Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Capital Health Plan

Conversion Option C
For Individuals Under 65
Non-Group Contract

JOHN HOGAN
PRESIDENT/CEO

Capital Health Plan Conversion Option C for Individuals Under 65

Schedule of Copayments

All Copayments are subject to the maximum Copayment limitations described in the Contract. The following description of services is not intended to create, and shall not create, any rights or obligations that differ from or are inconsistent with those set forth elsewhere in the Contract.

Benefit Description	Copayment
Physician Services	
A. Primary Care Physician (PCP)	$25
B. Specialist	$50
C. Allergy Injection	$25
Inpatient Services	
A. Inpatient Hospital	$300/day, for first 5 days
B. Inpatient Physician	$0
Outpatient Services	
A. Surgical - Outpatient Hospital Surgical	$200 (per surgical procedure)
B. Surgical - Ambulatory Surgical Center	$100 (per surgical procedure)
C. Dialysis	$0
D. Diagnostic Lab	$0
E. Diagnostic Testing	$0
F. Diagnostic Imagery Services Including MRI, PET and CT Scans	$100
Emergency Services and Care	
A. Emergency Room in a Contracting Hospital	$150 (Waived if admitted)
B. Emergency Room in a Non-Contracting Hospital	$150 (Waived if admitted)
C. Ambulance (Medically Necessary)	$100
D. Urgent Care Facility (where available)	$75

Benefit Description	Copayment
Special Services	
A. Behavioral Health Services	
Mental Health	
1. Outpatient (20 visits/Calendar Year with a maximum Allowance of $50 per visit)	$25
2. Inpatient (limit 10 days per Calendar Year)	$100/day
3. Partial Hospitalization	$0

Substance Dependency	
1. Outpatient (44 visits/Calendar Year with a maximum Allowance of $35 per visit)	$25
2. Inpatient	$100/day
Inpatient/Outpatient (Maximum Lifetime Benefit)	$2,000
B. Durable Medical Equipment	$0
C. Home Health Care (60 visits/Calendar Year)	$25
D. Hospice Care	$0 Covered in lieu of hospitalization
E. Prosthetic and Orthotic Devices	$0
F. Spinal Manipulations Non-Surgical Spine & Back Disorder Treatment (10 visits/Calendar Year)	$25
G. Outpatient Rehabilitation Services (e.g., Outpatient Physical, Speech, Cardiac or Occupational) 20 visits/Calendar Year	$25
H. Skilled Nursing Facility (100 Days/Lifetime Maximum)	$0 Covered in lieu of hospitalization
I. Preventive Services (Calendar Year Maximum Benefit)	$250 Subject to PCP or Specialist Copay, whichever is applicable

Out-of-Pocket Maximum Expense Limits (per Calendar Year)

A. Single	$3,000
B. Family	$6,000
Maximum Lifetime Benefit	$5,000,000 per Member

Prescription Drugs

Preferred Generic Prescription Drugs	$10
Preferred Brand Prescription Drugs	$30
Non-Preferred Prescription Drugs	$50

Table of Contents

PLEASE CALL MEMBER SERVICES at 1-800/390-1434
Monday through Friday, 8:00 a.m. to 5:00 p.m.
for assistance regarding claims and information about coverage.

Section 1: Introduction to the Contract

Thank you for your application to convert to the CAPITAL HEALTH PLAN, INC. Individual Under 65 Non-Group Conversion Option C Contract. This is your Contract, which includes the Schedule of Copayments and any Endorsement(s). You should read it carefully before you need Health Care Services. It contains valuable information about:

- your Capital Health Plan Individual Conversion HMO benefits;
- what is covered;
- what is excluded or limited;
- our coverage and payment rules;
- how to access your benefits;
- how and when to file a claim;
- how to resolve a complaint or grievance;
- how much, and under what circumstances, we will pay;
- what you will have to pay as your share; and
- other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how we will coordinate benefits with other policies or plans; our subrogation rights; and our right of reimbursement.

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

When Reading Your Contract, Please Remember That

- You should read this Contract in its entirety to determine if a particular Health Care Service is covered.
- The headings of sections contained in this Contract are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- References throughout to “you” or “your” refer to you as the Subscriber and to your Covered Dependents, unless expressly stated otherwise or, in the context in which the term is used, it is clearly intended otherwise. Any references that refer solely to your Covered Dependent(s) will be noted as such.
- References throughout to “we,” “us,” and “our” refer to Capital Health Plan, Inc. We also may refer to ourselves as “CHP.”
- If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will be defined either in the Definitions section or within the particular section in which it is used.

What is an HMO?

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

Although some HMOs are similar, not all HMOs operate or are organized in the same way. For

example, an HMO can be organized and operate as a staff model, a group model, an IPA model, or a network model. Refer to the Types of HMOs subsection of the General Provisions section for further information.

Where do you find information on . . .

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

  Read the Covered Services and Exclusions and Limitations sections.

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

  Read the Financial Obligations of the Member section.

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

  Read the Enrollment and Effective Date of Coverage section.

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

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

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

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

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

  Read the Complaint and Grievance section.

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

  Read the Duplication of Coverage section.

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

  Read the Termination of Coverage section.

- **What do the terms used throughout this Contract mean?**

  Read the Definitions section.

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

  Read the Coverage Access Rules section.

Section 2: Member's Rights and Responsibilities

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

RIGHTS

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

RESPONSIBILITIES

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

Section 3: Financial Obligations of the Member

Copayments

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

Non-Covered Services

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

Maximum Copayments

Total Copayments in any Calendar Year shall not exceed the amount indicated in the Schedule of Copayments, which in no event will exceed twice the total annual Premium costs that you would be required to pay if you were enrolled under an option with no Copayments. After you reach the out-of-pocket maximum expense limit for a Member or a family listed on the Schedule of Copayments, Covered Services will be provided for that Member or family with no Copayment charge for the remainder of the Calendar Year. It is your responsibility to submit a receipt to us for each Copayment you pay after either of these Copayment limits has been reached. When we receive the appropriate documentation, we will reimburse you for each Copayment you have paid.

Section 4: Coverage Access Rules

It is important that you become familiar with the rules for accessing health care coverage through CHP. The following subsections explain our role and the role of your Primary Care Physician (PCP), how to access specialty care coverage through CHP and your PCP, and what to do if Emergency Services and Care are needed. It is also important for you to review all Coverage Access Rules for particular types of Services and Contracting Providers within the Service Area.

Choosing a Primary Care Physician

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

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

Specialist Care

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

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

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

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

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

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

Continuity of Coverage and Care on Termination of a Provider Contract

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

1. the completion of treatment for the Condition; or
2. you select another Contracting Provider.

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

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

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

Emergency Services and Care

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

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

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

Service Area

All non-emergency services must be received within our Service Area. Refer to Attachment A for the counties in our Service Area. Refer to your provider directory for the providers in our Service Area.

Verifying Provider Participation

You are responsible for verifying the participation status of a Physician, Hospital, or other provider before receiving Health Care Services. To determine if a particular health care provider is in the CHP provider network, review the most recent provider directory. To verify a specific health care provider's participation status, contact CHP's Member Services office.

Case Management

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

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

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

Access to Osteopathic Hospitals

You may obtain inpatient and outpatient Services similar to inpatient and outpatient Services by allopathic hospitals from a Hospital accredited by the American Osteopathic Association when such Services are available in the Service Area and when such Hospital has not entered into a written agreement with us with regard to such Services. The Hospital providing such Services may not charge rates that exceed the Hospital's usual and customary rates less the average discount that we have with allopathic Hospitals within the Service Area. It is your responsibility to contact us to obtain the documents necessary to comply with this provision.

Special Access Rules for Other Providers

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

Dermatologists: You have access to network dermatologists for a maximum of five visits

within a Calendar Year for Covered Services without an authorization or referral from your PCP. Any Services rendered above these five visits require an authorization from your PCP. If you do not get an authorization, visits over five within a Calendar Year will not be covered.

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

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

Services Not Available from Contracting Providers

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

Physician Compensation

Capital Health Plan compensates physicians in ways that are intended to emphasize preventive care, promote quality care, and assure the most appropriate use of medical services. Working with PCPs, CHP makes decisions about the coverage of the member's health care based only on the suitability of care and service. CHP does not reward reviewers or provide financial incentives to deny coverage or service.

To keep you informed about matters related to your health care, we offer the following summary description of the ways that Capital Health Plan compensates physicians who participate in our network.

Salary

Physicians who are employed to work in a Capital Health Plan Health Center are paid a salary. The compensation is based on a dollar amount that is guaranteed regardless of the services provided. Physicians are eligible for additional payment for extra sessions worked and meeting or exceeding targeted quality of care goals.

Capitation

Some physicians are prepaid a fixed amount at regular intervals for each participant who selects the physician whether or not services are provided. This payment covers services routinely provided by the physician to his or her patients. Capitation offers physicians a predictable income, encourages physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork. Physicians paid by Capital Health Plan on a capitated basis are not put at risk for the cost of any services they do not routinely provide, such as referrals to specialists, hospital services, or prescription drugs.

Discounted Fee for Service

Some physicians are paid a specific discounted amount for services provided.

If you have any questions regarding Capital Health Plan's physician network, please feel free to call Member Services, Monday through Friday, 8am through 5pm or visit our website at www.capitalhealth.com.

Discretionary Authority

CHP has the discretionary authority to determine eligibility, to construe terms of this contract, and to make decisions concerning claims for covered services under the terms of this contract.

Section 5: BlueCard® Program

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

When the Member obtains Covered Services through the BlueCard® Program outside the State of Florida, the terms and conditions of the Agreement still will apply. CHP will reimburse the Host Blue for Covered Services calculated on the lower of 1) the billed charges for the Member's Covered Services; or 2) the negotiated price that the on-site Host Blue passes on to CHP.

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

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

A Member's financial responsibilities may vary depending on the provider chosen under the BlueCard® Program. For information on the BlueCard® participation status of providers, call the BlueCard® access number on the Membership Card when listed or call the Member Services number on the Membership Card for further assistance.

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

1. The payment of any applicable Copayment requirements;

2. The payment of expenses that are limited, excluded, or not covered;

3. The payment of any expenses in excess of any benefit maximum limitations; and

4. The payment of any expenses for services when coverage authorization from CHP was required and not obtained.

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

Section 6: Medical Necessity

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

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

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

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

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

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

Section 7: Covered Services

Introduction

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

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

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

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

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

Benefit Guidelines

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

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

Covered Services Categories

Accident Care

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

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded except for Services (not otherwise excluded) when you are not covered by Workers' Compensation and that

lack of coverage did not result from any intentional action or omission by you.

Allergy Testing and Treatments

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

Ambulance Services

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

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center include:

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

Anesthesia Administration Services

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

Exclusion:

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

Breast Reconstructive Surgery

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

Child Cleft Lip and Cleft Palate Treatment Services

Medical, dental, Speech Therapy, audiology, and nutrition Services for the treatment of a child under the age of 18 who has cleft lip or cleft palate. For such Services to be covered, your PCP, or a Contracting Provider on referral from your PCP, must specifically: 1) prescribe such Services, and 2) certify, in writing, that the Services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Child Health Supervision Services

Periodic Physician-delivered or Physician-supervised Services provided to a Covered Dependent from the moment of birth up to the 17th birthday as follows:

1. Periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
2. Oral and/or injectable immunizations; and

3. Laboratory tests normally performed for a well child.

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

Dental

Dental care is limited to the following:

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

Dermatology Services

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

Diabetes Treatment Services

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

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

To be covered, diabetes outpatient self-management training and educational Services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. Additionally, to be covered, nutrition counseling must be provided by a licensed Dietitian. Covered Services for the treatment of severe diabetic foot disease also may include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications).

Diagnostic Services

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

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

Dialysis Services

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

Durable Medical Equipment

Durable Medical Equipment including diabetic equipment and supplies prescribed by your PCP, or a Contracting Provider on referral from the PCP, and that has been authorized by us as a Covered Service. Diabetic equipment and supplies will not be subject to any Durable Medical Equipment Calendar Year Maximum or Lifetime Maximum that may apply to your benefit plan. We reserve the right to rent or purchase the most cost-effective Durable Medical Equipment that meets your needs. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. Services to repair medical equipment, which have been authorized by us, may be covered only if you own the equipment or are purchasing the equipment, or when necessary because of growth of a Covered Dependent child or because of change in your Condition.

The wide variety of Durable Medical Equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered Durable Medical Equipment, however, some Durable Medical Equipment specifically has been excluded.

Exclusions:

Equipment that is for convenience, comfort, and/or environmental control or equipment that has not been authorized by us is not covered. This exclusion includes, but is not limited to, modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools, or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers/cleaners/filters, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, and dehumidifiers.

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

Emergency Services and Care

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

Emergency Services and Care in or out of the Service Area without prior notification to us, subject to the Copayment amount set forth in the Schedule of Copayments. It is your responsibility, however, to notify us as soon as

possible, concerning the receipt of Emergency Services and Care and/or any admission that results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for Services rendered subsequent to that determination would be your responsibility.

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

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

Enteral Formulas

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

Coverage to treat inherited diseases of amino acid and organic acids up to your 25th birthday includes food products modified to be low protein in an amount not to exceed $2,500 annually.

Eye Care

Eye care including the following Services:

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

Exclusion:

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

Home Health Care

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

1. You are unable to leave your home without considerable effort and the assistance of another person because you are bedridden or chairbound, or because you are restricted in ambulation whether or not you use assistive devices, or you are limited significantly in physical activities because of a Condition;
2. The Home Health Care Services rendered have been prescribed by your PCP or a Contracting Provider when on referral from the PCP by way of a formal written treatment plan that has been reviewed and renewed by the prescribing Physician every 30 days. We reserve the right to request a copy of any written treatment plan to determine whether such Services are Covered Services;
3. We approve the formal written treatment plan;
4. The Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency within the Service Area; and

5. You are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Coverage for Home Health Care Services is limited to:

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

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

Exclusion:

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

Hospice Services

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

Exclusion:

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

Hospital Services

Hospital Services provided at Contracting Hospitals when you are an outpatient or inpatient admitted on the instruction, written authorization, or referral by a PCP. Such Services may include:

1. room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive, and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory therapy (e.g., oxygen);
6. drugs and medicines administered by the Hospital;
7. intravenous solutions;
8. administration, including the cost, of whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., EKG);
13. chemotherapy treatment for proven malignant disease;

14. Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Therapy (in connection with a covered Condition);
15. other Medically Necessary Services; and
16. transplants as described in the Transplant Services subsection.

Exclusion:

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

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

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

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

Mammograms

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

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards in a manner determined in consultation with you and the attending Physician. Outpatient post-surgical follow-up care for Mastectomy Services will be covered when provided by a Contracting Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Care

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

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

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

Exclusion:

Prenatal care and delivery outside the Service Area, unless the need for such Services was not, and reasonably could not have been, anticipated before leaving the Service Area.

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

Mental Health Services

1. Inpatient:

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

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

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

2. Outpatient:

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

Exclusion:

Mental Health Services that are:

1. rendered in connection with a Condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;
2. extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;
3. for marriage and juvenile counseling;
4. court-ordered care or testing, or required as a condition of parole or probation;
5. testing for aptitude, ability, intelligence, or interest;
6. testing and evaluation for the purpose of maintaining employment; or
7. cognitive remediation.

Newborn Child Care

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

1. Services for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth;
2. postnatal care for the newborn including the following: a postnatal assessment provided at the Hospital, the attending Physician's office, at a Birth Center, or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife, or Certified Nurse Midwife. The postnatal assessment Services include:
   a) the physical assessment of the newborn; and

b) performance of clinical tests and immunizations in keeping with prevailing medical standards.

3. Ambulance Services when necessary to transport the newborn child to and from the nearest appropriate facility that is appropriately staffed and equipped to treat the newborn child's Condition, as determined by us and certified by the PCP or a Contracting Physician as Medically Necessary to protect the health and safety of the newborn child.

Notes:

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

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

Orthotic Devices

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

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

Payment for splints for treatment of temporomandibular joint (TMJ) dysfunction is limited to payment for one splint in a six-month period unless a more frequent replacement is determined by us to be Medically Necessary.

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

Exclusion:

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

Osteoporosis Screening, Diagnosis, and Treatment

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

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

Outpatient Rehabilitation Services

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

1. Speech Therapy:

   Services of a Speech Therapist or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from illness, injury, stroke, or surgical procedure.

2. Physical/Occupational Therapy:

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

3. Cardiac Therapy:

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

Benefit Guidelines for Outpatient Rehabilitation Services

To be covered:

1. we must review, for coverage purposes only, a Rehabilitation Plan submitted or authorized by your PCP or a Contracting Provider on referral from the PCP;
2. we must agree that your Condition is likely to improve significantly within 60 days from the first date such Services are to be rendered;
3. such Services must be provided to treat functional defects that remain after an illness or injury; and
4. such Services must be Medically Necessary for the treatment of a Condition.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of rehabilitation Services to be provided to you with rehabilitation potential. The Rehabilitation Plan is required and must be renewed periodically as requested by CHP. Such a plan must have realistic goals that are attainable by you within a reasonable length of time and must be likely to result in significant improvement within 60 days from the first date such Services are to be rendered.

Exclusion:

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

1. Services or supplies provided to you as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, when the admission is primarily to provide rehabilitative Services;
2. Services that maintain rather than improve a level of physical function, or when it has been determined that the Services will not result in significant improvement in your Condition; or within a 60 day period; or
3. Services for treatment of abuse of or addiction to alcohol and drugs.
4. Long-term rehabilitation services (i.e., services in excess of 62 days from the first date the member begins such services).

Oxygen

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

Physician Services

Health Care Services provided by a Physician.

Prescription Drugs

Prescription Drugs, including syringes and needles when obtained with a prescription for insulin, are covered when prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of his or her license, and are received by you. The Copayments paid by you for Covered Prescription Drugs and/or covered syringes and needles will be applied to the out-of-pocket maximum expense limit set forth in the Schedule of Benefits.

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

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;
2. dispensed by a Pharmacist;
3. be Medically Necessary; and

4. not otherwise limited or excluded.

Pharmacy Alternatives and Payment Rules

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

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

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

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

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

Covered Prescription Drugs

1. Includes any drug, medicine, or medication or oral contraceptive that, under Federal or state law, may be dispensed only by Prescription from a Physician, or any compounded Prescription containing such drug medicine or medication;
2. Includes covered syringes and needles dispensed only by Prescription from a Physician;
3. Includes insulin, hypodermic needles, and syringes with insulin on Prescription;
4. Must be prescribed by a Physician or Health Care Provider for the treatment of a Condition;
5. Must be dispensed by a Pharmacist;
6. Are limited to the lesser of a 31-day or 100-unit dose supply per Prescription per month;
7. Includes Prescription refills, but will not be covered until at least 75% of the previous Prescription has been used by you, (based on the dosage schedule prescribed by the Physician); and
8. Injectable drugs and biologicals only if:
   a) They are furnished incidental to a Health Care Provider's covered professional services;
   b) They are reasonable and necessary for the diagnosis or treatment of the covered illness or injury for which they are administered according to our accepted standard;

c) They have not been determined by the FDA to be “less-than-effective”;

d) The injection is considered the indicated effective method of administration according to the accepted standards of medical practice for the covered Condition;

e) The frequency, amount, and duration of the course of injectable drug or biological meets accepted standards of medical practice as an appropriate level of care for a specific Condition unless there are extenuating circumstances that justify the need for additional injections; and

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

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

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

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

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

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

   c) They are not immunizing agents;

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

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

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

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

No coverage is provided for:

1. Any drug, medicine, or medication that is consumed at the place where the

Prescription is given or that is dispensed by a Health Care Provider;

2. Any portion of a Prescription or refill that exceeds a 31-Day Supply or a 100-unit dose per month, whichever is less;
3. Prescription refills in excess of the number specified by the Health Care Provider or dispensed more than 6 months from the date of the Physician's original order;
4. The administration of covered medication unless otherwise covered herein;
5. Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a Hospital, Skilled Nursing Facility, convalescent Hospital, inpatient hospice facility, or other facility in which drugs ordinarily are provided by the facility on an inpatient basis;
6. Prescriptions that are paid or received without charge under local, state, or federal programs, including Worker's Compensation;
7. Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision of this Contract;
8. Any drug or medication labeled "Caution-Limited by Federal Law to Investigational Use." Prescription Drugs that have not been approved by the FDA, as required by federal law, for distribution and delivery into interstate commerce;
9. Immunizing agents, biological serums, or allergy serums;
10. Any drug or medicine that is lawfully obtainable without a Prescription, with the exception of insulin;
11. Any appetite suppressant and/or other Prescription Drug indicated, or used, for purposes of weight reduction or control;
12. Prescription Drugs used for cosmetic purposes including but not limited to Minoxidil, Rogaine, and Renova. (Retin-A is excluded after age 26);
13. Drugs listed in the Homeopathic Pharmacopoeia;
14. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;
15. Any costs related to the mailing, sending, or delivery of Prescription drugs;
16. Mineral supplements, or vitamins, except Prescription prenatal vitamins, oral single product fluoride (non-vitamin supplementation), Prescription sustained release niacin, Prescription folic acid, Prescription oral hematinic agents, dihydrotachysterol, and calcitriol;
17. Smoking cessation Drugs (e.g., Zyban);
18. Drugs prescribed by a Pharmacist;
19. Drugs purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized by us;
20. Prescription Drugs that do not have a valid National Drug Code;
21. Any Prescription Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such

Prescription Drug. This exclusion does not apply if:

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

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

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

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

23. Fertility Drugs.

Preventive Health Services

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

1. periodic health assessments;
2. instruction in personal health care measures;
3. routine immunizations and inoculations, including flu shots;
4. eye and ear screening examinations in the office of a PCP to determine the need for vision and hearing correction;
5. prostate specific antigen (PSA) screening for men;
6. family planning counseling and information on birth control, sex education, including prevention of venereal disease, and fitting of diaphragms;
7. health education programs organized, sponsored, or offered by us, including nutrition education and counseling; instruction in personal health care and the appropriate use of Services; information regarding the coverage and benefits offered by us and the generally accepted medical standards for the use and frequency of each; and
8. one routine preventive gynecological examination per Calendar Year, including Medically Necessary covered follow-up care to treat a Condition detected at that visit without a referral from the PCP. The annual examination may include a manual breast

exam, a pelvic exam, and a pap smear. This examination must be provided by the Member's PCP or a Contracting Provider who is an obstetrician or gynecologist. For there to be coverage under this provision, follow-up care to treat a Condition detected during the annual examination may be provided by the same obstetrician or gynecologist who performed the annual examination. If you receive Services from the obstetrician or gynecologist for any Condition not detected during the annual routine preventive gynecological examination, a referral from the PCP will be required. **Reminder:** Any referral to another Specialist requires a referral from the PCP.

Prosthetic Devices

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

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

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

1. cardiac pacemakers;
2. prosthetic devices incident to Mastectomy; and
3. ventricular assist devices (see the Transplant Services subsection).

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

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

Second Medical Opinion

Members who elect to obtain a second medical opinion must notify their PCP of their intent to do so before obtaining the second medical opinion. You may request and obtain a second medical opinion when you dispute either our or a Contracting Physician's opinion of the reasonableness or necessity of a surgical procedure or you are subject to a serious injury or illness. You may request and obtain a second medical opinion if you feel that you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated. We also may require you to obtain such a second medical opinion. In either case, you 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 considered necessary by a Non-Contracting Physician, must be Medically Necessary and must be performed within the CHP network of Contracting Providers.**

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

We may deny benefits, granted under this provision, if you seek in excess of three second medical opinions per Calendar Year if the second medical opinion costs are considered by us to be evidence that you have unreasonably over-utilized the second medical opinion privileges. The decision of the Medical Director, derived after review of the documentation from the second medical opinion that you obtained, will be controlling as to our coverage obligations for the second medical opinion.

Skilled Nursing Facilities

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

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

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

Limitation:

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

Spinal Manipulations

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

Substance Dependency Treatment Services

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

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

Exclusions:

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

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

Surgical Assistant Services

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

Surgical Procedures

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

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

Transplant Services

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

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

1. Bone Marrow Transplant, as defined herein, which is listed specifically in rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;

5. kidney transplant;
6. liver transplant;
7. lung-whole single or whole bilateral transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. pancreas transplant alone or after a kidney transplant.

Note: Pre-transplant Services include ventricular assist devices for up to 30 days when used as a bridge during heart or heart-lung transplants.

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

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

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

Benefit Guidelines

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

Once a coverage decision is made, our Medical Director will advise you or your Physician of the coverage decision. Covered Services are payable only if the pre-transplant Services, the transplant, and post-discharge Services are performed in a facility acceptable to us.

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

Exclusion:

No benefit is payable for, or in connection with, transplant procedures:

1. not included in the list above, or otherwise excluded herein (e.g., Experimental or Investigational transplant procedures);
2. when our Medical Director and your PCP are not contacted for authorization before referral for evaluation of the transplant;
3. when our Medical Director does not pre-authorize coverage for the transplant;

4. involving the transplantation of any non-human organ or tissue;
5. related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us;
6. involving the implant of an artificial organ (e.g., artificial heart), including the artificial organ;
7. involving any organ, tissue, marrow, or stem cells that are sold rather than donated;
8. involving any Bone Marrow Transplant, as defined herein, that is not specifically listed in rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare under a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published *Medicare Coverage Issues Manual*;
9. involving any service in connection with identification of a donor from a local, state, or national listing, except in the case of a Bone Marrow Transplant; or
10. involving any artificial heart devices (if used as a bridge to transplant), except ventricular assist devices.

Section 8: Exclusions and Limitations

Exclusions

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

General Exclusions

General Exclusions include, but are not limited to, expenses for:

1. Any Health Care Services not listed specifically in the Covered Services section or in any Endorsement attached hereto, unless such expenses specifically are required to be covered by applicable law.
2. Any Health Care Services provided to, or received by you, if you do not follow our Coverage Access Rules. For further information, please refer to the Coverage Access Rules section.
3. Any Health Care Service, which in our opinion was, or is, not Medically Necessary. The ordering of a Service by a health care provider, including without limitation, a health care provider who is a Contracting Provider, other than as authorized by CHP, does not in itself make such Service Medically Necessary or a Covered Service.
4. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services;
5. Any Health Care Services received before your Effective Date or received on or after the date your coverage terminates under this Contract, unless coverage is extended in accordance with the Extension of Benefits section;
6. Any Health Care Services provided by a Physician or other health care provider related to you by blood or marriage or any Health Care Services you provide to yourself;
7. Any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;
8. Any Health Care Service rendered at no charge;
9. Elective care, routine care, or any care other than Medically Necessary emergency care, you require while outside of the Service Area;
10. Expenses for claims denied because we did not receive information requested from you regarding whether you have other coverage and the details of such coverage;
11. Any Health Care Services with respect to which CHP requests information from you regarding any other health plan coverage you had or have and you fail to provide the requested information; or
12. Any Health Care Services to diagnose or treat a Condition that, directly or indirectly, resulted from or is in connection with:
    a) war or an act of war, whether declared or not;
    b) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
    c) your engaging in an illegal occupation;
    d) Services received to treat a Condition arising out of your service in the armed forces, reserves, and/or National Guard.

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

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

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

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

Complementary and alternative healing methods including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy (except when used to treat metal toxicity and lead poisoning); thermography; mind-body interactions such as meditation, imagery, yoga, dance, music, or art therapy; biofeedback; prayer and mental healing; massage that is not part of a Rehabilitation Plan approved by CHP; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, Swedish massage, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

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

Contraceptive Appliances

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

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

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

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

Dental care, care or treatment of the teeth or their supporting structures or gums, or dental procedures, including, but not limited to: extraction of teeth (impacted or otherwise), restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to any non-surgical Phase II treatment (as defined by the American Dental Association) for TMJ dysfunction including, but not limited to,

orthodontic treatment. This exclusion does not apply to Accidental Dental Care and Child Cleft Lip and Cleft Palate Treatment Services described in the Covered Services section.

Drugs

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

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

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

Foot care, which is routine including any Health Care Service in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, corns, calluses, or trimming of toenails.

Gene Therapy

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

Hypnotism or hypnotic anesthesia.

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

Infertility Diagnostic and Treatment Services including without limitation:

1. Office visits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Weight control services, including any service to lose, gain, or maintain weight, including without limitation: surgical procedures performed on a covered person for the treatment of morbid obesity or to revise, or correct, defects related to a prior intestinal bypass, stomach stapling or balloon dilation; any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise programs; equipment; whether or not it is part of a treatment plan for a condition.

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

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

Limitations

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

Circumstances Beyond the Control of CHP:

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

Section 9: Eligibility for Coverage

Each individual who was a Member under a Group Contract for at least three months immediately before termination, who is eligible to convert his or her Coverage to non-group Coverage under 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 Individual non-group Conversion Coverage. Additionally, newly-acquired dependents of Members may be eligible for Coverage 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, an individual 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 months immediately before termination;
4. apply for Coverage under, and be named on the Application for, this Contract;
5. pay the required Premiums;
6. not be eligible for Medicare on the Effective Date of Coverage.

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

1. if you had not been covered continuously under a Group Contract for at least three months before your termination; or
2. if termination of your Group Contract occurred because of your failure to pay any required Premiums, supplemental charge, or Member contribution (e.g., Copayments) unless such nonpayment was because of acts of an employer or person other than the individual; or
3. because your discontinued Group coverage was replaced by similar Group coverage within 31-days of termination; or
4. because you provided fraudulent information or material misrepresentation in applying for Coverage under this Contract; or
5. if termination of your Group Contract occurred for cause as set forth in the *Termination of Individual Coverage 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 uninsured basis; or
2. if termination of your Group Contract occurred because of your failure to pay any required Premiums, supplemental charge, or Member contribution (e.g., Copayments), unless such nonpayment was because of acts of an employer or person other than the individual; or
3. because your discontinued Group coverage was replaced by similar Group coverage within 31 days of termination;

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

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

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

Eligibility Requirements for Dependents

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 Requirements for Subscribers*** subsection of this Contract; and

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

2. be a Member's natural child (including a newborn child), step-child, adopted child, foster child (including a newborn child who is required to be eligible for Coverage hereunder as an adopted child in conformity with applicable law), or a child for whom the Subscriber has been appointed legal guardian under a valid court order (or in the case of a foster child, is no longer eligible under the Foster Child Program), and who is:

   a) principally dependent on the Subscriber for financial support as determined by CHP; and

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

   (2) under 25 years of age and living in the household of the Subscriber or a full-time or part-time student; or

   (3) a Dependent child, 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 that commenced before the time such Dependent reached his or her 19th birthday, and who is principally dependent on the Subscriber for support and maintenance. Satisfactory proof of such incapacity and dependency must be furnished to CHP by the Subscriber within 30 days of such Dependent's 19th birthday and within 30 days of each birthday thereafter. If the Dependent ceases to be incapable of self-sustaining employment as set forth above, eligibility automatically terminates at the end of the month in which the Dependent ceases to be so incapable.

   (4) the newborn child of a Covered Dependent child. Coverage for such newborn child automatically will terminate 18 months after the birth of the newborn child.

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

Other Provisions Regarding Eligibility

1. 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.

2. The Subscriber must notify us as soon as possible when a Covered Dependent is no longer eligible for coverage (for example, no longer a Full-Time Student). If a Covered Dependent fails to continue to meet each of our eligibility requirements under this Contract, and such proper notification is not timely provided by the Subscriber to us, we shall have the right to retroactively terminate coverage of such Covered Dependent to the date any such eligibility requirement was not met, and to recover an amount equal to the Allowed Amount for services provided following such date less any Premium and other applicable charges received by us for such dependent for coverage after such date. On our request, the Subscriber shall provide proof, which is acceptable to us, of the Covered Dependent's continuing eligibility for coverage.

Section 10: Enrollment and Effective Date of Coverage

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

General Rules for Enrollment

1. Individuals may apply for coverage by completing and submitting the appropriate Enrollment Forms in accordance with the applicable enrollment procedures established by us.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) we may have, in disqualification for, termination of, or rescission of coverage
3. We will not provide coverage and/or benefits to any individual who would not have been entitled to enrollment with us, had accurate and complete information been provided on a timely basis on the Enrollment Forms. In such cases, we may require such individual, or an individual legally responsible for that individual, to reimburse us for any payments we made on behalf of such individual.

   Note: Any individual who is not enrolled properly will not be eligible for Covered Services hereunder and we shall have no obligation whatsoever under this Contract with respect to such individual

Enrollment of Members/Effective Date

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

1. complete and submit an Application to us within the 63-day period immediately following the termination date of coverage under the Group Contact;
2. provide any additional information needed to determine eligibility, if requested by us; and
3. pay the required Premium within 63 days following the termination date of coverage 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 us. There may be additional Premiums for each Dependent.

The Effective Date of Coverage under this Contract is the day following the termination of coverage under the Group Contract.

Additional Requirements for Enrollment of Dependents/ Effective Date

Individuals eligible for coverage 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 we receive the Member Status Change Request form before or within 30 days after the date of birth. If the form is received by us before or within this 30-day period, Premiums will not be

charged for the first 30 days of coverage. If we do not receive the form before or within 30 days after the date of birth, the newborn child will be added as of the date of birth and any applicable Premiums will be charged 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 automatically will terminate 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 coverage shall be:

   a) the moment of birth, provided that a written agreement to adopt such child has been entered into by the Member before 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 enrolled properly.

   To enroll an adopted newborn child, the Subscriber must submit to us a Member Status Change Request Form before birth or placement or within 30 days after the date of birth or placement, and pay the additional Premium. If the form is received by us before or within this 30-day period, Premiums will not be charged for the first 30 days of coverage. If we do not receive the form before or within 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 Premium is paid back to the date of birth.

   If the adopted newborn child ultimately is not 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 us within ten calendar days if the adopted newborn child is not placed in the residence of the Subscriber.

3. Adopted/Foster Child – The Effective Date for an adopted child (other than an adopted newborn child) or foster child eligible for coverage shall be the date such adopted child or foster child is placed in the residence of the Subscriber in compliance with Florida law, provided such adopted child or foster child is enrolled properly and provided that the adopted child or foster child is so placed in the residence of the Subscriber.

   To enroll an adopted child or foster child, the Subscriber must submit to us a Member Status Change Request Form before or within 30 days after placement, and pay the additional Premium. If the form is received by us before or within this 30-day period, Premiums will not be charged for the first 30 days of coverage. If we do not receive the form before or within 30 days after the date of placement, the adopted child or foster child will be added as of the date of placement as long as any applicable Premiums are 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 us. It is the responsibility of the Subscriber to notify CHP if the adoption does not take place. On

receipt of this notification, we will terminate the coverage of the child on the first billing date following our receipt of your written notice.

If your status as a foster parent is terminated, Coverage shall not be continued for any foster child. It is your responsibility to notify us that the foster child is no longer in your care. On receipt of this notification, we will terminate the Coverage of the child on the first billing date following receipt of the 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 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 18.

Any individual who is not enrolled properly will not be eligible for Covered Services hereunder and we shall have no obligation whatsoever under this Contract with respect to such individual.

Other Requirements/Rules Regarding Enrollment

All of the following additional requirements must be met 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 Premiums 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 Premiums in advance.
3. Subscribers are responsible for adding and deleting Dependents in a manner consistent with this Contract on a timely basis. Subscribers immediately must advise us if 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 11: Termination of Coverage

Termination of Subscriber Coverage

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

1. terminates this Contract (see Termination by Subscriber subsection);
2. fails to timely pay Premiums required under this Contract; or
3. moves out of the Service Area.

Termination of Covered Dependent Coverage

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

1. coverage of the Covered Dependent is terminated by the Subscriber;
2. this Contract terminates (see Termination by CHP subsection);
3. his or her Subscriber's Coverage terminates for any reason;
4. the Dependent fails to continue to meet each of the eligibility requirements under this Contract;
5. of failure to timely pay Premiums under this Contract.

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

Termination by Subscriber

This Contract may be terminated by the Subscriber by giving written notice to us at least 30 days before the end of the last period for which a Premium has been paid. In such event, termination of this entire Contract shall be effective at midnight on the last day of such period.

Certification of Creditable Coverage

If coverage terminates for any reason, we will issue you a written Certification of Creditable Coverage.

The Certification of Creditable Coverage will indicate the period of time you were enrolled with us. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period on subsequent health care coverage by the length of time you had prior Creditable Coverage.

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

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

Responsibilities of CHP on Termination of an Individual's Coverage

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

Section 12: Duplication of Coverage

Coordination of Benefits

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

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is your responsibility to provide us and your Physician with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at the time you apply for this Contract or at enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If we do not receive the information we request from you, we may deny your claims and you will be responsible for payment of any expenses related to denied claims.

Health plans, programs, or policies that may be subject to COB include, but are not limited to, the following, which will be referred to as "plan(s)" for purposes of this section:

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program, or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage with which the law permits us to coordinate benefits;
4. Medicare; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of our payment, if any, when we coordinate benefits under this section, is based on whether we are the primary payer. When we are primary, we will pay for Covered Services without regard to coverage under other plans. When we are not primary, our payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services.

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

1. When we cover you as a Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.
2. When we cover a dependent child whose parents are not separated or divorced:
   a) the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or
   b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than us, we will be secondary.
3. When we cover a dependent child whose parents are separated or divorced:
   a) if the parent with custody is not 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 stepparent's plan is secondary, and the plan of the parent without custody pays last;

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

4. When we cover a dependent child and the dependent child also is covered under another plan:

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

   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan that has covered you the longest shall be primary, unless you are age 65 or older and covered under Medicare parts A & B. In that case, this Contract will be secondary to Medicare.

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

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

Facility of Payment

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

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Contract shall not duplicate any benefits to which you or your Covered Dependents are entitled, or eligible for, under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program that may be provided or required by law.

Section 13: Subrogation

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

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

Section 14: Right of Reimbursement

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

Our right of reimbursement will be in addition to any subrogation right or claim available to us, and you must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement hereunder. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness.

You must do nothing to prejudice our right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written

Section 15: Claims Processing

How to File a Claim for Benefits/Time Requirement

Contracting Providers have agreed to file, when appropriate, claims for Covered Services with CHP on your behalf. If you obtain services or supplies from a Non-Contracting Provider who does not file the claim on your behalf, it is your 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 Identification Card within 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 year 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 Identification Card. The itemized statement must contain the following information:

1. the date the service or supply was provided;
2. a description of the service or supply;
3. the amount actually charged by the Provider;
4. the diagnosis;
5. the Provider's name and address;
6. the patient's name; and
7. the Subscriber's name.

Processing the Claim

Definitions

The following term, as used in this section, is defined as follows:

Post-Service Claim(s) means any paper or electronic request or application for coverage, benefits, or payment for a service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or in an electronic format acceptable to us in accordance with provisions of this section.

Processing Post-Service Claims

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

- Payment for Post-Service Claims

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

- Contested Post-Service Claims

If CHP contests an electronically submitted Post-Service Claim, or a portion of such a claim, CHP will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. If CHP contests a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, CHP use its best efforts to provide notice, within 3(

days of receipt, that the claim or a portion of the claim is contested. The notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that CHP reasonably expects to notify the Member of the decision. The notice also may indicate whether more or additional information is needed to complete processing of the claim.

If CHP requests additional information, CHP must receive it within 45 days of the request for the information. **If CHP does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in the possession of CHP at the time, and may be denied.** On receipt of the requested information, CHP will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- Denial of Post-Service Claims

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

Additional Processing Information

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

CHP will investigate any allegation of improper billing by a Provider on receipt of written notification from the Member. If CHP determines that the Member was billed for a service that actually was not performed, any payment amount will be adjusted and, if applicable, a refund will be requested.

Review of Claims that are Denied

If CHP denies a claim, the Member may request CHP to review the decision to deny the claim. The Member must request such review within 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 promptly will notify the Member of its review decision. The Member may designate, in writing, an individual to represent the Member during the review process.

Each Member (or a Provider acting on behalf of a Member) who has had a claim denied as not Medically Necessary, has the opportunity to appeal the claim denial. The appeal may be directed to an employee of CHP who is a licensed Physician responsible for Medical Necessity review. The appeal may be by telephone and CHP's Physician will respond to the Member within a reasonable time, not to exceed 15 business days.

Additional Claims Processing Provisions

1. Release of Information/Cooperation

To process claims, CHP may need information, including medical information, from the health care Provider who rendered the Health Care Service. 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 may result in a denial of the pending claim and CHP shall have no liability for such claim.

2. Physical Examination and Autopsy

   To make coverage and/or benefit decisions, 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. CHP also reserves the right, if the law permits, to have an autopsy performed on the Member in case of death. Failure by a Member to fully cooperate with such examination or the failure of CHP to obtain a requested autopsy report 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 coverage under the Contract may be brought against CHP within the 60-day period following CHP's receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

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

   CHP relies on the information provided on the itemized statement and the claim form 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.

5. Explanation of Benefits Form

   Claims decisions will be communicated to the Member in writing in an explanation of benefits form:

   This form may indicate:

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

6. Circumstances Beyond the Control of Capital Health Plan

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

Section 16: Complaint and Grievance Process

Introduction

Capital Health Plan (CHP) has established a process for reviewing Member Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, the Member's dissatisfaction with CHP, CHP's administrative practices, coverage, benefit, or payment decisions, or with the administrative practices and/or quality of care provided by any independent Contracting Provider. The Complaint and Grievance Process also permits the Member, or his or her Physician, to expedite CHP's review of certain types of Grievances. The process described below must be followed if the Member has a Complaint or Grievance.

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

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

Definitions

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

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

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

Clinical Grievance Review Panel means a panel established by CHP to review Grievances related to Adverse Benefit Determinations made by CHP that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based on the information provided, does not meet the CHP requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel includes Physicians who have appropriate expertise, and who previously were not involved in the initial Adverse Benefit Determination.

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

Concurrent Care Decision means a decision by CHP to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if CHP previously had approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

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

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

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

Informal Review—Complaints

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

Important Note:

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

Formal Review—Grievances

The Member, a provider acting on his or her behalf, a state agency, or another person designated by the Member, may submit a Grievance. To submit or pursue a Grievance on behalf of a Member, a health care provider previously must have been directly involved in the Member's treatment or diagnosis. A letter must be mailed to the CHP address listed in the Telephone Numbers and Addresses subsection.

If the Member needs assistance in preparing the Grievance, he or she may contact CHP for assistance. Hearing impaired Members may contact CHP via TDD (850/383-3534).

1. Level I Review

    a. Standard Grievances

        To begin the formal review process, the Member must write 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. The Grievance Review Panel will review the Grievance in accordance with the standard Grievance procedure and advise the Member of its

decision in writing. If the Grievance involves a Pre-Service Claim, CHP's decision regarding the Grievance will be made within 15 days of receipt of the Grievance. If the Grievance involves a Post-Service Claim, CHP's decision regarding the Grievance will be made within 30 days.

If the Member remains dissatisfied with the decision of the Grievance Review Panel, he or she may request a reconsideration of the decision by CHP's Executive Review Panel as described in the Level II Review section.

b. Request for Clinical Grievance Review

When a Member has a grievance that involves an Adverse Benefit Determination that an admission, availability of care, continued stay, or other Health Care Service does not meet CHP's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, the Member may request that the grievance be reviewed by a Clinical Grievance Review Panel. CHP must receive the Clinical Grievance Review Panel request within 30 calendar days from the date that the Member received the Adverse Benefit Determination. To request this type of review, send a **written request and supporting documentation** within the 30-day time limit to the CHP address listed in the Telephone Numbers and Addresses subsection.

If CHP does not receive the request for review by the Clinical Grievance Review Panel within 30 calendar days, the denial decision will be reviewed by the Grievance Review Committee in accordance with the standard Grievance procedure. If the Grievance involves a Pre-Service Claim, CHP's decision regarding the Grievance will be made within 15 days of receipt of the Grievance. If the Grievance involves a Post-Service Claim, CHP's decision regarding the Grievance will be made within 30 days.

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

If the Member remains dissatisfied with the decision of the Level I Committee, he or she may request a reconsideration of the decision by the Executive Review Panel as described in the Level II Review section.

c. Request for Expedited Review

For a Grievance involving an Adverse Benefit Determination, the Member, or a person acting on his or her behalf, may request that the review of the Grievance be expedited. To be eligible for an expedited review, a Grievance (i.e., a request for expedited review) must meet the following criteria as determined by CHP:

(1) The Member must be dissatisfied with a CHP Adverse Benefit Determination;

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

(3) The health care provider involved has refused to or will not provide the needed medical Service without a guarantee of coverage or payment from the Member or CHP.

The Member, or a provider acting on his or her behalf, specifically must request an expedited review. For example, this request may be made by saying: "I want an expedited review." Only the following Services that have yet to be rendered are subject to this Expedited Review process: (a) Pre-Service Claims; or (b) requests for extension of concurrent care Services made within 24 hours before the termination of authorization for those Services.

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

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

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

If the Member's request for expedited review arises out of a utilization review determination by 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 a request for expedited review within two working days after providing notification of that decision. If the Member is not satisfied with the decision, he or she may submit the Grievance to the Subscriber Assistance Panel.

2. Level II Review

   To appeal the Grievance Review Panel's decision to CHP's Executive Review Panel, CHP must receive, within 30 days of the Level I decision, a letter explaining why the Member feels that the Level I decision was wrong or not appropriate, and what he or she would like CHP to do to remedy the matter. CHP's Executive Grievance Panel will review the Level I decision as quickly as possible and advise the Member of its decision in writing.

Subscriber Assistance Program

The Member has the right at any time to submit a Complaint or Grievance to the Florida Department of Financial Services, the Agency for Health Care Administration, or the Subscriber Assistance Program. (The Member must submit the Grievance to the Subscriber Assistance Program within 365 days of CHP's final decision.) Telephone numbers and addresses are listed in the Telephone Numbers and Address subsection below.
The Member must complete the entire Complaint and Grievance Process and receive a final disposition from CHP before pursuing review by the Subscriber Assistance Program Panel. The Subscriber Assistance Program Panel may choose to investigate any complaint or grievance that it has received before CHP makes its final determination.

Time Frames for Resolution of a Grievance

CHP will resolve Grievances in a timely manner. In resolving Grievances, time frames may vary depending on the circumstances, between the Level I and Level II review. CHP will, however, resolve the Member's Grievance within 30 days after receipt for Pre-Service Claims, or within 60 days for Post-Service Claims.

General Rules

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

1. The Member must cooperate fully with CHP in its effort to promptly review and resolve a Complaint or Grievance. If the Member does not cooperate fully with CHP, he or she will be considered to have waived his or her right to have the Complaint or Grievance processed within the time frames set forth above.

2. CHP will offer to meet with the Member if the Member believes that a meeting will help CHP resolve the Complaint or Grievance to the Member's satisfaction. For the Member's convenience, and at his or her option, he or she may elect to meet with CHP's representatives in person, or by telephone conference call. CHP will not reimburse the Member for travel or lodging in connection with any meeting. Appropriate arrangements will be made to allow telephone conferencing to be held at CHP's administrative offices within the Service Area. CHP will make these telephone arrangements with no additional charge to you. The Member must notify CHP that he or she wishes to meet with CHP's representatives concerning the Complaint or Grievance.

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

4. CHP will not honor a request for expedited review that relates to Services that already have been performed, rendered, or provided to you or a request that is not eligible for expedited review in accordance with the criteria set forth in the Request for Expedited Review subsection. CHP will review any Grievance, however, in accordance with the standard Grievance procedure.

5. CHP must receive all Grievances within one year of the date of the occurrence that initiated the Grievance.

6. If the Grievance involves a determination that the Service did not meet CHP's Medical Necessity guidelines or is Experimental or Investigational (or a similar exclusion or limitation), the Member may request an explanation of the scientific or clinical judgment relied on, if any, that applies the terms of the Member Handbook to the Member's medical circumstances.

7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.

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

Telephone Numbers and Addresses:

The Member may contact a 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 CHP at the telephone numbers and addresses listed on this page.

Capital Health Plan Member Services
1545 Raymond Diehl Road
Suite 300
Tallahassee, FL 32308
1-850- 383-3311
(M-F, 8 a.m.–5 p.m.)
TDD: 1-850-383-3534
(M-F, 8 a.m.–5 p.m.)
Toll free: 1-800-390-1434
(24 hours a day, 7 days a week)
Florida State Relay: 1-800-955-8771
(for the hearing impaired, after business hours)

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

Website: http://www.capitalhealth.com

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

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

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

Section 17: Relationships Between the Parties

CHP and Providers

CHP Physicians, other CHP Staff, and other persons providing services authorized by CHP Staff shall be solely responsible for the performance of all health services rendered to a member.

The relationship between CHP and any Participating Provider, Non-Participating Provider, or other associated institution, organization, or practitioner, sometimes collectively referred to as "Independent Contractor(s)," is solely that of an independent contractor. Neither CHP nor any of its agents, servants, or employees shall be considered to be an agent, servant, or employee of any Independent Contractor, and neither the Independent Contractor nor any of its agents, servants, or employees shall be considered to be an agent, servant, or employee of CHP. CHP shall be considered not to be a health care provider with respect to any services performed or provided by any Independent Contractor. Any decisions made by CHP concerning appropriateness of setting, or whether any service or supply is Medically Necessary under this Contract, shall be considered 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.

Members and Providers

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.

CHP and Members

No Member is the agent or representative of CHP. Additionally, neither any member nor CHP shall be liable, whether in tort, contract, or otherwise, for any acts or omissions of any other person or organization with which CHP has made or hereafter makes arrangements for providing 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 his or her 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 he or she has not entered into this Contract based on representations by any person other than CHP, and that no person, entity, or organization other than CHP shall be held responsible 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 Covered Services to a Member, as determined by the Medical Director of CHP, CHP agrees to pay for equivalent services rendered by Non-Participating Providers chosen or approved by CHP.

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

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical Services, must be made solely by you, your family, and your treating Physician in accordance with the patient/physician relationship. It is possible that you or your treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 18: General Provisions

Access to Information

We have the right to receive, from you and any health care provider rendering Services to you, information that is reasonably necessary, as determined by us, to administer the coverage and benefits we provide, subject to all applicable confidentiality requirements described below. By accepting coverage, you authorize every health care provider who renders Services to you to disclose to us or to entities affiliated with us, on request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit us to copy any such records and reports so obtained.

Amendment

The terms of coverage and benefits to be provided by us may be amended annually on this Contract's Anniversary Date, without your consent or the consent of any other person, on 45 days prior written notice to the Subscriber. If the amendment is unacceptable to the Subscriber, the Subscriber may terminate this Contract on at least ten days prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to Covered Services before the date of such amendment. No agent or other person, except a duly authorized officer of CHP, has the authority to modify the terms of this Contract, or to bind us in any manner not expressly described herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us may not be amended by the Subscriber unless such amendment is evidenced in writing and signed by a duly authorized officer of CHP.

Assignment and Delegation

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

Payment of Premiums

This Contract is not enforceable until the Subscriber's Application for Coverage has been received by us and we have received the Subscriber's first Premium payment. All subsequent Premium payments are payable in advance or within the Grace Period. The amount of the Subscriber's initial monthly Premium is indicated on the front cover of this Contract. Failure on our part, for whatever reason, to provide the Subscriber with a notice of payment due does not justify the Subscriber's non-payment of Premiums. It is the Subscriber's responsibility to submit the indicated Premium by the end of the Grace Period or to notify us that a billing was not received.

The Premium automatically will change if the Subscriber changes Risk Classes, or if the number of individuals covered under this Contract changes. Additionally, the Premium may increase each year on the Anniversary Date because of the increase in the Subscriber's age and the covered spouse's age.

If we accept Premium for coverage for a Covered Dependent for a period extending beyond the date, age, or event specified for termination of such Covered Dependent, then coverage for such a Covered Dependent shall continue during the Grace Period for which an

identifiable Premium was accepted, except if such acceptance resulted from a misstatement of age or residence.

Premium payments are payable to:

Capital Health Plan

P.O. Box 1678

Tallahassee, FL 32302-1678

Premium Payment Due Date

The first Premium payment is due before the Effective Date of this Contract. Each following Premium payment is due as indicated on the Subscriber's application unless the Subscriber and we agree in writing on some other method and/or frequency of Premium payment. The Premium is due and payable on or before the due date of the Premium unless the Subscriber and we agree to another Premium due date.

Changes in Premium

We may modify the Rates at any time, without your consent, on at least 45 days prior notice to the Subscriber. Payments submitted to us following receipt of any such written notice of modification constitute acceptance by the Subscriber of any such modification.

Grace Period

This Contract has a 10-day Premium payment Grace Period that begins on the date the Premium payment is due. If any required Premium payment is not received by us on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If Premium payments are not received by the end of the Grace Period, coverage automatically shall terminate as of the Premium Due Date.

Complaint and Grievance Process

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

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

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under the Contract shall be considered to have been modified and shall be interpreted so as to comply with applicable state or federal laws and regulations dealing with Rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required for us to administer coverage and benefits, specific medical information concerning you, received from providers, shall be kept confidential by us in conformity with applicable law. Such

information may be disclosed to third parties, and by accepting coverage you hereby authorize us to disclose such information, for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and utilization review activities. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we use to assist us in providing coverage, benefits, or Services under this Contract. Furthermore, any document or information that properly is subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

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

Cooperation Required of You and Your Covered Dependents

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

Evidence of Coverage

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

Governing Law

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

Identification Cards

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

Modification of Provider Network

We may change our provider network at any time without prior approval of, or notice to, you. Additionally, we may, at any time, terminate or modify the terms of any provider contract and may enter into additional provider contracts without prior notice to, or approval of you.

Non-Waiver of Defaults

Any failure by us at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Furthermore, it will not affect our right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law, or this Contract.

Notices

Any notice required or permitted hereunder will be considered given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as listed below. Such notice will be considered effective as of the date delivered or so deposited in the mail.

If to us:

To the address printed on the Application and/or the Identification Card.

If to you:

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

You must notify us immediately of any address change.

Our Obligations on Termination

On termination of your coverage for any reason, we will have no further liability or responsibility to you under this Contract with respect to such individual, except as specifically described herein.

Promissory Estoppel

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

Right to Recovery

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

Right to Receive Necessary Information

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

Types of HMOs

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model, a network model, or a mixture of these. Here are a few important ways these types of HMOs differ:

1. Staff and Group Model HMOs:

   In a staff model HMO, the doctors and other providers furnishing care usually are salaried employees of the HMO, and may practice in large clinical office settings. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most health care services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

2. IPA and Network Model HMOs:

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

   In a network model HMO, the HMO contracts with individual, independent doctors, IPAs, and/or medical groups to make up a health care network. Unlike the

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

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

Capital Health Plan is a combination of a staff and a network Model HMO. **It is not an IPA or group model HMO.** [This means that the doctors and other providers with whom it contracts are both independent contractors and employees of Capital Health Plan.]

Misstatement of Age, Sex, or Residence

If any written information relevant to determining your Risk Class has been misstated by you, the Premium amount owed under this Contract will be what the Premium would have been had the correct information been provided to us. If such misstatement causes us to accept Premiums for a time period that we would not have accepted Premium for if the correct information had been stated, our only liability will be the return of any unearned Premium. We will not provide any coverage for that time period. This right is in addition to any other rights we may have under this Contract and applicable laws.

Section 19: Statement on Advance Directives

The following information is provided in accordance with the federal Patient Self-Determination Act. It details 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 explains our policy with respect to advance directives. The information is general, and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make treatment decisions for him or her if the patient 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 no longer are able to participate consciously in making their own health care decisions.

An "advance directive" is a witnessed oral or written statement that indicates the individual's choices and preferences with respect to medical care made by the individual while he or she still is competent. An advance directive can address issues such 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.

Three types of documents commonly are recognized in Florida and used to express an individual's advance directives: a Living Will, a Health Care 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 if 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 Health Care Surrogate Designation. When properly executed, a Health Care 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. Although 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 expressed clearly in the Health Care 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 Health Care 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 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 adviser, or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, physician, and whomever else will be faced with the task of carrying out those wishes knows what you would want.

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

Under §765.308 of the *Florida Statutes*, Florida law does not require a health care provider or facility to commit any act that 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, because of 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 advisers. Your physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical condition or environment.

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

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

Section 20: Definitions

The following definitions are used in this Contract. Other definitions may be found in the particular section or subsection in which they are used.

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

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

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

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

Ambulatory Surgical Center means a facility properly licensed under Chapter 395 of the *Florida Statutes*, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient admitted to and discharged from such facility within the same working day.

Anniversary Date means the date, one year after the Effective Date, stated on the Application, and subsequent annual anniversaries.

Application means the Application for Conversion From Group Coverage to Individual Coverage form(s), provided by or acceptable to CHP that an individual must complete and submit to CHP to apply for conversion to Non-Group Coverage.

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

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

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral

part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also encompasses any Services relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells, including any and all Hospital, Physician or other health care provider Services that are rendered to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary Services).

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

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

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

Certified Nurse Midwife means a person who is licensed under Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state, as an advanced registered nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse and a certified advanced registered nurse practitioner within the nurse anesthetist category under Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state.

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

Contract (or Member Handbook) includes this document, your Application for this Contract, any Enrollment Forms signed by the Subscriber, any Endorsement(s), and other attachments described herein and attached hereto.

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

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

Coverage means having the status of being a current Member.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is

enrolled, and actually covered, under the Contract other than as a Subscriber. (See the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section.)

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

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

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

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

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

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity, and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

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

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

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

Dialysis Center means an outpatient facility certified by the Centers for Medicare and

Medicaid Services (CMS) and the Florida Agency for Health Care Administration (AHCA) (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is licensed properly under Florida law, or a similar applicable law of another state, to provide nutrition counseling for diabetes outpatient self-management Services.

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

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

Effective Date means 12:01 a.m. on the date specified on the Application. With respect to individuals covered under this Contract, Effective Date means 12:01 a.m. on the date that the coverage will commence as described in the Enrollment and Effective Date of Coverage section of this Contract.

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

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

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

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

Endorsement means an amendment to the Contract.

Enrollment Forms means those CHP forms, electronic (when available) or paper, that are used to maintain accurate enrollment files under the Contract. Such forms may include the Application and the Member Status Change Request Form.

Experimental or Investigational means any evaluation, treatment, therapy, or device that involves the application, administration, or use of

procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by us:

1. such evaluation, treatment, therapy, or device cannot be marketed lawfully without approval of the United States Food and Drug Administration or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided under a written protocol that describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device used by practicing Physicians in treating other patients with the same or similar Condition.

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

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied on 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;

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

Note: Health Care Services that are determined by us to be Experimental or Investigational are excluded. (See the Covered Services section.) In determining whether a Health Care Service is Experimental or Investigational, we also may 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 to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

FDA means United States Food and Drug Administration.

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

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

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

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Drug that either (1) has been approved by the United States Food and Drug Administration (FDA) for sale or distribution as the bioequivalent of a Brand Name Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (2) is a Prescription Drug that is not a Brand Name Drug, is legally marketed in the United States and, in the judgment of CHP, is marketed and sold as a generic competitor to its Brand Name Drug equivalent. All Generic Prescription Drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Drug.

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

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

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

Home Health Care or Home Health Care Services means Physician-directed professional, technical, and related medical Services and personal care provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this

definition, a Hospital, Skilled Nursing Facility, nursing home, or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization, duly licensed by the State of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, the licensed entity must be engaged principally in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed under Chapter 395 of the *Florida Statutes*, or a similar applicable law of another state, that: offers Services that are more intensive than those required for room, board, personal services, and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory Services, diagnostic x-ray Services, and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center, a Skilled Nursing Facility, a stand-alone Birth Center; a Psychiatric Facility; a Substance Abuse Facility, a convalescent, rest, or nursing home; or a facility that primarily provides Custodial, educational, or rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital that is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities or is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting in which Covered Services can be performed for coverage purposes.

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

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

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

Massage Therapist means a person properly licensed to practice massage therapy under Chapter 480 of the *Florida Statutes*, or a similar applicable law of another state.

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

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

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

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

1. consistent with the symptom, diagnosis, and treatment of the Member's Condition;

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

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

Member means any Subscriber or Covered Dependent.

Mental Health Professional means a person properly licensed to provide mental health Services under Chapter 491 of the *Florida Statutes*, or a similar applicable law of another state. This professional may be a clinical social worker, mental health counselor, or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination or sect who are not licensed to provide counseling services under Chapter 491.

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

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

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

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

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

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

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly-restored or previously-impaired function.

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

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

Partial Hospitalization means treatment in which an individual receives at least seven hours of institutional care during a portion of a

24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Participating Pharmacy means a retail Pharmacy that has signed an agreement with CHP to dispense to Members Covered Prescription Drugs and/or Covered Supplies. A Participating Pharmacy also may be a retail Pharmacy that is part of a national network of retail Pharmacies. These retail Pharmacies outside of Florida are under contract with a vendor to provide Covered Prescription Drugs and Supplies to CHP Members.

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

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

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

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

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

Physician Assistant means a person properly licensed under Chapter 458 of the *Florida Statutes*, or a similar applicable law of another state.

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

Preferred Generic Prescription Drug means a Generic Prescription Drug on the Preferred Medication List then in effect.

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

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

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that can be dispensed only under a Prescription and/or that is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription."

Premium means the total amount required to be paid by the Subscriber to us for there to be coverage under this Contract. The Premium is determined on the basis of the applicable Rates, Risk Class, and the number of individuals covered under this Contract.

Primary Care Physician (PCP) means the Physician who is the PCP for the Member, according to our records, and who provides primary care medical Services to Members under a PCP provider contract with us then in effect. A PCP may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract

with us as a PCP. Refer to the PCPs who are listed as PCPs in the CHP Provider Directory.

Prosthetic Device means a device that replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

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

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

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

Rate(s) means the amount we charge Subscribers for Coverage. The Rate will vary depending on the individual's Risk Class.

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

Risk Class is a grouping of Members who have similar characteristics. For example, Members who are the same sex, in the same age bracket, live in the same geographical area, and who have elected the same benefit plan may be grouped into a Risk Class. The Subscriber's Risk Class is determined by CHP.

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

Skilled Nursing Facility means an institution or part thereof that meets CHP's criteria for eligibility as a Skilled Nursing Facility and that: 1) is licensed as a Skilled Nursing Facility by the State of Florida, or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by CHP.

Specialist means a Physician who is a Contracting Provider, or a Physician who is a Non-Contracting Provider when authorized by us, who limits practice to specific Services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board. (Refer to the Physicians who are listed as Specialty Physicians in the CHP Provider Directory.)

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

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

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

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

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

Substance Dependency means a condition in which a person's alcohol or drug use injures his or her health, interferes with his or her social or economic functioning, or causes the individual to lose self-control.

Urgent Care means medical screening, examination, and evaluation received in an Urgent Care Center or rendered in your Primary Care Physician’s office after-hours and the covered services for those conditions that (1) seriously could jeopardize the Member’s function; or (2) in the opinion of a Physician with knowledge of the Member’s condition, would subject the Member to severe pain that cannot be managed adequately without the proposed services being rendered.

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

CAPITAL HEALTH PLAN, INC.

ATTACHMENT A

CAPITAL HEALTH PLAN SERVICE AREA

Capital Health Plan's service area includes the following Florida counties only:

GADSDEN

JEFFERSON

LEON

WAKULLA