Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Non-Group Conversion Member Handbook

Capital Health Plan

SECTION 1: INTRODUCTION TO THE CONTRACT

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

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

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

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

SECTION 2: DEFINITIONS

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

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

Acute Condition means a condition of recent onset or origin.

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

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

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

Benefits means those covered health care services and supplies described in the Coverage Provisions and any endorsements which are a part of this Contract and which are not Exclusions.

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

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

transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "bone marrow transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all hospital, physician or other health care provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

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

Carrier means Capital Health Plan, Inc. doing business as Capital Health Plan (CHP), a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of State law.

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

Child(ren) means the subscriber's natural born child, stepchild, or a foster or legally adopted child of the subscriber upon placement in the subscriber's residence, or at the birth of a newborn adopted child, where written agreement to adopt such child had been entered into prior to the birth of the child, whether or not that agreement is enforceable. If the foster or adopted child is ultimately not placed in the residence of the subscriber, no benefit will apply. The term also includes any child for whom the subscriber is the legal guardian, a child who is dependent on the subscriber for health care coverage pursuant to a valid court order, or any child who lives with the subscriber in a normal parent-child relationship, if the child qualifies at all times for the dependent exemption, as defined in the Internal Revenue Code and the Federal Tax Code. CHP has the right to request proof of the child's dependency status at any time.

CHP means CAPITAL HEALTH PLAN, INC., D/B/A CAPITAL HEALTH PLAN, a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of Federal and/or State law.

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

Confinement means an approved Medically necessary covered stay as an inpatient in a Hospital that is:

A. due to a Condition; and
B. authorized by a licensed medical Health Care Provider with admission privileges.

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

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

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

Covered or Coverage means inclusion of an individual for payment of expenses related to Covered Services expenses under this Contract.

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

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

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

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

Emergency Medical Condition means

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

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

B. With respect to a pregnant woman:

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

Emergency Services and Care means 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 for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

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

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by CHP:

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

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

C. 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;

D. 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;

E. 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;

F. 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;

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

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

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

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

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

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

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

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

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

NOTE: Services or supplies which are determined by CHP to be Experimental or Investigational are excluded under this Contract (see Exclusions and Limitations section). In making Covered Service determinations under this Contract, CHP may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

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

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

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

Health Care Provider or Providers means the physicians, physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, ambulance services, hospitals, skilled nursing facilities, or other health care providers properly licensed in the State of Florida.

Home Health Care Visit means a period of up to 4 consecutive hours of home health care services in a 24-hour period. The time spent by a person providing services under the home health care plan, evaluating the need for, or developing such plan, will be a home health care visit.

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

Hospital means an institution:

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

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

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

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

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

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

2. furnishes principally domiciliary or custodial care, or

3. is operated primarily as a school.

Injury means an accidental bodily injury that:

A. is caused by a sudden unintentional, and unexpected event or force;
B. is sustained while the Member's coverage is in force; and
C. results in loss directly and independently of all other causes.

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

Medical Director of CHP means the Physician serving in the position of Medical Director in the Service Area of CHP in which the Member is enrolled.

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

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

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

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

Member means any Subscriber or Dependent.

Membership means having the status of being a current Member.

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

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

Mental and Nervous Disorders means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples include, but are not limited to, attention deficit hyperactivity, bulimia, anorexia-nervosa, bipolar affective disorder, autism, mental retardation, and Tourette's disorder.

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

Non-Participating Hospital means a Hospital which has not made an agreement with CHP to provide services to Members.

Non-Participating Pharmacy means a pharmacy that has not made an agreement with CHP to provide services to Members.

Non-Participating Physician means a Physician who has not made an agreement with CHP to provide services to Members.

Non-Participating Provider means a Non-Participating Hospital, a Non-Participating Physician or any other Health Care Provider who has not signed an agreement or been designated by CHP to provide services to Members.

Participating Pharmacy means a pharmacy which has made an agreement with CHP to provide service to Members.

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

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

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where prescription medications are dispensed by a Pharmacist.

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

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

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

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

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

Skilled Nursing Facility means an institution or part thereof which is licensed as a skilled nursing facility by the State, accredited as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States

under Medicare, unless such accreditation or recognition requirement has been waived by CHP; and which provides Covered Services that are skilled nursing services, as determined by CHP, to Members under a Participation Agreement then in effect.

Specialist means a Physician who is a Participating Provider, or a Non-Participating Provider when authorized by the Medical Director, who provides Covered Services that are regarded by CHP as "specialty" services (e.g., the Physicians who are listed under Specialty Physicians in your CHP Provider Directory).

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

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

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

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

Urgent Care Center means a medical office staffed by Physicians, with extended operating hours, that provides health care services or supplies to Members under a Participation Agreement then in effect.

SECTION 3: TERM OF CONTRACT

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

SECTION 4: ELIGIBILITY FOR MEMBERSHIP

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

Eligibility Requirements for Subscribers

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

A. no longer be eligible for CHP Group Coverage;

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

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

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

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

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

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

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

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

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

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

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

Additionally:

A. 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

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

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

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

Eligibility Requirements for Dependent(s)

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

A. be the present spouse of a Subscriber; or

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

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

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

(b) under 23 years of age and enrolled in an accredited school as a Full-time Student and attends class on a regular basis. Semester breaks do not jeopardize a child's full-time status. However, if a child is not a

Full-time Student for the entire semester immediately following such break, that child will not be considered a Dependent as of the first day of such following semester (eligibility will terminate on the last day of the month in which the child no longer meets any of the requirements for extended eligibility as a Dependent child): or

(c) 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 which commenced prior to the time such Dependent reached his or her 19th birthday, and who is principally dependent on the Subscriber for support and maintenance. If a child attains the limiting age for a Covered Dependent (see the Eligibility for Membership provision), Coverage will not terminate while that person is, and continues to be, both:

(1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

(2) Chiefly dependent on the Covered Employee for support and maintenance.

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

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

Other Requirements/Rules Regarding Eligibility

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

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

C. 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.

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

SECTION 5: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

General Rules for Enrollment

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

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

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

Enrollment of Members/Effective Date

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

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

B. provide any additional information needed to determine eligibility, if requested by CHP;

C. pay the required Prepayment Fees or Supplemental Charges within 63 days following the termination date of Membership under the Group Contract.

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

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

Additional Requirements for Enrollment of Dependents/Effective Date

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

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

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

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

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

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

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

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

C. Adopted Child -- The Effective Date for an adopted child (other than an adopted newborn child) eligible for Membership shall be the date such adopted child is placed in the residence of the Member in compliance with Florida law; provided such adopted child is properly enrolled and provided that the adopted child is so placed in the residence of the Member. To enroll an adopted child, the Subscriber must submit a Member Status Change Request Form to CHP prior to, or within this 30-day period, Prepayment Fees and/or Supplemental Charges will not be charged for the first 30 days of coverage. In the event CHP does not receive the form before or with 30 days after the date of placement, the adopted child will be added as of the date of placement as long as any applicable Prepayment Fees and/or Supplemental Charges 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 CHP. It is the responsibility of the Subscriber to notify CHP if the adoption does not take place. Upon receipt of this notification, CHP will terminate the coverage of the child on the first billing date following our receipt of your written notice.

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

Other Requirements/Rules Regarding Enrollment

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

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

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

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

SECTION 6: TERMINATION OF MEMBERSHIP

Termination of Subscriber Membership

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

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

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

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

D. the Subscriber becomes eligible for Group coverage; or

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

Termination of Dependent Membership

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

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

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

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

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

5. the Dependent becomes eligible for Group coverage; or

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

Termination of Membership for Cause

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

    1. disruptive, unruly, abusive, or uncooperative behavior to the extent that such Member’s continued Membership in CHP seriously impairs CHP’s ability to

administer this Contract or to arrange for the delivery of health care services to such Member or to other Members; or

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

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

4. misuse of the Membership Card; or

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

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

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

Termination by Subscriber

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

Extension of Benefits

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

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

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

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

Certification of Creditable Coverage

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

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

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

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

Responsibilities of CHP Upon Termination of Membership

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

SECTION 7: PAYMENTS

Payment of Prepayment Fees

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

Modification of Prepayment Fees

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

Grace Period

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

Copayments by Members

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

Maximum Copayments

Total Copayment charges in any Calendar Year shall not exceed the amount indicated in the Schedule of Copayments, which in no event shall exceed twice the total annual premium costs which a Subscriber (or, if there are Dependents, the Subscriber and his or

her Dependents) would be required to pay if such individual(s) were enrolled under an option with no Copayments. It is the Member's responsibility to retain receipts and to notify and document to the satisfaction of CHP when this Copayment limit has been reached. Thereafter, services will be provided with no Copayment charge for the remainder of the Calendar Year.

SECTION 8: DUPLICATION OF COVERAGE

Coordination of Benefits

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

A. any group insurance, group-type self-insurance, or HMO plan;

B. any group contract issued by any Blue Cross and/or Blue Shield plan(s);

C. any plan, program or insurance policy, including an automobile insurance policy;

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

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

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

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

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

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

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

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

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

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

3. 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.

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

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

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

E. When rules A, B, C, and D above do not establish an order of Covered Services, the Plan which has covered the Member the longest shall be primary.

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

Reduction of Coverage Due to Medicare

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

Subrogation

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

Right to Receive and Release Necessary Information

CHP has the right to receive and release necessary information. By accepting Coverage under this Contract, the Member gives permission for CHP to obtain from or release to any Carrier or other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a claim and to implement such provisions. CHP may obtain or release this information without consent from or notice to anyone. Any person who claims Benefits under this Contract agrees to furnish to CHP information that may be necessary to implement this provision.

Facility of Payment

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

Right of Recovery

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

Non-Duplication of Government Programs

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

Non-Duplication of Other Extension of Coverage

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

Cooperation Required of Members

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

SECTION 9: CLAIMS PROCESSING

Definitions

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

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

Post-Service Claims

How to File a Post-Service Claim:

This section defines and describes the three types of claims that may be submitted to CHP. Experience shows that the most common type of claim CHP will receive from the Member or his or her treating providers will likely by Post-Service Claims.

Contracting Providers have agreed to file Post-Service Claims for Services rendered to the Member. If the Member receives a bill from a Contracting Provider, it should be forwarded to CHP. If the Member requires Emergency Services and Care from a Non-Contracting Provider, CHP will pay for Covered Services provided to the Member. If the Member receives a bill from a Non-Contracting Provider for such services, it should be forwarded to CHP. CHP relies on the information the Member provides when processing a claim.

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

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

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);
3. the amount actually charged by the provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the provider's name and address;
6. the name of the individual who received the Service; and
7. the Member's name and contract number as they appear on the Membership Card.

The Processing of 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 timeframes described below.

Payment for Post-Service Claims:

When payment is due under the terms of the Non-Group Membership Conversion 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 CHP needs more or additional information, CHP may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims:

In the event 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. In the event CHP contests a paper Post-Service Claim, or a portion of such a 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 contested. The notice may identify: (1) the contested portion or portions of the claim; (2) the reason(s) for contesting the claim or a portion of the claim; and (3) the date that CHP reasonably expects to notify the Member of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If 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 CHP's possession at the time and may be denied.** Upon 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:

In the event 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. In the event CHP denies a paper Post-Service Claim, CHP will use its best efforts to provide notice, within 30 days of receipt of the claim, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Member's responsibility to ensure that CHP receives all information that CHP determines is 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 for Post-Service Claims:

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) paper Post-Service Claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by CHP or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by CHP within the applicable timeframe 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 upon receipt of written notification from the Member. If CHP determines that the Member was billed for a Service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the provider is reduced solely to the notification from the Member, CHP will pay the Member 20 percent of the amount of the reduction, up to a total of $500.

SECTION 10: GENERAL PROVISIONS

Access to Information

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

Amendment

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

Assignment and Delegation

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

Attorney Fees: Enforcement Costs

Unless the parties otherwise agree in writing, if any legal action or other proceeding is brought for the enforcement of this Contract, or because of an alleged dispute concerning, or breach of, this Contract, the successful or prevailing party or parties shall be entitled to recover reasonable attorney's fees, court costs, and other reasonable expenses incurred in connection with maintaining or defending such action or proceeding. Such entitlement to recover shall include attorney's fees, costs, or expenses incurred in connection with any

appeal. These recoveries are in addition to any other relief to which such party or parties may be entitled.

Authorization

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

Compliance With State and Federal Laws

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

Confidentiality

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

Entire Contract: Binding Effect

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

Evidence of Coverage

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

Governing Law

This Contract and the rights of the parties hereunder shall be construed in accordance with the laws of the State of Florida and/or the United States, when applicable.

Grievance Procedure

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

Indemnification

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

Liability of Member for Non-Covered Services

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

Membership Cards

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

Modification of Provider Network

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

Non-Waiver of Defaults

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

Notices

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

If to CHP:

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

If to Member:

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

Records

A. Reporting Changes of Member Status

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

B. Errors or Delays

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

Relationships Between the Parties

1. CHP and Providers

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

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

2. Members and Healthcare Providers

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

3. CHP and the Member

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

Reservation of Right to Contract

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

Service Mark

The Member hereby expressly acknowledges understanding that this Contract constitutes a contract solely between the Subscriber and CHP, that CHP is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting CHP to use the Blue Cross and Blue Shield Service Mark in the State of Florida and that CHP is not contracting as the agent of the Association. The Subscriber

further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than CHP and that no person, entity, or organization other than CHP shall be held accountable or liable to the Member for any of CHP's obligations to the Member created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of CHP other than those obligations created under other provisions of this Contract.

Services by Non-Participating Providers

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

SECTION 11: COVERAGE ACCESS RULES

It is important that Members become familiar with the rules for accessing health care coverage through CHP. The following sections explain the roles of CHP and the Primary Care Physician (PCP), how to access specialty care coverage through CHP and the Primary Care Physician, and what to do if Emergency Services and Care is needed. It is also important for the Member to review all Service Area-specific Coverage Access Rules for particular types of services and Contracting Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the Directory of Physicians & Service Providers and may vary based on negotiated provider contracts and other network factors specific to the Service Area.

Choosing A Primary Care Physician

The first and most important decision each Member must make when joining a health maintenance organization is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of Specialists, are obtained. The Member is free to choose any Primary Care Physician listed in CHP's published list of Primary Care Physicians whose practice is open to additional Members. This choice should be made when the Member enrolls. The Subscriber is responsible for choosing a Primary Care Physician for all minor Dependents including a newborn child or an adopted newborn child. Some important rules apply to the Member's Primary Care Physician relationship:

1. The Primary Care Physician selected by the Member will maintain a Physician-patient relationship with the Member, and will be, except as specified by the Coverage Access Rules set forth in the Directory of Physicians & Service Providers, if any, responsible for providing, authorizing and coordinating all medical services for the Member.

2. Except as specified in the Coverage Access Rules set forth in the Directory of Physicians & Service Providers, if any, the Member must look to the Primary Care Physician to provide or coordinate his/her care.

3. Except in an emergency, all services must be received from the Member's Primary Care Physician, from Contracting Providers on referral from or authorization of the Primary Care Physician, or through another health care provider designated by the Member's Primary Care Physician or CHP. See the *Access to Other Contracting Providers* subsection of this section for exceptions to this rule.

4. CHP wants the Member and the Primary Care Physician to have a good relationship. To be certain this relationship is conducive to effective health care, both the Member and the Primary Care Physician may request a change in the Primary Care Physician assignment:

a. The Member may request a transfer to another Primary Care Physician whose practice is open to enrollment of additional Members. The transfer of care to the newly selected Primary Care Physician shall be effective the first day of the following calendar month provided the date of receipt by CHP of the request is before the 15th of the month.

b. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with the Member. In such a circumstance, the Primary Care Physician may request that CHP assist the Member in the selection of another Primary Care Physician.

5. If the Primary Care Physician selected by the Member terminates his or her contract with CHP or is unable to perform his or her duties or is on a leave of absence, CHP may assist the Member in selecting, or CHP may assign, another Primary Care Physician to the Member.

Specialist Care

Except as specified in the Coverage Access Rules set forth in the provider directory, if any, the Primary Care Physician selected by the Member is responsible for referring the Member to Specialists when Medically Necessary, using the referral procedure authorized by CHP. The referral will identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the Member's Condition.

Once the referral has been obtained by the Member, the Member may make an appointment with the Specialist at his/her convenience provided it is within 60 days from the date of issue of the referral and does not exceed the specified number of visits or treatments.

When additional services or visits are suggested by the Specialist, Members must first consult with their Primary Care Physician to obtain additional authorization/referrals.

The Member's Primary Care Physician may consult with CHP regarding coverage or benefits and with the Specialist in order to coordinate the Member's care. This procedure provides the Member with continuity of treatment by the Physician who is most familiar with the Member's medical history and who understands the Member's total health profile.

If a specialist who is a Non-Contracting Provider is required, the Primary Care Physician may refer the Member but payment for such services will only be made if coverage is authorized by CHP. An agreed-upon treatment plan will then be implemented.

Emergency Services and Care

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

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

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

Verifying Provider Participation

The Member is responsible for verifying the participation status of the Physician, Hospital, or other provider prior to receiving the health care service. To determine if a particular health care provider is in the CHP provider network, review the most recent Directory of Physicians & Service Providers listing those Primary Care Physicians and Contracting Providers under the Plan and verify a specific health care provider's participation status by contacting the CHP Member Services Department. When failure to verify participation status or to show the Membership Card results in noncompliance with required CHP procedures, coverage may be denied.

Case Management

CHP reserves the right (but, in no event shall it be required) to offer its case management program to its Members. If the Member and the Member's Physician agree, CHP may use its case management program policies and procedures then in effect. CHP's use of case management program policies and/or procedures with respect to any Member shall not restrict or otherwise modify CHP's right to administer coverage and/or benefits in strict accordance with the terms of this Member Handbook with respect to said Member, or with respect to any other Member or other individual under any other policy or contract. Further, when the cost of providing alternative or equivalent services varies, depending upon whether or not a particular provider or supplier is used to provide such service, CHP may (but shall not be required to) take such variations into consideration when

authorizing or approving payment, coverage, or benefits for such services under the case management program.

Access to Osteopathic Hospitals

At the option of the Member, inpatient and outpatient services, similar to inpatient and outpatient services by allopathic hospitals, may be obtained from a Hospital accredited by the American Osteopathic Association when such services are available in the Service Area and when such Hospital has not entered into a written agreement with CHP 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 CHP has with allopathic Hospitals within the Service Area. It is the Member's responsibility to contact CHP to obtain the documents necessary to comply with this provision.

Access to Other Contracting Providers

Chiropractors and Podiatrists: Upon request by a Member, a Doctor of Chiropractic or a Doctor of Podiatry who is a Contracting Provider shall be assigned to the Member for the purpose of providing covered chiropractic services and covered podiatric services, respectively. Members shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need of referrals from the Primary Care Physician who is licensed as a Doctor of Medicine or Doctor of Osteopathy.

Dermatologists: Members have access to dermatologists who are Contracting Providers for a maximum of five (5) visits within a Calendar Year for covered services without an authorization or referral from the Member's Primary Care Physician. Any Covered Services rendered above these five (5) visits require an authorization from the Member's Primary Care Physician. If you do not get an authorization, visits over five (5) within a Calendar Year will not be covered.

Obstetricians and Gynecologists: Female Subscribers have access to obstetricians/gynecologists who are Contracting Providers for one annual visit within a calendar year for routine care without authorization or referral from the Subscriber's Primary Care Physician. Medically necessary follow-up care detected during the annual visit requires that the obstetrician/gynecologist coordinate care through the Subscriber's Primary Care Physician.

Physician Assistant: Members have access to surgical assistant services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other services covered hereunder may be rendered by licensed physician assistants, nurse practitioners or other individuals who are not Physicians.

Certified Registered Nurse Anesthetist: Members have access to anesthesia services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if the Member requests such services, provided such services are available, as determined by CHP, and are Covered Services under the Contract.

Services Not Available from Contracting Providers

Except as provided in the Covered Services sections, if a Covered Service is unavailable through Contracting Providers, the Medical Director will authorize coverage for such services to be rendered by a Non-Contracting Provider. Covered Services provided by a Non-Contracting Provider under this provision must be authorized by the Medical Director.

Contracting Provider Financial Incentive Disclosure

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

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 12: COVERED SERVICES INTRODUCTION

The sections that follow describe the Covered Services for which expenses are covered. It is very important that these sections be reviewed with the Exclusions and Limitations Section and other provisions. Important information is also contained in the Schedule of Copayments. The level of coverage and/or benefits for certain Covered Services depends on whether the Member has followed the Coverage Access Rules. (See the Coverage Access Rules Section.) ALL OF THE PROVISIONS OF THIS CONTRACT SHOULD BE READ CAREFULLY TO UNDERSTAND THE COVERAGE AND/OR BENEFITS PROVIDED.

Covered Services

Expenses for the health care services listed below will be covered under this Contract only if the services are:

1. within the service categories set forth in the Covered Services sections;

2. Medically Necessary;

3. rendered while coverage is in force;

4. not specifically limited or excluded; and

5. received in accordance with the Coverage Access Rules.

The applicable Copayments for which the Member is responsible for each category of Covered Services are set forth in the Schedule of Copayments.

Medical Necessity

Except for any preventive care benefits specifically described in the Covered Services sections, CHP does not cover or provide benefits for any service which is otherwise covered if, in the opinion of CHP, such service is not Medically Necessary, as defined in the Glossary Section. **CHP will make Medical Necessity decisions for coverage and payment purposes only.** In some instances, these decisions are made by CHP after the Member has been hospitalized or has received other health care services and after a claim for payment has been submitted.

CHP's Medical Necessity decisions under this Member Handbook, are solely for the purpose of coverage or payment. In this respect, CHP may review medical facts in making a coverage or payment decision, however, any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services, must be made solely by the Member and the Member's treating Physicians. It is

possible that a Member or the Member's treating Physician may conclude that a particular service is beneficial, appropriate, or desirable even though expenses for such service may be denied as not being Medically Necessary.

SECTION 13: PHYSICIAN AND OTHER MEDICAL SERVICES

The following Physician and other medical services may be Covered Services, subject to the Copayment amount set forth in the Schedule of Copayments, when provided to a Member by Contracting Providers:

Accidental dental care: Dental services rendered within 62 days of an Accidental Dental Injury provided such services were for the treatment of damage to sound natural teeth, resulting from an Accidental Dental Injury occurring while a Member of CHP. See the definition of Accidental Dental Injury in the Glossary Section.

Allergy treatment, including testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

Anesthesia services for medical care by a Physician, other than the operating Physician or his or her partner or associate.

Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Member in a Hospital or Ambulatory Surgical Center if:

1. the Member is under 8 years of age when it is determined by a dentist and the Member's Primary Care Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Member has a developmental disability in which patient management in the dental office has proved to be ineffective; or

2. the Member has one or more medical Conditions that would create significant or undue medical risk for the Member in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Breast Reconstructive Surgery and implanted prostheses, incident to Mastectomy. The term "Breast Reconstructive Surgery" means surgery to reestablish symmetry between the two breasts. In order to be covered, such surgery must be in a manner chosen by the Member's Contracting Physician, consistent with prevailing medical standards, and in consultation with the Member.

Casts, splints, and trusses when part of treatment in a health care provider facility or office or in a Hospital emergency room. This does not include the replacement of dental splints or trusses.

Child cleft lip and cleft palate treatment services: Medical, dental, Speech Therapy, audiology, and nutrition services for treatment of a child under the age of 18 who has cleft lip or cleft palate. In order for such services to be covered, the Member's Primary

Care Physician, or a Contracting Provider on referral from the Member's Primary Care Physician, must specifically (1) prescribe such services and (2) certify, in writing, that the services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Child health supervision services: Periodic Physician-delivered or Physician-supervised services that are Covered Services provided to a Dependent from the moment of birth up to the 17th birth date 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.

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

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

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

Diagnostic services, including radiology, ultrasound, laboratory, pathology, approved machine testing (e.g., electrocardiogram [EKG]). Diagnostic services involving bones or joints of the jaw and facial region if, under accepted medical standards, such diagnostic services are Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury.

Infertility services for a Member who meets the criteria established by CHP, for diagnostic procedures to determine the cause of infertility, limited to endometrial biopsy, sperm count and hysterosalpingography.

Mammogram screening services: Mammograms performed for breast cancer screening, but limited to the following:

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

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

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

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

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

Mastectomy services for breast cancer treatment and outpatient post-surgical follow-up in accordance with prevailing medical standards. As used in this subsection, the term "Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician. Outpatient post-surgical follow-up care for Mastectomy services shall be covered when provided by a Contracting Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Member. The treating Physician, after consultation with the Member, may choose the appropriate setting.

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

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

Health care services, including prenatal care, delivery and postnatal care, provided to a Member. Care for a mother and her newborn infant including a postpartum assessment and newborn assessment may be provided at the Hospital, at the attending Physician's

office, at a Birth Center or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife. These services include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

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

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

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

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

Non-surgical spine and back disorder treatments consisting of Medically Necessary manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by X-ray.

Oxygen, including the use of equipment for its administration.

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

Physician services, medical and surgical care, in a Physician's office, a Hospital, or a Skilled Nursing Facility. Both Specialist and Primary Care Physician services are available.

Prescription drugs prescribed for a Member by a Physician and dispensed by a Pharmacist may be Covered Services if provided for as an Endorsement to this Contract.

The benefits for Prescription Drugs are subject to, in addition to all of the other provisions of this Member Handbook, certain limitations. Please refer to the Pharmacy Program Endorsement for information on the Pharmacy Program provided in this Contract.

Preventive health services according to standards established by the Medical Directors of CHP 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;
4. eye and ear screening examinations in the office of a Primary Care Physician to determine the need for vision and hearing correction;
5. family planning counseling and services, including counseling and information on birth control; sex education, including prevention of venereal disease; and fitting of diaphragms;
6. health education programs organized, sponsored, or offered by CHP, including nutrition education and counseling; instruction in personal health care and the appropriate use of health services; information regarding the coverage and/or benefits offered by CHP and the generally accepted medical standards for the use and frequency of each.
7. one annual routine preventive gynecological examination per Calendar Year by a Contracting Provider, who is an obstetrician or gynecologist, without a referral from the Primary Care Physician. This examination may include a manual breast exam, a pelvic exam, and a pap smear.

Second medical opinion: Members who elect to obtain a second medical opinion must notify their Primary Care Physician of their intent to do so prior to obtaining the second medical opinion. The Member is entitled to request and to obtain a second medical opinion when the Member disputes either CHP's or a Contracting Physician's opinion of the reasonableness or necessity of a surgical procedure or is subject to a serious injury or illness. A Member may request and obtain a second medical opinion if they feel that they are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated. CHP also may require a Member to obtain such a second medical opinion. In either case, the Member may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion. **All tests in connection with rendering the second medical opinion, including tests deemed necessary by a Non-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.

CHP may deny benefits, granted under this provision, in the event a Member seeks in excess of three (3) second medical opinions per Calendar Year if the second medical opinion costs are deemed by CHP to be evidence that the Member has unreasonably over-utilized the second medical opinion privileges. The decision of the Medical Director, derived after review of the documentation from the second medical opinion which the Member obtained, will be controlling as to CHP's coverage obligations for the treatment.

Surgical sterilization including tubal ligations and vasectomies.

Surgical assistant services rendered by a Physician or a Physician Assistant. Surgical assistant services only rendered by a Physician Assistant when acting as a surgical assistant when such assistance is Medically Necessary.

Surgical procedures including:

1. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;

2. surgical procedures involving bones or joints of the jaw and facial region if, under accepted medical standards, such surgery is Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and,

3. surgery resulting from a traumatic injury or disease and for a congenital anomaly, performed to restore normal bodily function as determined by the Medical Director of CHP.

Vision care, limited to routine examinations for vision correction and the diagnosis/treatment of eye disease when provided in CHP's Health Centers. Lenses, frames and contact lenses are available from the Plan for the Member's convenience on a fee schedule structured to be competitive with the current local market. Initial eyeglasses following cataract surgery or accidental injury which would necessitate corrective lenses (initial pair of eyeglasses is limited to the cost of the lens and up to $25.00 for the frames and obtained only at CHP's Eye Care Centers.)

SECTION 14: HOSPITAL SERVICES

Hospital services provided at Contracting Hospitals for a Member when such Member is an outpatient or inpatient admitted upon the instruction, written authorization, or referral by a Primary Care Physician. Such services may include:

- room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
- intensive care units, including cardiac, progressive and neonatal care;
- use of operating and recovery rooms;
- use of emergency rooms;
- respiratory therapy (e.g., oxygen);
- drugs and medicines administered by the Hospital;
- intravenous solutions;
- administration of, including the cost of, whole blood or blood products;
- dressings, including ordinary casts;
- anesthetics and their administration;
- transfusion supplies and equipment;
- diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
- chemotherapy treatment for proven malignant disease;
- Physical Therapy (in connection with a covered Condition);
- other Medically Necessary services; and
- transplants as set forth in the Transplants section.

Maternity Care

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

SECTION 15: AMBULATORY SURGICAL CENTER SERVICES

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

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

SECTION 16: EMERGENCY SERVICES AND CARE

Emergency Services and Care

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

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

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

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

Ambulance Services for Emergency Services and Care

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

SECTION 17: BEHAVIORAL HEALTH SERVICES

Mental Health Services

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

Partial Hospitalization for mental health services is a Covered Service when it is provided in lieu of inpatient hospitalization and is 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.

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

Substance Dependency Treatment Services

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

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

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

SECTION 18: SPECIAL SERVICES

Durable Medical Equipment

Durable Medical Equipment which has been prescribed by the Member's Primary Care Physician, or a Contracting Provider on referral from the Primary Care Physician and which has been authorized by CHP as a Covered Service. CHP reserves the right to rent or purchase the most cost-effective durable medical equipment which meets the Member's needs. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. Supplies and services to repair medical equipment, which have been authorized by CHP, may be a Covered Service only if the Member owns the equipment or is purchasing the equipment, or when necessitated due to growth of a Dependent child or due to change in the Member's Condition.

The wide variety of durable medical equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered durable medical equipment, however, some Durable Medical Equipment has been specifically excluded. Please refer to the Exclusions and Limitations Section. Maximum payment for durable medical equipment (excluding medically appropriate and necessary diabetic equipment) will be for up to $2,500 annually for any Member.

Enteral Formulas

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

Coverage to treat inherited diseases of amino acid and organic acids shall include food products modified to be low protein, in an amount not to exceed $2,500 annually for any Member, through the age of 24. This section applies to any person or family notwithstanding the existence of any Pre-existing Condition.

Home Health Care

The following home health care services only when provided by or through a Home Health Agency within the Service Area if: (1) the Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician submits a written treatment plan to CHP; (2) CHP approves the written treatment plan; and (3) the Member is confined to home and is unable to carry out the basic activities of daily living:

1. part-time or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse;
2. Physical Therapy, by a Physical Therapist;

3. Occupational Therapy, by an Occupational Therapist;
4. Speech Therapy, by a Speech Therapist;
5. home health aide services;
6. medical social services;
7. nutritional guidance; and
8. respiratory or inhalation therapy (e.g., oxygen).

The following home health care services are not Covered Services:

1. homemaker services;
2. domestic maid services;
3. sitter services;
4. companion services;
5. services rendered by an employee or operator of an adult congregate living facility; an adult foster home; and adult day care center, or a nursing home facility; and
6. Custodial Care.

Hospice Services

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

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

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

Prosthetic and Orthotic Devices

Coverage includes the following, when authorized in advance by CHP and arranged by a Primary Care Physician or a Contracting Provider on referral from the Primary Care Physician or CHP:

Prosthetic and Orthotic Devices - braces, cardiac pacemakers, and artificial limbs and eyes to replace natural limbs and eyes lost while a Member. Covered prosthetic devices (except cardiac pacemakers and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be Medically Necessary) prescribed for each specific Condition. Coverage for Prosthetic and Orthotic Devices is based on the most cost-effective Prosthetic and Orthotic Device which meets the Member's medical needs as determined by CHP.

Benefits may be provided for necessary replacement of a Prosthetic or Orthotic Device which is owned by the Member when due to irreparable damage, wear, a change in the Member's Condition, or when necessitated due to growth of a Dependent child.

Rehabilitation Services

Prescribed short-term inpatient and outpatient rehabilitation services limited to the therapy categories listed below.

In order to be covered: (1) CHP must review, for coverage purposes only, a Rehabilitation Plan submitted or authorized by the Member's Primary Care Physician or a Contracting Provider on referral from the Primary Care Physician; (2) CHP must agree that the Member's Condition is likely to improve significantly within 62 days from the first date such services are to be rendered; (3) such services must be provided to treat functional defects which remain after an illness or injury; and (4) such services must be Medically Necessary for the treatment of a Condition.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of rehabilitation services to be provided to a Member with rehabilitation potential. Such a plan must have realistic goals which are attainable by the Member within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such services are to be rendered. The Rehabilitation Plan must be renewed every 30 days.

Outpatient

Outpatient rehabilitation services are limited per Member per Condition to the number of Medically Necessary rehabilitation services which are received by the Member within the consecutive 62-day period which immediately follows the first date that the Member begins such services. Outpatient rehabilitation services are limited to the therapy categories listed below:

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 while this coverage was in force.

Physical/Occupational Therapy: Services of a Physical Therapist or Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to illness, injury, stroke or a surgical procedure while this coverage was in force.

Inpatient

Rehabilitation services of the therapy categories described above provided during a covered inpatient confinement will be covered for the duration of the confinement.

Skilled Nursing Facilities

Those Skilled Nursing Facility services which are authorized in writing by a Primary Care Physician or Contracting Provider when on referral from the Primary Care Physician, and for which coverage is approved by the Medical Director of CHP. Such services may include:

1. room and board;
2. respiratory therapy (e.g., oxygen);
3. drugs and medicines administered while an inpatient;
4. intravenous solutions;
5. administration of, including the cost of, whole blood or blood products;
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease;
10. Physical Therapy (in connection with a covered Condition); and
11. other Medically Necessary services.

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

Transplant Services

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

Transplant includes pre-transplant, transplant and post-discharge services, expenses related to the donation or acquisition of an organ or tissue for a Member once the donor has been identified and has agreed to donate the organ, and treatment of complications after transplantation. CHP will pay Covered Services only for services, care and treatment received for or in connection with a:

1. Bone Marrow Transplant, as defined in this Agreement, which is specifically listed in Chapter 10D-127.001 of the Florida Administrative Code or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. Coverage for the reasonable costs of searching for donor will be limited to a search among family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. kidney transplant;
6. liver transplant;

7. lung-whole single or whole bilateral transplant; or
8. pancreas transplant performed simultaneously with a kidney transplant.

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

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

1. The transplant is excluded.

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

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

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

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

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

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

Artificial heart devices used as a bridge to transplant.

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

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

SECTION 19: EXCLUSIONS AND LIMITATIONS

Exclusions

The following are excluded from coverage:

1. Any services not specifically listed in the Covered Services sections or in any rider, or endorsement attached hereto, unless such expenses are specifically required to be covered by applicable law.

2. If the Member does not follow CHP's Coverage Access Rules, any services provided to, or received by, the Member are not covered. For further information, please refer to the Coverage Access Rules Section.

3. Any service which, in the opinion of CHP 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. **Abortion**, elective (by CHP; not Medically Necessary).

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

6. **Arch supports**, orthopedic shoes, sneakers, or support hose, or similar type devices/appliances regardless of intended use.

7. **Autopsy** or postmortem examination services, unless specifically requested by CHP.

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

9. **Complementary and alternative healing methods** including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; massage; 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.

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

11. **Contraceptive medications**, except when dispensed for specific treatment of a Condition; contraceptive devices; or contraceptive appliances.

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

13. **Cosmetic services**, including any service to improve the appearance or self-perception of an individual, including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A).

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

15. **Custodial Care**, and any service of a custodial nature, including without limitation: services or supplies primarily to assist the Member in the activities of daily living; rest homes; home companions or sitters; home mothers; domestic maid services; and respite care.

16. **Dental care**, care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion does not apply to Accidental Dental Care, Child Cleft Lip and Cleft Palate Treatment Services.

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

18. **Durable Medical Equipment** which is for patient convenience and/or comfort or which has not been authorized by CHP. 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, dental braces, air

conditioners, humidifiers, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails, heat appliances and dehumidifiers. Also excluded is coverage for repair or replacement except when authorized by CHP.

19. **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 the Member's cancer in a Standard Reference Compendium or recommended for treatment of the Member's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

20. **Family planning services**, other than those services specifically described in the Covered Services sections.

21. **Foot care (routine)**, including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, corns, or calluses, unless determined by CHP to be Medically Necessary.

22. **Hearing aids** (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

23. **Immunizations and physical examinations**, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements; or except immunizations necessary in the course of other medical treatments of an illness or injury.

24. **Infertility treatment** services and In Vitro Fertilization including, but not limited to, associated services, supplies, and medications, Gamete Intrafallopian Transfer procedures, Zygote Intrafallopian Transfer procedure, Artificial Insemination, embryo transport, surrogate parenting, donor semen and related costs except as specified in Section 16 of this member Handbook.

25. **Mental health services** which are (a) 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; (b) extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities due to mental retardation; (c) for marriage and juvenile counseling; (d) court ordered care or testing, or required as a condition of parole or probation; (e) testing for aptitude, ability, intelligence or interest; (f) testing and evaluation for the purpose of maintaining employment; or (g) cognitive

remediation.

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

27. **Non-Prescription drugs or products,** except insulin, including any non-Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

28. **Obesity treatment**, including but not limited to, surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be Medically Necessary.

29. **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 sections.

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

31. **Penile prosthesis** and surgery to insert penile prosthesis except when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

32. **Personal comfort, hygiene or convenience items**, and services deemed to be not Medically Necessary and not directly related to the care of the Member, including, but not limited to, beauty and barber services, clothing, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the Covered Services sections, motel/hotel accommodations, air conditioners, humidifiers or physical fitness equipment.

33. **Prescription drugs**, purchased, prescribed, or dispensed while other than an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital, except for immuno-suppressant therapy following a major human organ/tissue transplant, or chemotherapy in connection with a diagnosed malignancy.

34. **Private duty nursing care**.

35. **Rehabilitation services**, including physical, speech, occupational and other rehabilitation therapy, except as described in the Covered Services section. This exclusion includes:

a. Services or supplies provided to a Member as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, where the admission is primarily to provide rehabilitative services;

b. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Member's Condition within a 62-day period;

c. Services for treatment of abuse of or addiction to alcohol and drugs; or

d. Long term rehabilitation services (i.e., services in excess of 62 days from the first date the Member begins such services).

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

37. **Services or supplies** that are:

a. Determined to be not Medically Necessary;

b. Not specifically listed in the Covered Services sections unless such services are specifically required to be covered by state or federal law. CHP will provide coverage on a primary or secondary basis as required by applicable COB state or federal laws;

c. Court ordered care or treatment, unless otherwise covered;

d. Received prior to a Member's Effective Date or received on or after the date a Member's Coverage terminates under the Contract, unless coverage is extended in accordance with the Extension of Benefits subsection;

e. Provided by a Physician or other health care provider related to the Member by blood or marriage;

f. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;

g. For treatment of non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

h. Supplied at no charge;

i. For elective care, routine care, or any care other than Medically Necessary emergency care, required by a Member while outside of the Service Area; or

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

38. **Sexual reassignment, or modification services,** including but not limited to any service or supply related to such treatment, including psychiatric services.

39. **Skilled Nursing Facility services** not provided in lieu of hospitalization.

40. **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, transdermal patches).

41. **Sports-related devices** used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

42. **Substance dependency care and treatment services** that are long-term treatment services (i.e., more than the number of outpatient visits set forth on the Schedule of Copayments) for treatment of alcoholism or drug addiction, and including treatment in a specialized inpatient or residential facility.

43. **Tobacco** or tobacco related products.

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

45. **Transplantation or implantation** services, including the transplant or implant, other than those specifically listed in the Covered Services sections. This exclusion includes:

    a. Any service in connection with the implant of an artificial organ, including the implant of the artificial organ.

    b. Any organ which is sold rather than donated to the Member.

    c. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in Chapter 10D-127.001 of the *Florida Administrative Code* or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published *Medicare Coverage Issues Manual*.

    d. Any service in connection with identification of a donor from a local, state or national listing.

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

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

48**.** **Vision care**, including

a. the purchase, examination, or fitting of eyeglasses or contact lenses, except **only the first** glasses or contact lenses following cataract surgery or following an accident;

b. any surgery for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error (e.g., radial keratotomy, myopic keratomelusis); and

c. training or orthoptics, including eye exercises.

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

50. **Weight control services** including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise programs, equipment or memberships; or surgical procedures.

51. **Wigs** or cranial prosthesis.

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

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, CHP shall have no liability or obligation for any delay in the provision of, or any failure by any provider to provide, such Covered Services, except that CHP shall make a good faith effort to arrange such services, taking into account the impact of the event. 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 20: STATEMENT ON ADVANCE DIRECTIVES

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

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

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

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

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

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

Finally, there is the Durable Power of Attorney for Healthcare. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for

and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical condition.

A suggested form of Living Will and Designation of Healthcare Surrogate is contained in Chapter 765 of the *Florida Statutes*. There is no requirement that a patient have an advance directive and your health care provider cannot condition treatment on whether or not you have one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

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

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

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

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

your advance directive, you may request treatment from another provider or facility.

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

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

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

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

SECTION 21: MEMBER'S RIGHTS AND RESPONSIBILITIES

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

Rights to:

1. Receive information about CHP, the services, benefits, member rights and responsibilities, and affiliated practitioners who provide care.

2. Receive medical care and treatment from practitioners and providers who have met the credentialing standards of CHP.

3. Expect CHP affiliated practitioners to permit you to participate in decision-making about your health care consistent with legal, ethical, and relevant patient-practitioner relationship requirements. If you are unable to fully participate in treatment decisions you have a right to be represented by your parents, guardians, family members, health care surrogates or other conservators to the extent permitted by applicable laws.

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

5. Communicate complaints or appeals about CHP or the care provided through the established appeal or grievance procedures found in your Member Handbook and the master policy or contract provided to your employer.

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

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

8. 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.

9. 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 to:

1. Seek all non-emergency care through your Primary Care Physician (PCP), to obtain a referral from your PCP for medical services from a specialist, and to cooperate with those providing care and treatment.

2. Respect the rights, needs and privacy of other patients, office staff and providers of care.

3. Provide accurate and complete information related to your health problems and medical history. Answer all questions truthfully and completely.

4. Follow the plans and instructions for care that you have agreed to with your practitioners. Ask questions and seek clarification as necessary.

5. Pay copayments and to provide current information concerning your CHP membership status to any CHP affiliated practitioner or provider.

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

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

8. Seek access to medical and member information through your Primary Care Physician or through CHP Member Services.

9. Follow the coverage access rules in your Member Handbook.

SECTION 22: COMPLAINT AND GRIEVANCE PROCESS

Introduction

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

Under the CHP Complaint and Grievance Process a Member may bring his/her dissatisfaction to CHP's attention either informally or formally. A verbal (i.e., nonwritten) expression of dissatisfaction will be handled informally in accordance with the Informal Review section set forth below. A written expression of a Member's dissatisfaction is a grievance.

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

A. ***Informal Review***

Complaints

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

Important Note:

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

*****CHP's Medicare members have a separate process for handling grievances and appeals which is governed by Federal Medicare legal requirements.

B. ***Formal Review***

Grievances

A Member, his or her representative, a practitioner acting on behalf of the Member, or a state agency, may submit a grievance. To submit or pursue a grievance on behalf of a Member, a health care practitioner must previously have been directly involved in the treatment or diagnosis of the Member.

Level I.

In order to begin the formal review process, the Member must complete, and submit to CHP, 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. All grievances, except those resulting from determination of medical necessity, must be filed with CHP within one (1) year of the date of the occurrence that initiated the grievance.

If the grievance results from a coverage determination regarding Medical Necessity, the grievance will be reviewed by a committee consisting of a majority of practitioners who have appropriate expertise in the medical issue. In this instance, the Member must submit his/her grievance within thirty (30) days of notice of CHP's coverage determination.

At the Member's request, the Grievance Coordinator or designee may meet or conduct a telephone conference call with the Member or the authorized representative of his or her choice during this process to discuss the grievance. The appropriate details of the discussion will be reviewed by the full Grievance Committee, which will advise the Member of its decision in writing.

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

Level II.

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

The submission must be received by Capital Health Plan within thirty (30) days of the date of the CHP Level I decision.

The Member, and/or authorized representative of his/her choice, may attend the Board of Director's Member Relations Committee meeting to present his or her appeal. If the Member is unable to attend, arrangements for teleconferencing may be made.

Level III.

If the Member is not satisfied with the decision of the CHP Board of Directors, he/she may submit the grievance to the Statewide Provider and Subscriber Assistance Program, an independent review organization, within 365 days of the CHP Board of Director's decision. The Member does not bear any costs for this independent review.

Expedited Review of Urgent Complaints or Grievances

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

Process for Requesting an Expedited Review

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

A request for expedited review will be evaluated by a medical or osteopathic health care practitioner who was not involved in the initial decision and who is licensed in the State of Florida in the same or similar specialty, if any, as typically manages the medical condition, process, or treatment which the Member or practitioner are requesting be reviewed. The medical or osteopathic practitioner may also have an active, unencumbered license in another state with similar licensing requirements.

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

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

If a Member's request for expedited review arises out of 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 the course of treatment will continue until the Member has been notified of the determination.

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

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

Binding Arbitration

In the event the grievance is not finally resolved to the Member's satisfaction, the grievance may be settled by binding arbitration (see the *Member Grievance Procedure/Binding Arbitration* subsection of this Agreement). The binding arbitration process shall be completed within two hundred ten (210) days of the date CHP receives a written request to arbitrate. CHP must receive the written request to arbitrate within thirty (30) days of the date of the notice of CHP's final disposition of the grievance. The subscriber may incur some cost with arbitration.

General Rules

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

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

2. A Level I grievance must be filed with CHP within one (1) year of the date of the occurrence that initiated the grievance. An exception to this is a grievance that concerns determinations of Medical Necessity. In order for this type of grievance to be reviewed by a committee of practitioners with the majority having appropriate medical expertise in the medical condition, the Member must submit the grievance within thirty (30) days from the receipt of CHP's coverage determination.

3. All non-expedited grievances must be in writing, with the signature of the person presenting the grievance. Although grievances can be sent to CHP via letter, fax, or e-mail, those without signatures will be copied and returned to the sender for signature. The time frame of the appeal will begin with the receipt of the signed grievance. Due to confidentiality requirements, CHP will respond only via regular mail in matters concerning grievances.

4. A Member must cooperate fully with CHP in its effort to promptly review and resolve a complaint or grievance. In the event the Member does not fully cooperate with CHP, the Member will be deemed to have waived his or her right to have the complaint or grievance processed within the time frames set forth above. If CHP does not receive requested information within the limitations of the mandated time frame, CHP reserves the right to make a determination regarding the complaint or grievance using the information available.

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

6. CHP will provide assistance to the Member in completing written notices upon request of the Member. The Member may obtain such assistance by contacting a CHP Member Service Representative.

7. A Member may authorize someone else to represent him/her during any portion of the appeal process. A written statement authorizing another person to represent the member must be submitted to the plan.

8. 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 Statewide Provider and Subscriber Assistance Program at any time.

9. CHP will resolve a Member's grievance within thirty (30) days after receipt unless the grievance involves the collection of external supporting documentation. If the grievance involves the collection of external supporting documentation, CHP will render a decision within sixty (60) days after the receipt of the original grievance. CHP may toll these time periods by notifying the Member, in writing, that additional information is required in order for CHP to complete its review of

the grievance. Time is tolled until CHP receives such information. After CHP receives the requested information, the time allowed for completion of the formal process will resume.

Telephone Numbers and Addresses

The Member may contact a CHP Grievance Coordinator at the number listed on the Membership Card or at the number listed below. If a Grievance is unresolved, the Member may, at any time, contact any agency at the telephone numbers and addresses listed below. Participating practitioners are also required to post this information in their reception areas.

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

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

Statewide Provider and Subscriber Assistance Program
2727 Mahan Drive, Building 1, Room 301
Tallahassee, FL 32308
1-850-921-5458
1-888-419-3456

Capital Health Plan Administrative Offices:

Capital Health Plan
2140 Centerville Place
Tallahassee, FL 32308
1-850-383-3311
1-800-390-1434
TDD: (850) 383-353