denied.

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

6. CHP's case management program is administered for certain Members having catastrophic or chronic Conditions. Under this voluntary program, CHP may elect (but is not required to) offer to arrange for the delivery of alternative health care services and supplies on a case-by-case basis. Under the case management program, CHP may arrange for the delivery of health care services and supplies, which are not otherwise Covered Services under this Contract, for those individual Members who meet certain program criteria. Any decision to offer alternative health care services and supplies under this program shall be made solely by CHP. Such alternative health care services and supplies, if any, will be provided in accordance with a plan with which the Member, or the Member's representative, and the Member's Physician agree in writing. To the extent of any inconsistency between the terms of any such agreement and this Contract, the terms of the alternative health care services and supplies agreement control. CHP's offer to arrange for the delivery of any alternative health care services and supplies in no way obligates CHP to continue to offer such alternative health care services and supplies or to offer alternative health care services and supplies to the Member or any other Member at any time. Nothing contained in this paragraph shall be deemed a waiver of CHP's right to enforce this Contract in strict accordance with its terms. The terms of this Contract apply to any alternative health care services and supplies arranged for by CHP, except as specifically modified in writing by CHP when administering this program for the Member.

7. Certain types of medical procedures and other services covered hereunder may be rendered by licensed physician assistants, nurse practitioners or other individuals who are not Physicians.

8. At the option of the Member, inpatient and outpatient services, similar to inpatient and outpatient services by allopathic hospitals, may be obtained from a Hospital accredited by the American

Osteopathic Association when such services are available in the Service Area and when such Hospital has not entered into a written agreement with CHP with regard to such services. If such osteopathic services are received at an osteopathic Hospital, the Member will be required to release CHP from any liability arising from any act or omission constituting malpractice in the delivery for osteopathic care from that Hospital. The Hospital providing such services may not charge rates that exceed the Hospital's usual and customary rates less the average discount that CHP has with allopathic Hospitals within the Service Area. It is the Member's responsibility to contact CHP to obtain the documents necessary to comply with this provision.

9. **Any and all decisions made by CHP in administering the provisions of this Contract, including, without limitation, the provisions of this Covered Services Section are made only to determine whether payment for any Covered Services will be made by CHP. Any and all decisions that pertain to the medical need for, or desirability of, the provision or non-provision of medical services or supplies, including without limitation the most appropriate level of such services or supplies, must be made solely by the Member and the Member's Physician in accordance with the normal patient/physician relationship for purposes of determining what is in the best interests of the Member. The Member acknowledges it therefore is possible that a Member, and such Member's Physician, may conclude that services or supplies are needed, appropriate, or desirable, even though such services or supplies are not Covered Services, and therefore will not be paid for or arranged by CHP.**

Physician Services

Upon joining CHP, every Member shall select or be assigned a Primary Care Physician who has contracted with CHP and who is licensed as a Doctor of Medicine or who is a Doctor of Osteopathy.

Upon request by a Member, a Doctor of Chiropractic or a Doctor of Podiatry shall be assigned to the Member for the purpose of providing chiropractic services and podiatric services, respectively.

Members shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need of referrals from the Primary Care Physician who is licensed as a Doctor of Medicine or Doctor of Osteopathy.

Physician services provided to a Member on an inpatient or outpatient basis when provided by a Primary Care Physician or a Participating Provider when on referral from the Primary Care Physician, as follows:

1. visits while the Member is an inpatient in a Hospital or Skilled Nursing Facility;
2. visits while the Member is an outpatient (e.g., office visits or Member's home);
3. surgical procedures including oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth, and surgical procedures involving bones or joints of the jaw and facial region if, under accepted medical standards, such surgery is Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. consultations, provided the attending Physician requests the consultation and the consulting Physician prepares a written report;
5. diagnostic services, including radiology, ultrasound, laboratory, pathology, allergy testing, approved machine testing (e.g., electrocardiogram [EKG]) and diagnostic services involving bones or joints of the jaw and facial region if, under accepted medical standards, such diagnostic services are Medically necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;

7. allergy testing and desensitization therapy (e.g., injections), not including cost of hyposensitization serum;
8. anesthesia services by a Physician, other than the operating Physician or his or her partner or associate; and
9. concurrent Physician care, provided the Physician actively participates in the Member's treatment, and (a) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (b) the Physicians have different specialties or have the same specialty with different sub-specialties.
10. plastic surgery resulting from a traumatic injury or disease and for a congenital anomaly, performed to restore normal bodily function as determined by the Medical Director of CHP.

Dermatology services are limited to the following: Medically Necessary minor surgery, tests, and office visits provided by a dermatologist who is a Participating Provider for a maximum of five (5) visits within a Calendar Year without an authorization or referral from the Member's Primary Care Physician. Any services rendered above these five (5) visits require an authorization from the Member's Primary Care Physician.

Infertility services, when determined by the Medical Director of CHP to be medically appropriate are limited to endometrial biopsy, sperm count, and hysterosalpingogram to determine the cause for infertility.

Prescribed short-term **physical, speech, or other rehabilitation therapies** designed to treat functional defects which remain after an illness or injury, not including rehabilitation programs for the treatment of abuse of or addiction to alcohol and drugs, when medically appropriate for the treatment of a Condition, provided that significant improvement of the Member's Condition, as determined by the Medical Director of CHP, is expected within two months from the first date of treatment. This Covered Service is limited to a maximum of two months of treatment per Member per Condition.

Physician Assistant Services

Surgical assistant services rendered by a Physician Assistant when acting as a surgical assistant and the assistance is Medically Necessary.

Certified Registered Nurse Anesthetist

Anesthesia services which are Covered Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license will be made available to the Member if the Member requests such services, provided such services are available, as determined by CHP.

Hospital Care

Hospital services provided at participating Hospitals for a Member when such Member is an inpatient or outpatient admitted upon the instruction, written authorization, or referral by a Primary Care Physician, as follows:

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);
5. drugs and medicines administered while an inpatient;
7. intravenous solutions;
8. administration of, but not 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., electrocardiogram [EKG];
13. chemotherapy treatment for proven malignant disease; and
14. other Medically Necessary services and supplies.

Surgically implanted prostheses, as approved by the Medical Director of CHP, not including artificial organs, are limited to the following, when pre-authorized by CHP and arranged by a Primary Care Physician or CHP: cardiac pacemakers, and artificial limbs and eyes to replace natural limbs and eyes lost while a Member.

Prescribed short-term **physical, speech, or other rehabilitation therapies** designed to treat functional defects which remain after an illness or injury, not including rehabilitation programs for the treatment of abuse of or addiction to alcohol and drugs, when medically appropriate for the treatment of a Condition, provided that significant improvement of the Member's Condition, as determined by the Medical Director of CHP, is expected within two months from the first date of treatment. This Covered Service is limited to a maximum of two months of treatment per Member per Condition.

Breast Reconstructive Surgery

Breast Reconstructive Surgery and implanted prostheses, when Medically Necessary and related to Mastectomy. As used in this subsection, the term "Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician. The term "Breast Reconstructive Surgery" means surgery to re-establish symmetry between the two breasts. Outpatient follow-up care for Breast Reconstructive Surgery shall be provided at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Member. The treating Physician, after consultation with the Member, may choose the appropriate setting.

Preventive Health Services

Preventive health services when provided to Members by a Primary Care Physician, a Participating Provider on referral from the Primary Care Physician, or by a Non-Participating Provider authorized by the Medical Director of CHP, according to standards established by the Medical Director of CHP, for health maintenance and the prevention and detection of disease. Preventive health services include:

1. periodic health assessments;
2. instruction in personal health care measures;
3. routine prostate screening;
4 routine immunizations and inoculations;

5. eye and ear examinations in the office of a Primary Care Physician for children under age 19 to determine the need for vision and hearing correction;
6. family planning counseling and services, including 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, including nutrition education and counseling; instruction in personal health care and the appropriate use of health services; information regarding the health services offered by CHP and the generally accepted medical standards for the use and frequency of each.
8. one annual routine preventive gynecological examination per Calendar Year by a Participating Provider, who is an obstetrician or gynecologist, without a referral from the Primary Care Physician. This examination may include a manual breast exam, a pelvic exam, and a pap smear. Any referral services resulting from this examination must have prior authorization from the Member's Primary Care Physician.

Mammogram Screening Services: Mammograms performed for breast-cancer screening, but limited to the following:

A. a baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age;

B. a mammogram for every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based upon a Physician's recommendation;

C. a mammogram every year for any woman who is 50 years or age or older; or,

D. one or more mammograms a year, based upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before age 30.

Except for mammograms done more frequently than every two years for women 40 years of age or older, but younger than 50 years of age, Covered Services are payable when, with or without a prescription from a Physician, the Member obtains a mammogram in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the Florida Department of Health and Rehabilitative Services for breast-cancer screening. Covered Services are subject to all other terms and conditions applicable to other Covered Services.

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

Ambulatory Surgical Center Services

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

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, but not 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., electrocardiogram [EKG]);
10. chemotherapy treatment for proven malignant disease; and
11. other Medically Necessary services and supplies.

Accidental Dental Care

Health care services and supplies for the treatment of short-term consequences (i.e., two months) of damage to sound natural teeth, not previously compromised by decay or periodontal disease, and immediate adjacent structures (e.g., periodontium), resulting from an Accidental Dental Injury occurring while a Member of CHP. However, an unexpected event during the chewing of food which causes traumatic injury to natural teeth is not an Accidental Dental Injury as defined in this Contract.

Emergency Services and Care

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:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

   1. Serious jeopardy to the health of a patient, including a pregnant woman or fetus.
   2. Serious impairment of bodily functions.
   3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

   1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
   2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
   3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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

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 shall be Covered Services without prior notification to CHP, subject to the Copayment amount set forth in the Schedule of Copayments. It is the Member's responsibility to notify CHP as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. **Follow-up care must be received, prescribed, directed or authorized by the Member's Primary Care Physician.** If the follow-up care is provided by other than the Member's Primary Care Physician, coverage may be denied. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination will be the responsibility of the Member.

Payment for Emergency Services and Care rendered by Non-Participating Providers will be based on the Reasonable Charges for such Emergency Services and Care. It is the responsibility of the Member to furnish to CHP written proof of loss in accordance with the Claim Provisions set forth in the Contract.

Ambulance Services for Emergency Services and Care

Medically Necessary transportation by ambulance to the nearest medical facility capable of providing required Emergency Services and Care to determine if an Emergency Medical Condition exists; **except as previously stated, all ambulance or other transportation services must be authorized by CHP or ordered by the Member's Primary Care Physician.**

Maternity Care

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

Routine office visits to a Primary Care Physician or Participating Provider when on referral from the Primary Care Physician for pre- and post-natal care.

Health care services and supplies, including prenatal care, delivery and postnatal care, provided to a Member. Care for a mother and her newborn infant including a postpartum assessment and newborn assessment may be provided at the Hospital, at 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. These services include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Sterilization

The following sterilization procedures when provided to a Member by the Primary Care Physician, a Participating Provider on referral from the Primary Care Physician, or by a Non-Participating Provider authorized by the Medical Director of CHP:

1. tubal ligations; and
2. vasectomies.

Newborn Child Care

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

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

Ambulance services when necessary to transport the newborn Member to and from the nearest appropriate facility which is appropriately staffed and equipped to treat the newborn Member's Condition, as determined by CHP and certified by the Primary Care Physician or a Participating Physician as Medically Necessary to protect the health and safety of the newborn child.

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

Well Child Care Services

Periodic Physician-delivered or Physician-supervised services that are Covered Services provided to a Dependent from the moment of birth up to the seventeenth (17th) birth date as follows:

1. Periodic examinations, which include a history of physical examination, 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.

These Covered Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Transplant Services and Supplies

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

Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. CHP will pay Covered Services only for services, care and treatment received for or in connection with a:

1. Bone Marrow Transplant, as defined in this Contract, which is specifically listed in Chapter 10D-127.001 of the *Florida Administrative Code* or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Health Care Financing Administration.
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.

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

No benefit is payable for or in connection with a transplant if:

1. The transplant is excluded.

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

3. CHP's Medical Director does not pre-authorize coverage for the transplant.

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

5. The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by CHP.

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

Artificial heart devices used as a bridge to transplant.

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

For covered transplants and all related complications, CHP will cover Hospital expenses and Physician's expenses provided that such services will be paid under the *Hospital Services* Subsection and *Physician Services* Subsection in this Contract in accordance with the same terms and conditions for care and treatment of any other covered Condition.

Emergency Services and Care for Alcohol or Drug Abuse

1. Inpatient detoxification, limited to the time necessary, but generally not to exceed four (4) days, for removal of the toxic substance or substances from the blood, and aftercare or outpatient treatment, provided such treatment is the result of an Emergency Medical Condition and is Medically Necessary.

2. Outpatient and/or inpatient services related to medical complications of alcoholism and/or substance abuse to the extent of coverage for other Conditions, as specified in the *Physician Services* and *Hospital Services* subsections of this Covered Services Section.

3. Referral to, but not payment of, non-medical ancillary services such as vocational rehabilitation or employment counseling, when CHP is appropriately able to make such referrals. Such services are to be provided solely at Member's expense. The Member acknowledges that CHP does not have any contractual or other formal arrangements with the providers of such services.

Skilled Nursing Facilities

Those Skilled Nursing Facility services which are authorized in writing by a Primary Care Physician or Participating Provider when on referral from the Primary Care Physician, and are approved by the Medical Director of CHP. Such services shall include: semiprivate room and board; administration of drugs, medications, fluids, medical supplies; and general nursing care. This Covered Service is limited to the number of days per Member set forth in the Schedule of Copayments.

Home Health Care

Home health care provided within the Service Area, upon approval of the Member's Primary Care Physician or Participating Provider when on referral from the Primary Care Physician, including visits by Physicians, Physician's assistants, nurses, therapists, and home health aides.

Hospice Services

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

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

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

Durable Medical Equipment

Coverage is limited to the following, when authorized in advance by CHP and arranged by a Primary Care Physician or CHP:

- durable medical equipment (DME) - nebulizers, peak flow meters, crutches, canes, and wheelchairs;

- prosthetics - braces, cardiac pacemakers, and artificial limbs and eyes to replace natural limbs and eyes lost while a Member. Covered prosthetic devices (except cardiac pacemakers and breast reconstructive prosthetics) are limited to the first such item prescribed for each specific Condition.

All other durable medical equipment and prosthetic devices are excluded unless such items are specifically approved by the Medical Director of CHP. CHP reserves the right to rent or purchase the most cost effective durable medical equipment which meets the Member's medical need as determined by CHP. Members are entitled to use but not own such equipment.

Diabetes Treatment Services

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

Second Medical Opinion

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

Services rendered by a Participating Provider related to a second medical opinion will be subject to the same Copayment requirement as set forth in the Schedule of Copayments. Services rendered by a Non-Participating Provider for a second medical opinion are subject to a Copayment amount equal to forty percent (40%) of the Reasonable Charges applicable to those services in the community.

CHP may deny benefits, granted under this Covered Services Section, in the event a Member seeks in excess of three (3) second medical opinions per Calendar Year if the second medical opinion costs are deemed by CHP to be evidence that the Member has unreasonably over-utilized the second medical opinion privileges. The professional judgment of a Participating Provider, derived after review of the documentation from the second medical opinion which you obtained, will be controlling as to CHP's coverage obligations for the treatment. Members who elect to obtain a second medical opinion must notify the respective Primary Care Physician of their intent to do so prior to obtaining the second medical opinion.

SECTION 12: EXCLUSIONS AND LIMITATIONS

Exclusions

The following services and/or supplies are excluded from coverage, and are not Covered Services under this Contract.

All services and supplies not specifically listed in the Covered Services Section or in any endorsement attached hereto, as a Covered Service unless such service is specifically required by applicable state or federal law.

Any service or supply provided or received without having been prescribed, directed or authorized by the Member's Primary Care Physician, unless such services otherwise have been expressly authorized under the terms of this Contract.

Any service or supply which, in the opinion of CHP, was, or is not Medically Necessary. The ordering of a service by a Physician, including without limitation a Physician who is a Participating Provider, other than as authorized by CHP does not in itself make such service Medically Necessary or a Covered Service.

Services received prior to a Member's Effective Date or received on or after the date an individual's Membership terminates under this Contract.

Services or supplies provided by a Physician or other provider related to the Member by blood or marriage.

Abortion, including any service or supply related to an elective abortion.

Alcoholism or substance abuse services in conjunction with the abuse of or addiction to alcohol and drugs (including long-term rehabilitation services for treatment of alcoholism and drug addiction, and including prolonged rehabilitation in a specialized inpatient or residential facility), except as specified in the Covered Services Section.

Ambulance or transportation services, unless Medically Necessary, including non-emergency transportation between institutional care facilities, or to and from the Member's residence.

Autopsy or postmortem examination services or supplies.

Blood, including the costs of whole blood or blood products.

Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.

Any **Bone Marrow Transplant**, as defined in this Contract, which is not specifically listed in Chapter 10D-127.001 of the *Florida Administrative Code* or covered by Medicare pursuant to a national coverage decision made by the Health Care Financing Administration as evidenced in the most recently published *Medicare Coverage Issues Manual*.

Contraceptives, except when dispensed for specific treatment of a Condition, or contraceptive devices or appliances.

Cosmetic surgery or procedures undertaken primarily to improve or otherwise modify the Member's external appearance, except as specified in the Covered Services Section of this Contract.

Any treatment received by a Member solely as a result of a **court order** to do so, unless the services would otherwise be covered by this Contract.

Custodial care such as that provided at health resorts, rest homes, nursing homes, and health spas. Custodial care comprised of services and supplies, including room and board and other institutional or home services, which are provided to an individual, whether disabled or not, primarily to assist him or her in activities of daily living.

Dental care, care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays.

Drugs and medicines, including prescription drugs, purchased, prescribed, or dispensed while other than an inpatient in a Hospital, Ambulatory Surgical Center, or outpatient department of a Hospital, except for immunosuppressant therapy following a major human organ/tissue transplant, or chemotherapy drugs or medicines in connection with a diagnosed malignancy.

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

Durable medical equipment, appliances, services, and supplies, except as specified in the Covered Services Section.

Treatment determined by CHP to be **Experimental or Investigational**, as defined in this Contract.

Eye exercise, visual training or orthoptics.

Family planning services, except as specified in the Covered Services Section.

Non-symptomatic **foot care** such as removal of warts, corns, or calluses, including, but not limited to, podiatric treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain, unless determined by a Primary Care Physician or assigned Doctor of Podiatry to be Medically Necessary.

Glasses and contact lenses, except initial glasses or contact lenses following cataract surgery, or following an accident to your eyes, while a Member. Additionally, radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses is not covered.

Hearing aids (external or implantable) and services related to the fitting or provision of hearing

aids.

Immunizations required for travel and physical examinations needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment guidelines recommended by the Medical Director of CHP.

Intersex surgery (trans-sexual operations).

Any service or supply in connection with the treatment of **Infertility** including Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and in-vitro fertilization and any services associated with these procedures, or any services associated with the donation or purchase of sperm.

The treatment of **Mental and Nervous Disorders.**

Mental health services including, but not limited to, care or testing by court order or as a condition of parole or probation, services for mental retardation after diagnosis, testing for aptitude, ability, intelligence or interest, care for chronic mental or nervous conditions and personality disorders, and long-term therapy.

Care for **military service-connected disabilities** for which the Member is legally entitled to care from military or government facilities, and for which such facilities are reasonably accessible to the Member.

Nicotine withdrawal programs, facilities and supplies.

Non-prescription drugs.

Surgical operations or medical procedures for the treatment of morbid **obesity**, unless determined to be Medically Necessary by the Medical Director of CHP.

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

Any and all services related to organ or artificial **organ transplant** or organ donation, except as specifically provided in the Covered Services Section.

Services and supplies associated with elective care, routine care, or any care other than Medically Necessary Emergency Services and Care, required by a Member while **outside of the Service Area.**

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

Personal comfort or convenience items, including, but not limited to, guest meals and accommodations, telephone charges, take-home supplies, and travel expenses other than ambulance or other transportation services that are Covered Services.

Physical therapy, speech therapy, and other rehabilitation therapies, except as specified in the Covered Services Section.

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

Private duty nursing care, except when prescribed by a Primary Care Physician or Participating Provider when on referral from the Primary Care Physician.

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

Vision care, except as otherwise specified in the Covered Services Section.

Vitamins, mineral supplements, fluoride drugs, food supplements or appetite suppressants.

Volunteer services or services which would normally be provided free of charge to a Member (for example, in a Hospice program approved by CHP); services of a person who ordinarily resides in the home of the terminally ill Member, or is a member of the Member's family, or of the Member's spouse's family; or any service not provided through the Hospice program approved by CHP.

Weight reduction programs, including without limitation, food supplements and appetite suppressants.

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

Limitations

The rights of Members and obligations of CHP hereunder are subject to the following limitations.

Direct Service Required

Except in emergency situations, or as otherwise specifically provided for in this Contract, all services must be received from a Primary Care Physician, Participating Providers on referral from Primary Care Physicians, or through organizations specifically designated by CHP for the Member's treatment.

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 contained in this Contract, CHP 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 CHP shall make a good faith effort to arrange such services, taking into account the impact of the event. In the case of labor disputes with CHP employed personnel, CHP shall arrange and pay for an alternate method of receiving care as necessary. For the purposes of this paragraph, an event is not within the control of CHP if CHP cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Fees and Non-Participating Providers

Except in cases of emergency or when authorized by the Medical Director of CHP, the cost of health care services rendered by persons other than Participating Providers shall be the sole responsibility of the Member.

SECTION 13: STATEMENT ON ADVANCE DIRECTIVES

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

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

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

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

Pursuant to Section 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 non-compliance 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 14: MEMBER'S RIGHTS AND RESPONSIBILITIES

CHP is committed to provide and/or arrange for the provision of quality health care in a cost effective manner while maintaining the dignity and integrity of our members. Consistent with our commitment, the following statement of Member's Rights and Responsibilities has been adopted.

RIGHTS

A. To receive information about CHP, its services, practitioners, providers and member rights and responsibilities.

B. To receive medical care and treatment from providers who have met the credentialing standards of CHP.

C. To expect health care practitioners who participate with CHP 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 member or other conservators to the extent permitted by applicable laws.

D. To expect health care practitioners who participate with CHP to provide treatment, with courtesy, respect, and with recognition of your dignity and right to privacy.

E. To communicate complaints or appeals about CHP or the care provided through the established appeal or grievance procedures found in your Member Handbook and the Group Health Services Agreement provided to your employer.

F. To have candid discussions with practitioners regarding appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

G. To have access to your medical records, and to have confidentiality of these records and member information maintained in accordance with Florida law and CHP policies.

RESPONSIBILITIES

A. To seek care through your Primary Care Physician (PCP), to obtain medically appropriate referrals from your PCP for specialist care, and to cooperate with all practitioners providing you care and treatment.

B. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.

C. To provide to the extent possible accurate and complete information concerning your health problems and medical history. To answer all questions truthfully and completely. To follow the plans and instructions for care that you have agreed to with your practitioners. To ask questions and seek clarification as necessary.

D. To pay copayments and to provide current information concerning your CHP membership status to any CHP affiliated practitioner or provider.

E. To follow established procedures for filing a complaint, appeal or grievance concerning medical or administrative decisions which you feel are in erorr.

F. To review and understand the benefit structure, both covered benefits and exclusions, as outlined in the Member Handbook.

G. To seek access to medical and member information through your Primary Care Physician or thorugh CHP Member Services.

SECTION 15: COMPLAINT AND GRIEVANCE PROCESS

Introduction

CHP has established a process for reviewing a Member's complaints and grievances. The purpose of this process is to facilitate review of, among other things, a Member's dissatisfaction with CHP, its administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care of any of the independent contracting healthcare providers in the CHP provider network. The CHP Complaint and Grievance Process also permits a Member, or his/her physician, to expedite CHP's review of certain types of complaints or grievances. (See *Expedited Review of Urgent Complaints or Grievances*). Members must follow the process set forth below in the event a complaint or grievance arises under this Contract.

Under the CHP Complaint and Grievance Process a Member may bring his/her dissatisfaction to CHP's attention either informally or formally. A verbal (i.e., nonwritten) expression of dissatisfaction

will be handled informally in accordance with the Informal Review subsection set forth below. A nonwritten expression of dissatisfaction is a complaint. A written expression of dissatisfaction will be handled formally in accordance with the Formal Review subsection set forth below. A written expression of a Member's dissatisfaction is a grievance.

CHP encourages Members to first attempt informal resolution of any dissatisfaction by calling CHP. If CHP is unable to resolve the matter on an informal basis, Members may submit their formal request for review in writing.

A. ***Informal Review***

Complaints

If a Member is dissatisfied with CHP, the Member should first contact an CHP Member Service Representative at the local CHP office, either by phone or in person, to advise CHP of the complaint. The telephone number is listed on the Membership Card and the address of the CHP local office is listed below. The Member Service Representative, working with appropriate personnel, will review the Member's complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction. If the Member remains dissatisfied with CHP's resolution of the complaint, the Member may request a formal review in accordance with the Formal Review subsection below.

***Important Note*:**

The Member must provide to the Member Service Representative all of the facts relevant to the complaint. Failure of the Member to provide any requested or relevant information may delay CHP's review of the complaint. Consequently, Members are obliged to cooperate with CHP in its review of the matter.

B. ***Formal Review***

Grievances

A Member, a provider acting on behalf of the Member, or a state agency, may submit a grievance. To submit or pursue a grievance on behalf of a Member, a healthcare provider must previously have been directly involved in the treatment or diagnosis of the Member.

1. *Level I*

   In order to begin the formal review process, the Member must complete, and submit to the local CHP office, a letter explaining the facts and circumstances relating to the grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation.

   If the grievance results from a coverage determination regarding Medically Necessity, the grievance will be reviewed by a committee consisting of a majority of providers. In this instance, the Member must submit his/her grievance within thirty (30) days of notice of CHP's coverage determination. All other grievances must be filed with CHP within one (1) year of the date of the occurrence that initiated the grievance.

CHP will review a Member's grievance and advise the Member of its decision in writing within approximately thirty (30) days from receipt of the grievance. If the Member remains dissatisfied with the decision of CHP, he/she may request reconsideration of the decision by the CHP Board of Directors' Grievance Committee as set forth below.

2. *Level II*

   In order to have the Level I decision reconsidered by CHP's Board of Directors, the Member must complete, and submit to CHP's Executive Director, a letter explaining why the Member feels that the Level I decision was wrong or not appropriate and what the Member would like CHP to do to remedy the matter.

   At the Member's request the CHP Board of Directors Grievance Committee will review the Level I decision as quickly as possible and advise the Member of its decision in writing within approximately thirty (30) days from receipt of the letter requesting reconsideration.

3. *Level III*

   If the Member is not satisfied with the decision of the CHP Board of Directors, he/she may submit the grievance to the Statewide Provider and Subscriber Assistance Panel within 365 days of the CHP Board of Director's decision.

Expedited Review of Urgent Complaints or Grievances

If CHP, based on information provided to it, makes a coverage determination that a service, which has yet to be provided to the Member, is not Medically Necessary, as defined in this Contract, the Member, or a provider acting on behalf of the Member, may submit a verbal (i.e., nonwritten) or written request for expedited review. A Member, or a provider acting on behalf of the Member, may request expedited review if the Member or the provider reasonably believes that a delay in reviewing the coverage decision due to the standard timeframes of the Complaint and Grievance Process would seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function and a healthcare provider has or will refuse to provide the service unless coverage or payment will be provided by CHP for the service.

Process for Requesting An Expedited Review

The Member, or a provider acting on the Member's behalf, must specifically request an expedited review. For example, this request may be made by saying: "I want an expedited review."

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

Information necessary to evaluate an expedited review may be transmitted by telephone, facsimile transmission, or such other expeditious method as is appropriate under the circumstances.

CHP will make a decision and notify the Member, or the provider acting on behalf of the Member, within seventy-two (72) hours after receipt of the request for expedited review.

If a Member's request for expedited review arises out of a utilization review determination by CHP that a continued hospitalization or continuation of a course of treatment is not medically necessary, coverage for the hospitalization or course of treatment will continue until the Member has been notified of the determination.

CHP will provide written confirmation of its decision concerning an expedited review within two (2) working days after providing notification of that decision, if the initial notification was not in writing.

CHP will not honor a request for expedited review which relates to services which have already been performed, rendered, or provided to the Member. Members must submit any such dissatisfaction or dispute to CHP in accordance with the standard complaint and grievance process described in subsections A and B above.

General Rules

General rules regarding CHP's Complaint and Grievance Process include the following:

1. The Member always has the right, at any time, to have a complaint or a grievance reviewed by the Florida Department of Insurance or the Agency for Health Care Administration or the Statewide Provider and Subscriber Assistance Program Panel. Telephone numbers and addresses are listed below. It is advisable that the Member complete the entire Complaint and Grievance Process outlined above before pursuing review by the Panel.

2. A grievance must be filed with CHP within one (1) year of the date of the occurrence that initiated the grievance. In order for grievances concerning coverage determinations of Medical Necessity to be reviewed by a committee consisting of a majority of providers, the Member must submit the grievance within thirty (30) days from the receipt of CHP's coverage determination.

3. A Member must cooperate fully with CHP in its effort to promptly review and resolve a complaint or grievance. In the event the Member does not fully cooperate with CHP, the Member will be deemed to have waived his or her right to have the complaint or grievance processed within the timeframes set forth above.

4. CHP shall offer to meet with the Member if the Member believes that such a meeting will help CHP resolve the complaint or grievance to the Member's satisfaction. The meeting will be held at CHP's Local Office within the Service Area or at a location within the Service Area which is convenient to the Member. For the convenience of the Member, and at the Member's option, the Member may elect to meet with CHP representatives in person, by telephone conference call. Appropriate arrangements will be made to allow telephone conferencing to be held at the administrative offices of CHP. These arrangements will be made by CHP with no additional charge to the Member. The Member must notify CHP that he/she wishes to meet with CHP representatives concerning the complaint or grievance.

5. CHP will provide assistance to the Member in completing written notices upon request of the Member. The Member may obtain such assistance by contacting a CHP Member Service Representative at CHP's Local Office.

6. The timeframes set forth herein may be modified by the mutual consent of CHP and the Member, however, any mutually agreed timeframe extension does not preclude the Member from having CHP's decisions reviewed by the Statewide Provider and Subscriber Assistance Program Panel at any time.

7. CHP will resolve a Member's grievance within sixty (60) days after receipt, or within ninety (90) days if the grievance involves the collection of information outside the Service Area. CHP may toll these time periods by notifying the Member, in writing, that additional information is required in order for CHP to complete its review of the grievance. Time is tolled until CHP receives such information. After CHP receives the requested information, the time allowed for completion of the formal process will resume.

Telephone Numbers and Addresses

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

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

Agency for Health Care Administration
2727 Mahan Drive, Building 1, Room 301
Tallahassee, Florida 32308
1-850-414-9367
1-800-226-1062

Statewide Provider and Subscriber Assistance Program
2727 Mahan Drive, Building 1, Room 301
Tallahassee, Florida 32308
1-850-414-9367
1-800-226-1062

Local Office Location

Capital Health Plan
2140 Centerville Place
P.O. Box 15349
Tallahassee, FL 32317-5349
(850) 383-3311
(800) 390-1434

Exhibit IV(a)
Capital Health Plan
Conversion Option A
Form No. 98200 999SC
Scope of Benefits

Description of Benefits			Copayment
I.	**PHYSICIAN SERVICES**		
	A.	Office visits for services provided by a Member's Primary Care Physician (PCP)	$15.00
	B.	Office visits for services provided by a Participating Provider on referral from the PCP or Non-Participating Provider authorized by the Medical Director of CHP	$25.00
	C.	Outpatient Surgical procedures or services, provided by the PCP, Participating Provider on referral from the PCP or Non-Participating Provider authorized by the Medial Director of CHP when rendered in the Provider's office	$25.00
	D.	Outpatient laboratory, x-ray, and other diagnostic testing authorized by the Medical Director of CHP	$0
II.	**HOSPITAL SERVICES**		
	A.	All Hospital Benefits	$150/day for days 1-7
	B.	Outpatient surgical procedures performed in a Hospital or ambulatory surgery center	$100 per visit
III.	**PREVENTIVE HEALTH SERVICES**		
	A.	Office visit(s) for services provided by a Member's PCP	$15.00
IV.	**MATERNITY SERVICES**		
	A.	**PHYSICIAN SERVICES**	
	1.	Office visit for services provided by a Member's PCP	$15.00
	2.	Office visit(s) for services provided by a Participating Provider on referral from the PCP or Non-Participating Provider authorized by the Medical Director of CHP	$25.00 initial visit only
	3.	Services of a Certified Nurse Midwife or Midwife	$0
	B.	**HOSPITAL SERVICES**	
	1.	Maternity inpatient care.	$150/day for days 1-7
	2.	Birth Center services	$0
V.	**EMERGENCY SERVICES**		
	A.	Emergency room visits in a Participating Hospital	$100.00
	B.	Emergency room visits in a non-participating Hospital	$100.00

Exhibit IV(b)
Conversion Option A
Form No. 98200 999SC

Scope of Benefits

Description of Benefits			Copayment
VI.	**OTHER BENEFITS**		
	A.	Home Health Services (60 days per Calendar Year)	$0
	B.	Hospice Care	$0
	C.	Skilled Nursing Facilities (100 days lifetime max per Member)	$0
	D.	Prosthetic Medical Appliances	$0
	E.	Durable Medial Equipment	$0
	F.	**Second Medical Opinion**	
		1. Services rendered by a Participating Provider	$25.00
		2. Services rendered by a Non-Participating Provider	40% of reasonable Charges
	G.	Out of Pocket Maximum per Calendar Year	$1,500 single $3,000 family