Capital Health Plan, your medical home for 30 years

Capital Health Plan
Member Handbook
Certificate of Coverage for Health Maintenance Organizations

State of Florida
Employees' Group Insurance Program

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2013.43.C.SOF.Handbook
Effective Date: 2/4/2014

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ADMINISTRATIVE PROVISIONS

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS)website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

This section provides important information on the administration of Capital Health Plan, explaining:

1. Who is eligible for benefits under Capital Health Plan, when coverage becomes effective, when coverage terminates, and what the covered person can do to continue coverage or convert to other coverage;

2. How Capital Health Plan shall relate to other plans under which covered persons have coverage or other situations when payment is made for the services covered under Capital Health Plan; and

3. How the covered person can appeal to Capital Health Plan and the State of Florida on benefit decisions.

4. Capital Health Plan is not the plan sponsor or plan administrator, as defined by the Employee Retirement Income Security Act ("ERISA"), as amended; of the Group Plan. The Group, as either plan sponsor or plan administrator of an employee welfare benefit plan, is responsible for ensuring compliance with ERISA.

This HMO benefit plan is designed to cover most major medical expenses for a covered Illness or injury, including Hospital and Physician services. However, you will be responsible for any:

1. Deductibles (if applicable, e.g., HIHP Plan);
2. Copayments;
3. Coinsurance (as applicable and is a percentage of the Network Allowed Amount for the service provided);
4. Admission fees;
5. Non-covered services;
6. Amounts above or beyond the Plan's limitations;

7. Penalties for not certifying Hospital admissions or stays in a non-network Hospital; and
8. Non-emergency services in a non-network hospital, facility or office unless authorized in advance by the HMO, not the Primary Care Physician (i.e., anesthesiology, nurse anesthetists, radiology, pathology, laboratory, and/or emergency room physician services.)

Eligibility

All State of Florida employees as defined in Section 110.123(2)(c) and (f), Florida Statutes, qualify for coverage under the active employee benefit plans described in this guide. If you work part-time, you pay more because premiums are based on your full-time equivalency (FTE). Log into https://peoplefirst.myflorida.com to see your premium rates.

State officers or state employees may continue to participate in the State Group Insurance Program if they retire under a State of Florida retirement system or a state optional annuity or retirement program or go on disability retirement under the State of Florida retirement system. They must have been covered by the Program at the time of retirement and receive retirement benefits immediately after retirement or maintained continuous coverage under the Program from termination until receiving retirement benefits.

Employees thinking of retirement should review the "State Group Insurance Benefits Package for New Retirees," available on the mybenefits site under Forms and Publications. Employees who do not continue health and life insurance coverage at the time of retirement will not be allowed to enroll in state health or life insurance at a later date as a retiree.

Dependents Eligible for Coverage

If you are enrolled in the State Group Insurance plans, you may also cover your eligible dependents. You must:

1. ***Register your dependent online in People First; and***
2. ***Select the correct family coverage tier for each plan that is to cover your dependents; and***
3. ***Enroll each dependent in the appropriate plan; and***
4. ***Click the Complete Enrollment button in People First.***

In accordance with Chapter 60P, Florida Administrative Code, dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. Eligible dependents include:

Your spouse – a person of the opposite sex to whom you are legally married. See Section 741.212(3), Florida Statutes.

Your child – your biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.

- ***Your child with a disability – your covered child who is permanently intellectually or physically disabled. This child may continue health insurance coverage after reaching age 26 if the required documentation supporting the intellectual or physical disability has been reviewed and confirmed by Capital Health Plan prior to their 26th birthday and remains continuously covered in a State Group Insurance health plan. The child must be unmarried, dependent on you for care and for financial support, and can have no dependents of his/her own.***
- ***Your stepchild – the child of your spouse for as long as you remain legally married to the child's parent.***
- ***Your foster child – a child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible to their age of maturity.***
- ***Legal guardianship – a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible until his or her age of maturity.***
- ***Your grandchild – a newborn dependent of your covered child. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered.***
- ***Your over-age dependent – your child after the end of the calendar year in which they turned age 26 through the end of the calendar year in which they reach 30 if they are unmarried, have no dependents of their own, are dependent on you for financial support, live in Florida or attend school in another state, and have no other health insurance.***

You may be required to provide documentation for your eligible dependents. If you fail to provide requested documentation, you may be liable for medical and prescription claims or premiums back to the date you enrolled. Fax documentation to (800) 422-3128 or mail it to People First Service Center, P.O. Box 6830, Tallahassee, Florida 32314. Write your People First ID number on the top right corner of each page of your fax or other documentation.

Over-Age Dependent (ages 26-30) Coverage
This individual health coverage for your over-age dependent requires an additional monthly premium and you and your eligible over-age dependent must be enrolled in the same health plan. The amount of financial support you provide determines if the monthly premium for coverage comes out of your paycheck pretax (active employees only) or if you must mail in payment post-tax. Call the People First Service Center for more information.

When Coverage Ends

Your coverage in State Group Insurance plans ends:

When your employment is terminated. Active employees pay premiums one month in advance, so coverage ends on the last day of the month following the month you terminated employment. For example, if your last day of work is April 23, your coverage ends May 31.

On the last day of the month in which you do not make the required contributions for coverage, including the months when you are on leave without pay, suspension or layoff status. Payment is due the 10th of the month before the month of coverage. For example, payment for July coverage is due June 10.

On the last day of the month in which you remarry, if you have coverage as a surviving spouse of an employee or retiree.

If your spouse is enrolled as your covered dependent, your spouse's coverage ends on the last day of the month in which:

Your coverage is terminated.

You and your spouse divorce – you are required to notify People First within 60 days of the divorce.

Your spouse dies.

Your dependent children's coverage ends:

On the last day of the month in which your coverage is terminated.

The end of the calendar year in which your dependent turns age 26 (or 30 for over-age health coverage).

On the last day of the month your dependent no longer meets the definition of an eligible dependent (e.g., If you divorce, you may no longer cover your stepchildren.)

When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they become ineligible, unless otherwise noted above. If your dependents become ineligible for coverage, go to the People First website to remove them from your plans or call the People First Service Center at (866) 663-4735 within 60 days of the ineligibility. Service Center hours are 8 a.m. to 6 p.m. Eastern Standard Time (5 p.m. Central Time). Send required documentation to People First. If you fail to provide the required documentation, you risk paying for more coverage than you need.

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the Florida Department of Financial Services Division of Insurance Fraud.

Chapter 60P, Florida Administrative Code, governs eligibility and enrollment for the State Group Insurance Program. Additionally, our plans fall under Internal Revenue Code (IRC) cafeteria plan guidelines. Consequently, participants are required to stay in the plans they select. Per the IRC, participants can only make

changes during Open Enrollment or if they have a Qualifying Status Change (QSC) event, such as a birth, marriage, or change in employment status, only if it results in a gain or loss of eligibility for insurance. (Retirees may decrease or cancel coverage at any time. Those who cancel will not be allowed to reenroll as a retiree.)

Enrolling and Making Changes

You could have up to five options to enroll or change your coverage:

Option 1 – Hired as a New Employee

If you are newly-hired[1], you have 60 days from the date you were hired to enroll in State Group Insurance benefits. Enroll online at https://peoplefirst.myflorida.com. If you do not enroll within 60 days of your hire date, you can only enroll during the next Open Enrollment period or if you experience an appropriate Qualifying Status Change (QSC) event. Choose your options carefully. Once you make your elections, you can only change them during the next Open Enrollment unless you have an appropriate QSC event (see below).

Your coverage begins on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and continues for the rest of the calendar year, as long as you pay premiums on time and you remain eligible.

[1] If you have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria the first time you enroll in the State Group Insurance Program, you may enroll that child in your plan.

For example, assume you are hired on July 20. If People First receives your enrollment information before August 1, your coverage begins September 1, after one full month's premium is deducted from your paycheck. For health insurance only, you can elect an early effective date, provided you submit the full month's employee share by check. For example, if you are hired July 20, you can elect to have your health insurance start on August 1. If you do, you must send a check for the full month's employee premium to People First

For OPS/Variable hour employees, the earliest coverage will start is on the first day of the third month of employment following and including the month of hire.

Option 2 – Qualifying Status Change (QSC) Event

If you have a Qualifying Status Change (QSC) event, you have 60 days (unless otherwise noted) from the date of the event to make changes to your benefits. Changes include enrolling or cancelling, increasing or decreasing coverage, or adding or removing dependents. See the QSC Matrix for the complete list of

QSC events and documentation requirements.

If you have a QSC event and want to change your benefit elections:

- ***Make the change online at the** [People First website](#) **within 60 days of the event. If your specific QSC event is not listed, call the People First Service Center within 60 days of the event. You should call People First within 60 days even if you do not yet have the supporting documentation; otherwise, you will have missed your election window and will be unable to make any changes.***
- ***Divorce, death, Medicare disability and court orders require documentation before your QSC event can be processed. If you experience one of these events, send your documentation to People First within 60 days of the event; then call People First to make changes to your insurance. If you miss your window, you may pay more for insurance than you need to or be responsible for claims incurred (for ineligible dependents, for example).***

If you enroll yourself or your eligible dependents during the year because of a QSC event, coverage begins on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and continues for the rest of the calendar year, as long as you pay premiums on time and you and your dependents remain eligible.

Active employees: If you go off the payroll, you must pay your share of the premium by personal check, cashier's check or money order to continue coverage. You may be required to pay the full premium cost—your share and the state's share, depending on the reason you are not working. Call People First for more information.

If you do not want to continue your insurance coverage while you are off the payroll, call People First within 60 days of your leave date to cancel. This ensures you can enroll in coverage if you return to work. If you do not cancel and are later cancelled because you did not pay your premiums, you will only be allowed to enroll during the next Open Enrollment.

Option 3 – Open Enrollment

Held in the fall, annual Open Enrollment gives you the opportunity to review available benefit plan options and make any changes you want for the next plan year, which starts January 1 and goes through December 31. Any changes you make remain in effect for the entire calendar year if you pay premiums on time and you remain eligible, unless you make changes because of a QSC event.

Option 4 – Spouse Program

If both you and your spouse are active state employees, you are eligible for health insurance coverage at a reduced monthly premium. You can enroll in the Spouse Program during Open Enrollment. You can also enroll within 60 days of

an appropriate Qualifying Status Change (QSC) event; for example, if your spouse gets a full-time state job or you marry another state employee, you would be eligible to enroll. You and your spouse must take the following steps to enroll in the Spouse Program:

- ***Complete and sign the Spouse Program Election Form located at*** myflorida.com/mybenefits ***and list all eligible dependents; and***
- ***Enroll in the same health plan; and***
- ***Agree to notify the People First Service Center within 60 days of becoming ineligible for the Spouse Program. You and your spouse become ineligible for the Spouse Program if:***
  - ***One or both of you end employment with the state, including retirement***
  - ***You divorce***
  - ***A spouse dies***

It is your responsibility to notify the People First Service Center if you become ineligible for the Spouse Program. If you fail to do so within 60 days of one of the listed events, you will be liable for claims or premiums back to the date you lost eligibility. Additionally, you may have to pay for a higher level of coverage than you need; for example, you may be required to pay for family coverage instead of individual coverage. Upon notification of ineligibility for the Spouse Program, the People First Service Center adds covered, eligible dependents to the primary spouse's plan, unless you request otherwise.

To make an enrollment change based on a Qualifying Status Change (QSC) event, federal law requires the event to result in a gain or loss of eligibility for coverage, and your elections must meet general consistency rules. For example, if you have individual health insurance coverage and get married, you may change from individual to family coverage. However, you cannot change health insurance plans because the QSC event only changes the level of coverage

eligibility. In this case, changing plans is not consistent with the nature of the QSC event.

Option 5 – Surviving Spouse

Surviving spouses are also eligible for coverage. The term "surviving spouse" means the widow or widower of:

- ***A deceased state officer, state employee or retiree if the spouse was covered as a dependent at the time of the participant's death.***
- ***An employee or retiree who died before July 1, 1979.***
- ***A retiree who retired before January 1, 1976, under any state retirement system and who is not eligible for any Social Security benefits.***

The surviving spouse and dependents, if any, must have been covered at the time of the participant's death. To enroll, the surviving spouse has 60 days to notify the People First Service Center of the death and 31 days to enroll after receipt of the enrollment package. Coverage is effective retroactively once the enrollment form and premiums have been received. Coverage begins the first of the month following the last month of coverage for the deceased; in other words, coverage must be continuous.

Coverage for surviving spouses ends on the first of the month following remarriage; however, they are eligible to continue coverage under COBRA for a limited time, provided they provide a copy of the marriage certificate within 60 days of the marriage.

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.

Address Corrections: It is extremely important for you to keep your address updated in People First. If your addressis not up to date, you may not receive important information, such as benefit plan changes and proof of your insurance coverage. A current address ensures you receive your State Group Insurance information, including benefit plan documents and changes, member identification cards, proof of insurance coverage, etc. Log into People First or follow your employer's process to update your address.

Important Reasons to Call People First, the State of Florida's third-party administrator for insurance administration

There are several important events that may affect your HMO coverage. Call People First **immediately** if:

1. you go off the payroll for any reason;
2. you or your dependent becomes eligible for Medicare;
3. you have a change of mailing address;
4. your dependent becomes ineligible for coverage; or
5. your spouse becomes employed by or ends employment with the state.

Certificate of Creditable Coverage

If you or a dependent loses coverage under the Plan, you will receive a certificate showing your creditable coverage under the Plan. You will receive this certificate when coverage ends and again when any COBRA coverage ends. In addition, you may request a certificate in writing at any time during the 24-month period following your initial loss of coverage and/or the loss of COBRA coverage. You will need this certificate as proof of creditable coverage if you enroll in a new health plan that has a pre-existing Condition limitation.

Employee Enrollment

Eligible employees who become insured under Capital Health Plan shall be included in the definition of "covered persons." To become a covered person, the employee shall:

1. Make your benefit elections for any of the options listed above through the People First Website (https://peoplefirst.myflorida.com); and,

2. Agree to pay his or her portion of the premium required by the State of Florida.

Dependent Effective Date

The effective date of a dependent's coverage under Capital Health Plan depends on when the dependent is enrolled:

1. If the dependent is eligible for coverage on the group effective date, coverage for the dependent shall become effective on the group effective date if the employee enrolls the dependent for coverage at the same time that the employee enrolls during the initial enrollment period.

2. If the employee through whom the dependent is eligible first becomes eligible after the group effective date and the employee enrolls himself or herself and his or her dependents during the initial enrollment period, coverage for the dependents shall be effective on the same date that the employee's coverage becomes effective.

3. The effective date of coverage for a dependent of a covered employee shall be the date of birth or acquisition when:

    a. the covered employee has family coverage;

    b. the dependent becomes eligible after the covered employee's effective date; and,

    c. the covered employee enrolls the dependent within 60 days after eligibility as a dependent begins.

4. The effective date of coverage for a dependent of a covered employee enrolled in individual coverage shall be:

    a. the date of birth or acquisition; and,

    b. the first day of the month after the month in which a full month's premium for family coverage has been received by the Division of

State Group Insurance.

If, on the date that dependent coverage becomes effective, the dependent is covered for a condition under an extension of group health benefits from a previous employer-related health plan, health insurance plan, or other coverage arrangement, coverage under Capital Health Plan, for extension related services or supplies for that condition, shall not begin until the extension under the prior plan ends.

Preexisting Condition Limitations

For health maintenance organizations under contract with the State, preexisting condition limitations do not apply.

Coverage For Newborn Children

All health benefits for children under Capital Health Plan shall be provided from the moment of birth to the newborn child of a covered person and to the newborn child of a covered dependent if the covered person has family coverage. However, with respect to the newborn child of a dependent child who is enrolled through the end of the calendar year in which the dependent child turns age 26, the coverage for the newborn child terminates 18 months after the birth of the newborn child.

The coverage for newborn children shall consist of coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity, and the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. The transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.

The covered person must provide to the Division of State Group Insurance written notice of the child's birth within 60 days after the birth. Coverage may be denied for a newborn child because of the covered person's failure to provide notice within the 60-day period of the birth of the child if the covered person has family coverage.

Note: Coverage for a newborn child of a covered dependent child who has not reached the end of the calendar year in which he or she becomes age 26, will automatically terminate 18 months after the birth of the newborn child. For a covered dependent child who has reached the end of the calendar year in which he or she becomes age 26, if the covered dependent child obtains a dependent of his or her own (e.g. through birth or adoption), such newborn child will not be eligible for this coverage and cannot enroll. Further, the covered dependent child

will also lose his or her eligibility for this coverage.

Coverage For Adopted Children

All health benefits applicable to children shall be provided to a child adopted by the covered person if the covered person has family coverage from the moment of

1. placement in the covered person's residence in compliance with Chapter 63, Florida Statutes; and

2. birth, if a written agreement to adopt a newborn child has been entered into before the birth of the child.

The covered person must give the state written notice of the birth or placement of the child no later than 60 days after the occurrence. Coverage shall not be denied for a child because of the covered person's failure to provide timely notice of birth or placement of the child if the covered person has family coverage. Covered services for the adopted child shall be the same as any other dependent child. No coverage shall be provided under this provision for the child who ultimately is not placed in the covered person’s home.

Coverage For Foster Children

Coverage for a foster child or a child otherwise placed in the covered person's custody by a court order shall be provided from the date of placement if the covered person has family coverage on the date of placement. Covered services for the foster child shall be the same as any other dependent child. No coverage shall be provided under this provision for the child who ultimately is not placed in the covered person's home. For children in the covered person's custody, coverage shall terminate the date on which the covered person no longer has legal custody.

Dependent Child As Employee

A covered dependent child shall be eligible as a covered employee as long as he or she meets the eligibility requirements for a covered employee. However, a covered dependent child may be insured as a dependent if the covered parent can claim the child as an exemption on his or her federal income tax return and if the child meets all eligibility criteria for a dependent child under Capital Health Plan. A dependent child shall not be covered under Capital Health Plan as a dependent of more than one employee.

Medicare Eligible Retirees

State of Florida retirees and their eligible dependents are able to continue Capital

Health Plan coverage after retirement. When a retired Capital Health Plan member becomes Medicare eligible (or the dependent of a retiree becomes Medicare eligible) they must enroll in Capital Health Plan Retiree Advantage. Capital Health Plan Retiree Advantage is a Medicare plan offered exclusively to State of Florida retirees with Medicare and their dependents with Medicare. Generally the coverage is similar; review the Capital Health Plan Retiree Advantage Evidence of Coverage (EOC) and Summary of Benefits for the applicable year to learn about the benefits.

To enroll in the State of Florida Capital Health Plan Retiree Advantage Plan:

1. Must be a member of Capital Health Plan through the State of Florida or must choose Capital Health Plan during the State of Florida Open Enrollment.
2. Must live in the Capital Health Plan Service area.
3. Must be entitled to Medicare Part A and enrolled in Medicare Part B.
4. Must complete and submit a Capital Health Plan Retiree Advantage form directly to Capital Health Plan. To request a Capital Health Plan Retiree Advantage enrollment packet call (850) 523-7441.

If a Medicare eligible State of Florida retiree or their Medicare eligible dependent chooses not to enroll in Capital Health Plan Retiree Advantage Plan, the covered member will no longer be eligible for Capital Health Plan.

Not Eligible for Medicare

If you are not eligible for Medicare, send a copy of your Medicare ineligibility letter to People First immediately. People First will reverse your enrollment so that Captial Health Plan continues as the primary plan with the corresponding higher monthly insurance premium. If you delay, Captial Health Plan will pay claims secondary as if you had Medicare, which will require you to pay significantly more out-of-pocket.

TERMINATION OF COVERAGE

The termination of coverage depends on the decisions of the state and on the covered person's continued employment relationship to the state. The following sections explain when coverage shall end and the options available to the covered person to continue or convert coverage.

When Coverage Ends

Your coverage in the Plan ends:

- When your employment is terminated. Active employees pay premiums one month in advance, so coverage ends on the last day of the month following the month they end employment. For example, if their last day of work is April 23, their coverage ends May 31 because they already paid for May coverage.
- On the last day of the month in which you do not make the required contributions for coverage, including the months when you are on leave without pay, suspension or layoff status. Payment is due the tenth of the month prior to the month of coverage. For example, payment for July coverage is due June 10.
- On the last day of the month in which you remarry, if you have coverage as a surviving spouse of an employee or retiree.

If your spouse is enrolled as a covered dependent, your spouse's coverage ends on the last day of the month in which:

- Your coverage is terminated.
- You and your spouse divorce. You are required to notify People First within 60 days of the divorce.
- Your spouse dies.

Coverage for dependent children (as defined above) ends:

- On the last day of the month in which your coverage ends.
- The end of the calendar year in which the children turn 26 (30 for over-age health coverage).
- On the last day of the month the children no longer meet the definition of an eligible dependent (e.g., if you divorce the children's parent, you may no longer cover stepchildren).
- On the last day of the month in which they die.

If dependents become ineligible for coverage, you must go to the People First website to remove them from all applicable plans or call the People First Service Center at (866) 663-4735 within 60 days of the ineligibility, including for death. Service Center hours are 8 a.m. to 6 p.m. Eastern standard time. You must also send required documentation to People First to remove ineligible dependents from coverage (e.g., a divorce decree). Failing to provide the required

documentation means you risk losing coverage or paying for more coverage than you need.

Handicapped Children Coverage Termination

If a child attains the limiting age for a covered dependent, coverage shall not terminate while that person is, and continues to be, both:

1. Incapable of self-sustaining employment by reason of intellectual or physical handicap; and,

2. Chiefly dependent on the covered person for support and maintenance.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage, the covered person shall have the burden of establishing that the child is and has continued to be handicapped.

The coverage of the handicapped child may be continued, but not beyond the termination date of the incapacity or the dependence. This provision shall not limit the application of any other provision of Capital Health Plan terminating the child's coverage for any other reason than the attainment of the limiting age.

Termination Of Coverage For Cause

If, in the opinion of Capital Health Plan, any of the following events occur, Capital Health Plan may request that the state terminate a covered person for any of the following reasons:

1. Disruptive, unruly, abusive, or uncooperative behavior to the extent that the covered person's continued membership in Capital Health Plan impairs Capital Health Plan's ability to administer this plan or to arrange for the delivery of health care services to the covered person or to other covered persons if:

    a. an effort has been made to resolve the problem;

    b. consideration has been given to extenuating circumstances; and,

    c. the problems, efforts, and medical conditions have been documented.

2. Fraud or material misrepresentation or omission in applying for membership or in requesting the receipt of coverage.

3. Misuse of the membership identification card.

Any termination made under this provision is subject to review in accordance with the grievance procedures described in the FILING A GRIEVANCE OR COMPLAINT section.

RIGHTS TO EXTENSION, CONVERSION, AND CONTINUATION

If coverage for a covered person ends, the covered person may, depending on his or her situation, have the right to have coverage extended under the extension of benefits provision. Also, the covered person may be eligible for coverage under the federal continuation of coverage provisions or an alternative coverage plan under the conversion privilege provision.

Extension Of Hospital Inpatient Benefits

Capital Health Plan shall extend coverage to a covered person who is a hospital inpatient on the date that the Capital Health Plan contract is terminated. However, Capital Health Plan shall not be required to provide extended hospital benefits beyond 12 calendar months from the date that the contract is terminated. This provision applies if Capital Health Plan terminates its contract with the state but not if the employee terminates coverage with Capital Health Plan.

Extension Of Disability Coverage And Maternity Benefits

If Capital Health Plan terminates its contract with the state, disability coverage and maternity benefits shall be extended in accordance with applicable statutes.

Coverage Continuation Family and Medical Leave and Job-Protected Leave

This provision is administered by each employing agency just like any other leave, paid or unpaid. This section is provided for general information only. Each employing agency may administer family and medical leave differently. Contact your personnel office or People First for exact information concerning this provision.

As an employee, you may be entitled under the federal Family and Medical Leave Act (FMLA) for up to 12 work weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for the State of Florida for at least one year and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, the placement of a child for adoption or foster care, a serious health Condition of a family member (child, spouse or parent) or a personal, serious health Condition.

In addition, the FMLA provides special unpaid, job-protected leave for up to 12 weeks if you have a family member called to active military duty and for up to 26

weeks when such family member is injured while on military duty.

As a participant in the Plan, when you are on authorized FMLA leave, you have the option to continue your health benefits on the same terms and conditions as immediately prior to your taking such leave. The State of Florida will continue to pay its share of the premium (if any) throughout your FMLA leave. You will still be responsible for your portion of the premium (if any). Premium payments will be collected by People First. You and your eligible dependents shall remain covered under this Plan while you are on FMLA leave as if you were still at work as long as premiums are paid.

Furthermore, under the laws of the State of Florida, certain employees may be eligible to have their unpaid job-protected parental or family medical leave extended up to six months. You may call your personnel office if you need more details. If you are on authorized parental or family medical leave, your employer will continue to pay its share of the premium (if any) for up to six months of unpaid leave. Your coverage will be maintained until you return to work as long as premiums are paid. If you do not cancel coverage within 60 days of going out on leave and your coverage is subsequently canceled for non-payment, you will only be able to enroll during the next Open Enrollment period.

Coverage Continuation When You are Off Payroll

Active employees who go off the payroll must pay their share of the health insurance premium by personal check, cashier’s check or money order to continue coverage. Employees may be required to pay the full premium cost—their share and the state’s share, depending on the reason they are not working. Employees should call People First for more information at (866) 663-4735. Employees who do not want to continue insurance coverage while off the payroll must call People First within 60 days of their leave date to cancel. This ensures they can enroll in coverage if they return to work. Employees who do not cancel and are later cancelled because they did not pay their health insurance premiums will only be allowed to enroll during the next Open Enrollment.

COBRA

The Consolidated Omnibus Budget Reconciliation Act is referred to as COBRA. Under COBRA, you can continue healthcare coverage that would otherwise end because of dependent eligibility and because of voluntary or involuntary termination for reasons other than gross misconduct. You may also continue healthcare coverage that would otherwise end because you did not return to work after an unpaid leave under the Family and Medical Leave Act. You may keep this continuation coverage for up to 18 months, provided you pay the required cost of the continued coverage. The monthly premium is 102 percent of the cost of coverage.

If you or your dependent is disabled under the Social Security Act at any time during the first 60 days of COBRA continuation coverage you have because of

termination of employment or change in employment status, an additional 11 months of coverage may be available. To be eligible for this disability extension, the disabled person must receive a Social Security disability determination and notify People First within 60 days of the determination. Both the Social Security disability determination and the notice to People First must happen before the end of the initial 18 months of COBRA coverage. Non-disabled family members who receive COBRA coverage because of the same termination of employment or change in employment status as the disabled person are also eligible for the disability extension. The monthly premium for the additional 11 months of coverage is 150% of the cost of coverage.
Under COBRA, spouses of employees and/or their dependent children may choose continuation coverage and keep it for up to 36 months, as long as they pay the required costs, if their healthcare coverage ends because of:

1. death of the covered employee, whether active or on an approved leave of absence;
2. divorce or legal separation from the employee; or
3. employee becomes entitled to Medicare.

If you have a newborn child or adopt a child during the time you are covered by COBRA continuation coverage, that child can be enrolled under the continuation coverage. Like your other dependents, that child can keep continuation coverage for up to 36 months from the date your COBRA coverage began if the coverage would otherwise end because of one of the three events described above.

If you acquire a new dependent by marriage during the time you are covered by COBRA continuation coverage, that dependent can also be enrolled under the continuation coverage. Your new spouse can keep continuation coverage for as long as your COBRA coverage continues.

Dependent children covered by the Plan may also choose continuation coverage and keep it for up to 36 months if their group coverage ends because they no longer qualify as an eligible dependent under the Plan.

Under COBRA, the employee or spouse is responsible for notifying People First of a divorce, legal separation, death or a child's losing dependent status under the Plan. Notice must be given within 60 days of the event. Involved individuals must also provide People First with a current and complete mailing address. If notice is not received within 60 days of the event, the dependent will not be entitled to choose continuation coverage.

Upon notification, People First will send an enrollment form for COBRA continuation coverage to the eligible individual, along with notification of the premium. The eligible individual must complete the enrollment form and return it to People First within 60 days of:
1. the date coverage is lost because of one of the events described above; or

2. the date the form is received from People First, whichever is later.

If an individual does not complete the COBRA election form and return it to People First within the 60-day period, coverage will end:
1. on the last day of the month in which the event, such as divorce, that caused ineligibility for coverage took place; or
2. on the last day of the month following the month you were terminated.

If an eligible individual chooses COBRA continuation coverage, the state must provide coverage identical to that provided to comparably situated employees. An eligible individual's COBRA continuation coverage will end when:
1. the state stops providing group health coverage for employees;
2. payment for continuation coverage is not made by the deadline, or your check is returned for insufficient funds;
3. the individual later becomes covered by another group health plan. If the new group plan excludes benefits because of a pre-existing Condition, however, you may continue your COBRA continuation coverage through the end of the COBRA eligibility period or until the other plan's pre-existing Condition limits no longer apply, whichever is earlier;
4. the individual later becomes entitled to Medicare;
5. if the employee became entitled to Medicare before employment termination, coverage for other covered dependents may be continued for 18 months or for up to 36 months from the date the employee became entitled to Medicare, whichever is longer; or
6. the 18-, 29-, or 36-month COBRA period ends.

Conversion Privilege

Covered persons whose coverage under Capital Health Plan has terminated for any reason other than for nonpayment of premium shall have the right to apply for a conversion policy.

The new conversion plan shall be a benefit plan in use by Capital Health Plan on the date of the request for group conversions. The new coverage shall be issued at the rates for Capital Health Plan's conversion policies as filed and approved by the Florida Department of Financial Services on the date that coverage under Capital Health Plan terminates.

Requesting Conversion

A covered person who is eligible for conversion shall obtain conversion coverage without having to submit evidence of health qualification. The covered person shall apply in writing and pay the first premium on the conversion plan within 63 days after his or her coverage under Capital Health Plan terminates. If you choose COBRA continuation coverage when your Plan coverage ends, you can convert to a private policy when COBRA coverage ends. In this case, you must

still apply in writing and pay the first month's premium within 63 days of the date your COBRA coverage ends. The application form to be used and information about conversion benefits shall be obtained from Capital Health Plan. It shall be the sole responsibility of the covered person to exercise this conversion privilege.

Conversion shall not be available if:

1. Coverage under Capital Health Plan ends because of failure to pay any required premium;

2. Capital Health Plan is replaced by similar group coverage within 31 days of the termination date of Capital Health Plan;

3. The covered person is or could be covered by Medicare; or,

4. The covered person is eligible for the following coverage and those benefits together with the benefits provided by the conversion plan would result in excessive duplication of benefits, such as:

    a. Any arrangements of coverage for individuals in a group whether on an insured or self-insured basis;

    b. Similar benefits under any state or federal program; or,

    c. Similar benefits by another group hospital, surgical, medical or major medical expense insurance policy or group hospital and medical service plan or group medical practice or any other prepayment plan or program.

5. The covered person does not maintain his/her primary residence in the Capital Health Plan service area.

COORDINATION WITH OTHER GROUP INSURANCE PLANS

If the covered person or his or her spouse or dependents are covered under Capital Health Plan and any other group medical insurance plan, group self-insurance, no-fault automobile insurance, a health maintenance organization, Medicare, or any other insurance providing medical expense coverage; Capital Health Plan shall reserve the right to coordinate the benefits of the Plan with any other benefits that the covered person or his or her spouse or dependents receive. When benefits are coordinated, the total benefits payable from both plans will not be more than 100% of the total allowed expenses actually incurred.

The term "group medical insurance plan" means a plan provided under a master policy issued to:

1. an employer

2. the trustees of a fund established by an employer or by several employers

3. employers for one or more unions according to a collective bargaining agreement

4. a union group, or

5. any other group to which a group master policy may be issued legally in the State of Florida or any other jurisdiction for the purpose of insuring a group of individuals.

To ensure claims processing accuracy and appropriate coordination of benefits, Capital Health Plan will verify if the covered person or his or her spouse or dependents have other insurance coverage or other insurance liability (OPL).

How Coordination Works

The plan that considers expenses first is the primary plan. The plan that considers expenses after the primary plan pays benefits is the secondary plan. If Capital Health Plan is primary, it will pay benefits first. Benefits will be paid as they normally would under the plan, regardless of the covered person's other insurance coverage.

If Capital Health Plan is secondary, it will pay benefits second. In this case, benefits from Capital Health Plan and from the primary plan will not be more than 100% of total reasonable expenses. Also, when Capital Health Plan is secondary, it will not pay benefits above what it would pay if it were the primary plan.

Here are some guidelines for determining which plan pays first (or is the primary plan) and which plan is the secondary plan.

For All Covered Individuals

The plan covering a person as an employee or subscriber, rather than as a dependent, pays first.

The plan covering a person as an active employee, or that employee's dependent, pays before the plan that covers a person as a laid-off or retired employee, or that employee's dependent. When the other policy or plan does not have this rule and the plans do not agree on the order of benefits, this rule will not apply.

For Eligible Dependent Children

The plan of the parent whose birthday comes first in the calendar year pays first for covered dependent children, unless the parents are divorced or separated. If both parents have the same birthday, the plan that has covered the parent for the longest time pays first.

In the case of divorce or separation, the plan of the parent with custody pays first, except when a court decrees otherwise.

If the parent with legal custody has remarried, the following payment order applies unless a court decrees otherwise:

- the plan of the parent with legal custody pays first
- the plan of the spouse of the parent with custody pays second
- the plan of the parent without custody pays last

If this plan coordinates benefits with an out-of-state plan that says the plan covering the male parent pays first and the two plans do not agree on the order of benefits, the rules of the other plan will determine the order of benefits for eligible dependent children.

If none of the rules listed in this section apply, the plan that has covered a person for the longest time pays first.

COORDINATION WITH MEDICARE

It is important for the covered person and his or her dependents to enroll for Medicare coverage when they first become eligible.

Active Employees

If the covered person is an active employee enrolled in Medicare Part A or Part B, Capital Health Plan will pay benefits for the covered person and his or her dependent spouse first. Medicare will pay second. However, if Capital Health Plan's payment is above what Medicare normally would allow for the service if Medicare were paying first, Medicare will not pay benefits. If the covered person is an active employee or the spouse of an active employee and became eligible for Medicare because of age or disability, the covered person may choose to defer Medicare Part B benefits until the covered person or his or her spouse retires.

For active employees with a dependent who is disabled for reasons other than

end-stage renal disease, Capital Health Plan will pay benefits first for the disabled dependent until he or she reaches age 65. At age 65, Medicare becomes the primary plan and will pay benefits first for any disabled dependent other than the spouse. If the disabled dependent is the covered person's spouse, that spouse's coverage under Capital Health Plan will continue to be primary, paying benefits first, as long as the covered person is an active employee.

If the covered person or his or her dependent requires treatment for end-stage renal disease, Capital Health Plan will pay benefits first for the first 30 months of treatment and Medicare will pay second. After that, Medicare will pay benefits first and Capital Health Plan will pay benefits second. If the covered person becomes eligible for Medicare because of age or disability, before becoming eligible because of end-stage renal disease, however, Medicare would continue to pay first as the covered person's primary carrier and Capital Health Plan would pay second.

Retired Employees

If the covered person is a retiree, spouse of a retiree, or the surviving spouse of a retiree enrolled in Medicare, the covered person must enroll in the Capital Health Plan Medicare Advantage Plan with Part D Prescription Drug benefits. If the covered person who is a retiree, spouse of a retiree, or the surviving spouse of a retiree chooses not to enroll in the Capital Health Plan Medicare Advantage Plan with Part D Prescription Drug benefits, his or her coverage with Capital Health Plan will cease.

CLAIMS PROCESSING

REIMBURSEMENT FOR NONPARTICIPATING PROVIDER SERVICES

Capital Health Plan shall provide or arrange for covered services to be received from participating providers on a direct service basis. If a covered person receives covered services from a participating provider, Capital Health Plan shall pay the provider directly for all care received. The covered person shall not have to submit a claim for payment, and shall be responsible only for any applicable copayment amount or applicable coinsurance amount after deductible.

If the covered person requires emergency services from a nonparticipating provider while inside or outside the service area, or if Capital Health Plan refers the covered person to a nonparticipating provider, Capital Health Plan shall attempt to arrange for direct payment with the nonparticipating provider. If the nonparticipating provider refuses direct payment, or if the arrangements are not possible, the covered person must submit a claim to Capital Health Plan for the services, and will be reimbursed for the cost of the services. The covered person shall not be reimbursed for more than the actual out-of-pocket expenses related

to the services.

The following provisions apply when the covered person needs to file a claim for nonparticipating provider services:

1. Claim Forms

   Claim forms may be required for submission of a proof of loss by a covered person for nonparticipating provider services. The covered person is responsible for following the procedures established by Capital Health Plan.

2. Proof of Loss

   For services rendered by nonparticipating providers, written proof of loss shall be given to Capital Health Plan. If proof of loss is not submitted and received by Capital Health Plan within one year, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit written proof of loss within the allowed time period and that the proof was submitted as soon as possible, the claim shall not be reduced or invalidated.

3. Time of Payment of Claims

   After receiving written proof of loss for a covered service, Capital Health Plan shall reimburse all uncontested claims or any portion of any claim received by Capital Health Plan from a covered person or a covered person's assignees within 30 days.

   If a claim or portion of a claim is contested by Capital Health Plan, the covered person or the covered person's assignees shall be notified, in writing. Capital Health Plan must send the covered person or the covered person’s assignees notice when Capital Health Plan contests a claim or a portion of a claim. The notice shall identify the contested portion of the claim and the reasons for contesting the claim. On receipt of additional information requested from a covered person or the covered person's assignees, Capital Health Plan shall pay or deny the contested claim or portion of the contested claim within 30 days.

   Payment shall be treated as being made on the date a draft or valid instrument that is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

4. Assignment of Claim

For covered services rendered by nonparticipating providers, benefits shall be payable to the covered person less any applicable copayment amount or coinsurance amount after deductible that are the responsibility of the covered person. Capital Health Plan may pay all or any part of the benefits to the health care provider on whose charge the claim is based. Capital Health Plan is under no obligation to honor assignments from nonparticipating providers.

Important - Timely Filing of Claims

All claim forms must be submitted within 12 months after the date of service. Otherwise, we will not pay any benefits for that eligible expense or benefits will be reduced as determined by State of Florida. For inpatient stays, the date of service is the date your inpatient stay ends. This 12-month requirement does not apply if you are legally incapacitated.

CLAIMS REVIEW

Introduction

This section is intended to:

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

- provide the covered person with a general description of the applicable procedures Capital Health Plan will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying the covered person when Capital Health Plan denies benefits.

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

Under no circumstances will Capital Health Plan be held responsible for, nor will it accept liability relating to, the failure of the Group Plan's sponsor or plan administrator to: (1) comply with ERISA's disclosure requirements; (2) provide

the covered person with a Summary Plan Description (SPD) as that term is defined by ERISA; or (3) comply with any other legal requirements. The covered person should contact the plan sponsor or administrator if he or she has questions relating to the Group Plan's SPD. Capital Health Plan is not the Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

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

Definitions

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

Adverse Benefit Determination means

- a denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit;
- any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay or other health care service does not meet Capital Health Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
- a decision or a denial based in whole or in part on medical judgment, including the failure to cover services because they are determined to be experimental, investigational, cosmetic, not medically necessary or inappropriate;
- a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required premiums or contributions toward cost of coverage.

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

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

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

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

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to the covered person (not just proposed or recommended) that is received by Capital Health Plan in a format acceptable to Capital Health Plan in accordance with the provisions of this section.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to the covered person and with respect to which the terms of this Member Handbook condition payment for the Service (in whole or in part) on approval by Capital Health Plan of coverage or benefits for the Service before the covered person receives the Service. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by Capital Health Plan regarding coverage, benefits, or payment for a Service that has not actually been rendered to the covered person if the terms of this Member Handbook do not require approval by Capital Health Plan of coverage or benefits (or condition payment) for the Service before it is received.

Post-Service Claims

<u>How to File a Post-Service Claim</u>

This section defines and describes the three types of claims that may be submitted to Capital Health Plan. Experience shows that the most common type of claim Capital Health Plan will receive from the covered person or his or treating providers will likely be Post-Service Claims.

Participating providers have agreed to file Post-Service Claims for Services rendered to the covered person. If the covered person receives a bill from a Contracting Provider, it should be forwarded to Capital Health Plan. If the

covered person requires Emergency Services and Care from a non-participating Provider while inside or outside the Service Area, or if Capital Health Plan refers the covered person to a non-participating Provider, Capital Health Plan will pay for Covered Services provided to the covered person. If the covered person receives a bill from a non-participating Provider for such Services, it should be forwarded to Capital Health Plan. Capital Health Plan relies on the information the covered person provides when processing a claim.

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

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

- the date the Service was provided;
- a description of the Service including any applicable procedure code(s);
- the amount actually charged by the provider;
- the diagnosis including any applicable diagnosis code(s);
- the provider's name and address;
- the name of the individual who received the Service; and
- the covered person's name and contract number as they appear on the Membership Card.

The Processing of Post-Service Claims

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

1. **Payment for Post-Service Claims**

When payment is due under the terms of this Member Handbook, Capital Health Plan will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, Capital Health Plan will use its best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. The covered person may receive notice of payment for paper claims within 30 days of receipt. If Capital Health Plan is unable to determine whether the claim or a portion of the claim is payable because Capital Health Plan needs more or additional information, Capital Health Plan may contest or

deny the claim within the timeframes set forth below.

2. **Contested Post-Service Claims**

In the event Capital Health Plan contests an electronically submitted Post-Service Claim, or a portion of such a claim, Capital Health Plan will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event Capital Health Plan contests a paper Post-Service Claim, or a portion of such a claim, Capital Health Plan will use its best efforts to provide notice, within 30 days or 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 Capital Health Plan reasonably expects to notify the covered person of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If Capital Health Plan requests additional information, Capital Health Plan must receive it within 45 days of the request for information. **If Capital Health Plan does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in Capital Health Plan's possession at the time and may be denied.** Upon receipt of the requested information, Capital Health Plan will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

3. **Denial of Post-Service Claims**

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

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

4. **Additional Processing Information for Post Service Claims**

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

Pre-Service Claims

<u>How to file a Pre-Service Claim</u>

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

Capital Health Plan is not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to the covered person unless the terms of this Member Handbook require approval by Capital Health Plan (or condition payment) for the Service before it is received.

<u>Benefit Determinations on Pre-Service Claims Involving Urgent Care</u>

For a Pre-Service Claim Involving Urgent Care, Capital Health Plan will use its best efforts to provide notice of the determination (whether adverse or not) as soon as possible, but not later than 24 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, Capital Health Plan will use its best efforts to provide notice within 24 hours of: (1) the need for additional information; (2) the specific information that the covered person or the provider may need to provide; and (3) the date that Capital Health Plan reasonably expects to provide notice of the decision. If Capital Health Plan requests additional information, Capital Health Plan must receive it within 48 hours of the request. Capital Health Plan will use its best efforts to provide notice of the decision on the Pre-Service Claim within 48 hours after the earlier of: (1)

receipt of the requested information; or (2) the end of the period the covered person was afforded to provide the specified additional information as described above.

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

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

If additional information is necessary to make a determination, Capital Health Plan will use its best efforts to: (1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; (2) identify the specific information that the covered person or the provider may need to provide; and (3) inform the covered person of the date that Capital Health Plan reasonably expects to notify him or her of the decision. If Capital Health Plan requests additional information, Capital Health Plan must receive it within 45 days of the request for the information. Capital Health Plan will use its best efforts to provide notice of the decision on the Pre-Service Claim within 15 days of receipt of the requested information. A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this section, and the appeal procedures described in the Complaint and Grievance Process section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

- Capital Health Plan has approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of Service(s); and
- the reduction or termination of coverage or benefits by Capital Health Plan was not due to an amendment to the Member

Handbook or termination of the covered person's coverage as provided by this Member Handbook.

Capital Health Plan will use its best efforts to notify the covered person of such reduction or termination in advance so that he or she will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Complaint and Grievance Process described in this Member Handbook. In no event shall Capital Health Plan be required to provide more than a reasonable period of time within which the covered person may develop his or her appeal before Capital Health Plan actually terminates or reduces coverage for the Services.

Requests for Extension of Services

The covered person's provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, Capital Health Plan will use its best efforts to notify the covered person of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. Capital Health Plan will use its best efforts to notify the covered person within 24 hours if: (1) Capital Health Plan needs additional information; or (2) the covered person, or the covered person's representative failed to follow proper procedures in the request for an extension. If Capital Health Plan requests additional information, the covered person will have 48 hours to provide the requested information. Capital Health Plan may notify the covered person orally or in writing, unless the covered person or the covered person's representative specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Member Handbook.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

Capital Health Plan will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to the covered person free of charge upon request):

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

- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and,
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the covered person how to obtain the specific explanation of the scientific or clinical judgment for the determination.
- Capital Health Plan will determine whether the covered person seeking to file an Appeal is entitled to receive notices in an appropriate non-English language. In the event the covered person is so entitled, Capital Health Plan shall provide all notices to the covered person in the appropriate non-English language if the covered person has made a request to Capital Health Plan. If the covered person has not already made such a request, Capital Health Plan must provide all notices to the covered person in the appropriate non-English language only upon the request of the covered person or the covered person's authorized representative.

If the claim is a Claim Involving Urgent Care, Capital Health Plan may notify the covered person orally within the proper timeframes, provided Capital Health Plan follows up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims, Capital Health Plan may need certain information, including information regarding other health care coverage the covered person may have. The covered person must cooperate with Capital Health Plan in its effort to obtain such information by, among other ways, signing any release of information form at Capital Health Plan's request. Failure by the covered person to fully cooperate with Capital Health Plan may result in a denial of the pending claim and Capital Health Plan will have no liability for such claim.

Physical Examination

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

Legal Actions

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

Fraud, Misrepresentation or Omission in Applying for Benefits

Capital Health Plan relies on the information provided on the itemized statement when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy Capital Health Plan may have, in denial of the claim or cancellation. Capital Health Plan may rescind coverage only due to an act or practice constituting fraud or an intentional misrepresentation of a material fact.

Communication of Claims Decisions

All claims decisions, including denial and claims review decisions, will be communicated to you. Explanation of Payments will be posted through the covered person's Portal of CHPConnect for all Claims Payments. Should you not have access to the Member's Portal of CHPConnect, a written explanation of Payment can be obtained by contacting our Member Service Department at 850-383-3311 or you may request it in writing at:

Capital Health Plan
PO Box 12400
Tallahassee, Fl. 32317-2400

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

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Member Handbook provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- A description of any additional information that would change the initial determination and why that information is necessary;
- A description of the applicable Adverse Benefit Determination review procedures and time limits applicable to such procedures; and
- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement

telling the covered person how they can obtain the specific explanation of the scientific or clinical judgment for the determination.

- Capital Health Plan will determine whether the covered person seeking to file an Appeal is entitled to receive notices in an appropriate non-English language. In the event the covered person is so entitled, Capital Health Plan shall provide all notices to the covered person in the appropriate non-English language if the covered person has made a request to Capital Health Plan. If the covered person has not already made such a request, Capital Health Plan must provide all notices to the covered person in the appropriate non-English language only upon the request of the covered person or the covered person's authorized representative.

Circumstances Beyond the Control of Capital Health Plan

UNUSUAL CIRCUMSTANCES

If the rendering of services or benefits under this plan is delayed or impractical because of: (a) complete or partial destruction of facilities; (b) war; (c) riot; (d) civil insurrection; (e) major disaster; (f) disability of a significant part of a participating hospital and practitioner network; (g) epidemic; (h) labor dispute not involving Capital Health Plan, participating providers shall use their best efforts to provide services and benefits within the limitations of available facilities and personnel. However, neither Capital Health Plan nor any participating providers shall have any liability or obligation because of a delay or failure to provide services or benefits. If the rendering of services or benefits under Capital Health Plan is delayed because of a labor dispute involving Capital Health Plan or participating providers, nonemergency care shall be deferred until after the resolution of the labor dispute.

RIGHT TO RECOVER AND SUE FOR LOSSES

Capital Health Plan reserves the right to be reimbursed for benefits paid under this plan if the covered person has a right to recover those benefits from a third party. This provision helps the State and Capital Health Plan to continue providing cost-effective health care benefits. The covered person will not be asked to reimburse Capital Health Plan for an amount higher than the actual payments it made on behalf of the covered person.

If the covered person or his or her dependent receives plan benefits for a claim that is in connection with a condition caused, directly or indirectly, by an intentional act or from the negligence or fault of any third person or entity, Capital Health Plan will be subrogated to the right of recovery that the covered person or his or her dependent has against the other person or entity. Capital Health Plan's subrogation rights apply to any settlement of a claim, regardless of whether there is a lawsuit, and will not be offset by any premiums that the

covered person has paid.

This right to subrogation will be for the amount of benefits paid by the plan for health care services. The covered person, his or her dependent or legal representative will be required to:

- provide Capital Health Plan with information pertaining to any settlement, settlement negotiations, or litigation
- provide the assistance necessary to enforce this right to subrogation
- notify Capital Health Plan of any settlement negotiations before entering into any settlement agreement
- notify Capital Health Plan of any amount recovered from the person or entity that may be liable

No waiver, release of liability, or other documents that the covered person executes without notice to Capital Health Plan shall be binding on Capital Health Plan.

COVERAGE ACCESS RULES

It is important that Capital Health Plan covered persons become familiar with the rules for accessing health care services through Capital Health Plan. The following sections explain the role of Capital Health Plan and the primary care physician, how to access specialty care through Capital Health Plan and the primary care physician, and what to do if emergency care is needed.

Capital Health Plan AND HEALTH CARE PROVIDERS

Capital Health Plan does not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care provider. Any decisions made by Capital Health Plan concerning appropriateness of setting or whether any service is medically necessary, shall be deemed to be made solely for purposes of determining whether covered services are due, and not for purposes of recommending any treatment or non-treatment. Neither Capital Health Plan nor the employer group will assume liability for any loss or damage arising as a result of acts or omissions of any health care provider.

MEDICAL DECISIONS – RESPONSIBILITY OF COVERED PERSON'S PHYSICIAN NOT Capital Health Plan

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services or supplies, must be made solely by the covered person, the covered person's family, and the covered person's treating physician in accordance with the patient/physician relationship. It is possible that the covered person or the covered person's treating physician may conclude that a particular medical service or supply is needed, appropriate, or desirable, even though that medical service or supply may not be covered.

ROLE OF PRIMARY CARE PHYSICIAN (PCP)

The first and most important decision each covered person must make when joining a health maintenance organization is the selection of a primary care physician. This decision is important because it is through this physician that all other health services, particularly those of specialists, are obtained. The covered person is free to choose any primary care physician listed in Capital Health Plan's Directory of Physicians and Service Providers whose practice is open to additional Capital Health Plan covered persons. However, the covered person should verify the physician's status through Capital Health Plan's Member Services staff or the Internet at www.capitalhealth.com. This choice should be made when the covered person enrolls. If the covered person fails to choose a primary care physician when enrolling, Capital Health Plan shall assign one to

the covered person and notify the covered person of that assignment.

Some important guidelines apply to the covered person's primary care physician relationship:

1. The primary care physician shall maintain a physician-patient relationship with the covered person, and shall be responsible for providing, authorizing, and coordinating all medical services for the covered person.

2. The covered person must look to the primary care physician to direct his or her care, and should accept procedures and treatment recommended by the primary care physician.

3. Except in emergency situations or as otherwise directed by Capital Health Plan, all services shall be received from the covered person's primary care physician, from participating providers on referral from the primary care physician, or through another health care provider designated by Capital Health Plan. If services are not received in this manner and the covered person uses a health care provider that is not a participating provider or that has not been referred by a primary care physician, services shall not be reimbursed by Capital Health Plan.

4. Capital Health Plan wants the covered person and the primary care physician to have a good relationship. Instances may occur when the primary care physician or the covered person, for good cause, finds it impossible to establish an appropriate and viable physician-patient relationship. In that case, the primary care physician or the covered person may request that the covered person choose another primary care physician.

5. If, for any reason, the primary care physician or other contracting health care provider fails to or is unable to provide the covered person with services that the primary care physician or other contracting health care provider has agreed to provide, Capital Health Plan agrees to provide, arrange, or pay for services equivalent to those described in the covered services section up to the date for which payment has been made by the covered person.

6. If the covered person's primary care physician terminates his or her agreement with Capital Health Plan, Capital Health Plan shall assist the covered person in selecting another primary care physician whose practice is open to new Capital Health Plan covered persons.

SPECIALTY CARE

The primary care physician may refer the covered person to participating specialists or facilities when medically necessary. The referral may identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the covered person's condition. Covered persons shall have direct access to gynecologists, dermatologists, chiropractors, podiatrists, and other practitioners as specified by law.

Female covered persons have access to obstetricians/gynecologists who are participating providers for routine care without authorization or referral from the covered person's primary care physician.

When additional services or visits are suggested by the specialist, a covered person first should consult with his or her primary care physician or Capital Health Plan.

If a specialist beyond those participating with Capital Health Plan is required, the primary care physician shall authorize that treatment only if authorized by Capital Health Plan. The covered person is responsible for following the procedures established by Capital Health Plan.

EMERGENCY SERVICES AND CARE

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

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

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

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

INTER-PLAN PROGRAMS

Out-of-Area Services

Capital Health Plan has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

Capital Health Plan covers only limited healthcare services received outside of our service area. As used in this section "Out-of-Area Covered Healthcare Services" include *emergency care, urgent care, or care authorized by Capital Health Plan* obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your primary care physician ("PCP").

A. BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Capital Health Plan will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers. The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment amount, as stated in your Schedule of Copayments.

Emergency Care Services: If you experience a Medical Emergency while traveling outside Capital Health Plan's service area, go to the nearest Emergency (or Urgent Care) facility.

Whenever you access covered healthcare services outside the

State of Florida and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Capital Health Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers Outside Our Service Area

1. Your Liability Calculation

When Out-of-Area Covered Healthcare Services (*emergency care, urgent care, or care authorized by Capital Health Plan)* are received from nonparticipating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Capital Health Plan will make for the covered services.

2. Exceptions

In certain situations, Capital Health Plan may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Capital Health Plan will make for the covered services.

CASE MANAGEMENT

Capital Health Plan reserves the right (but, in no event shall it be required) to offer its case management program to covered persons. If the covered person and the covered person’s physician agree, Capital Health Plan may use its case management program then in effect. Capital Health Plan’s use of the case management program with respect to any covered person shall not restrict or otherwise modify Capital Health Plan’s right to administer covered and/or benefits in strict accordance with the terms of this Member Handbook with respect to the covered person, or with respect to any other covered person or other individual under any other policy or contract. Furthermore, whether cost of providing alternative or equivalent services varies, depending on whether a particular provider or supplier is used to provide the service, Capital Health Plan may (but shall not be required to) take variations into consideration when authorizing or approving payment, coverage, or benefits for services under the case management program.

CONTINUING CARE FACILITY/RESIDENT FACILITY RESIDENT MEMBER RIGHTS

If the covered person is a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the covered person's primary care physician must refer the covered person to that facility's skilled nursing unit or assisted living facility if:

1. requested by the covered person and agreed to by the facility;
2. the covered person's primary care physician finds that such care is medically necessary;
3. the facility agrees to be reimbursed at the Capital Health Plan, Inc., contract rate negotiated with similar providers for the same covered services and supplies; and

4. the facility meets all guidelines established by Capital Health Plan, Inc., related to:

   a. quality of care;
   b. utilization;
   c. referral authorization;
   d. risk assumption;
   e. use of the Capital Health Plan, Inc., provider network; and,
   f. other criteria applicable to providers under contract with Capital Health Plan, Inc., for the same services.

If a covered person's request to be referred to the skilled nursing unit or assisted living facility that is part of that covered person's place of residence is not honored, the covered person has the right to initiate a grievance under the process described in the Member Handbook.

COVERED PERSON COPAYMENTS OR COINSURANCE AND DEDUCTIBLE

For certain services, the covered person is responsible for paying a portion of the cost of covered services. This portion can be a flat dollar amount referred to as a copayment or a percentage of the cost referred to as coinsurance. The Health Investor HMO Plan also contains an amount the covered person must pay before Capital Health Plan will begin paying for covered services in that calendar year, referred to as a deductible. The copayment, coinsurance, and/or deductible requirements for Capital Health Plan are shown in the Summary of Benefits. The covered person also may call Capital Health Plan Member Services for information on copayment, coinsurance, and/or deductible amounts or log into CHPConnect at www.capitalhealth.com.

The maximum out-of-pocket amount is the total copayments or coinsurance (including the plan deductible) the covered person or family is responsible for in any single calendar year. These amounts are listed on the Summary of Benefits. When the covered person or family has paid copayments or coinsurance and deductible that total the annual maximum out-of-pocket amount, no further copayments or coinsurance shall be required from that covered person or family for the remainder of the calendar year. The covered person is responsible for providing documentation of the amount of copayments or coinsurance paid. Expenses that will not count toward the annual maximum out-of-pocket amount include (i) expenses related to services that are not covered, (ii) expenses exceeding the allowed amount, and (iii) prescription copayments on the HMO Standard Plan option.

LIFETIME MAXIMUM COVERAGE LIMIT

There is no lifetime maximum coverage limit under Capital Health Plan.

COVERED SERVICES

This section provides a description of services and supplies covered under the State Group Health Insurance Plan (through Capital Health Plan). Services and supplies not described here bu,t mandated by state or federal law and applicable to the Health Plan, will be covered by Capital Health Plan.

Coverage Access Rules

If you do not follow the coverage access rules described in this document, services and supplies may not be covered by Capital Health Plan. In such a circumstance, you may be responsible for the full cost of services and supplies**.**

Also, covered persons shall understand that the ordering of a service by a physician does not in itself make such a service a medically necessary covered service. As provided by Florida Statute 110.123(5), final decisions concerning the existence of coverage or benefits under the Health Plan shall not be delegated or deemed to have been delegated by the state. However, the Health Plan administrator(s) hired by the state are responsible for processing claims in accordance with the terms of this document.

Capital Health Plan pays the cost of covered care and medical supplies, less the copayment amount, as long as the care or supplies are:

- Ordered by a network provider (a provider who is in the Health Plan's network);
- Considered medically necessary for the covered person's treatment as a result of a covered accident, illness, condition, or mental or nervous disorder;
- Not specifically limited or excluded under Capital Health Plan; and
- Rendered while this health plan is in effect.

Ambulance

- Ambulance Transportation and Service when medically necessary
  - Ambulance service to the nearest hospital
  - Ambulance service to a covered person's home or skilled nursing facility
  - Ambulance service from a hospital that is unable to provide proper care to the nearest hospital that can provide proper care
- For services by boat, airplane or helicopter
  - When the pick-up point is inaccessible by ground transportation
  - When the travel distance involved in getting the covered person to the nearest hospital that can provide proper care is too far for medical safety
  - When speed in excess of ground vehicle speed is critical for medical safety

Anesthesia Services

- Both inpatient and outpatient.

Autism Spectrum Disorder

- Diagnosis and treatment through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services for an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability prior to the member's 9th birthday.
- Coverage is limited to services prescribed by the covered person's treating physician in accordance with a treatment plan.
- The required treatment plan includes, but is not limited to: a diagnosis, proposed treatment by type, frequency and duration of treatment, anticipated outcomes stated as goals, frequency with which the treatment plan will be updated, and signature of the treatment physicianannually.
- Coverage as required by Florida Statues 627.6686 and 641.31098 and as further amended by state and federal law.
- See page 59-60 for additional information and details.

Bone Marrow Transplants

- If the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration.
-

Cancer Services

- Diagnosis and Treatment—Includes both inpatient and outpatient diagnostic tests and treatment (including anti-cancer medications administered by network providers), including clinical trials as set forth in the Florida Clinical Trial Compact. Does not include Experimental or Investigational Treatments.

Child Health Supervision Services

- Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.
- Services as otherwise defined by the Patient Protection and Affordable Care Act.

Cleft Lip and Cleft Palate

- Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology, and nutrition services only as required by sections 627.64193 and 641.31(35), Florida Statutes..

Clinical Trials

- Includes routine patient care costs that are incurred by an insured individual who participates in an approved Phase II, III or iV clinical cancer trial if those

services, including drugs, items and devices, would otherwise be covered under the plan or contract if those drugs, items, devices and services were not provided in connection with an approved cancer clinical trial program. Experimental Treatment is excluded.

Contraceptive Supplies

- Insertion and removal of IUD
- Diaphragm
- Insertion and removal of contraceptive implants
- Contraceptive injections
- Oral contraceptives
- With respect to Women's Preventive Services (see also Preventive Services), coverage is limited to:
    - Contraceptive methods – Medical
        - Barrier: Diaphragm
        - Implanted: IUD
        - Sterilization: Tubal ligations
    - Contraceptive methods – Prescription Drug Benefit
        - Hormonal: All generic oral contraceptives
    - Other contraceptives may be covered based on medical necessity.

  For additional information on medical coverage please call Capital Health Plan at (850) 383-3311. For additional information on prescription coverage, please call Express Scripts at 1-877-531-4793.

Cosmetic Surgery

- Plastic & reconstructive when clinically indicated.
- Reduction mammoplasty
- Repair or alleviation of damage if result of an accident.
- Correction of a congenital anomaly for an eligible dependent.
- Correction of an abnormal bodily function.
- For an area of the body which was altered by the treatment of a disease.
- All stages of reconstruction of a breast on which a mastectomy was performed in accordance with federal law. However, if there is no evidence of malignancy, reconstruction and initial prosthetic device shall be covered only if received within two years after the date of the mastectomy.

Dental Care

- General anesthesia and facility services to the extent required by Florida Statute 641.34(34). Only in cases of dental care provided to a person under age 8 if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a hospital or surgical center is necessary.

Dermatology Services

- Direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a network dermatologist

as required by sections 627.6472(16) and 641.31(33) Florida Statutes**.**

Diabetes Treatment

- All medically appropriate and necessary equipment, supplies, and outpatient self-management training and educational services used to treat diabetes and pre-diabetes, if the treating physician or a physician who specializes in the treatment of diabetes and pre-diabetes certifies that such services are necessary.
- Certain diabetic equipment and supplies are covered through your HMO. Those not covered by the HMO may be covered by the Prescription Drug Plan. See page 66 (Prescription Drugs) for additional information.

Doctor's Care

- Office visits
- Medical treatment in hospital or outpatient facility or surgery (other than office visit) includes anesthesia services; concurrent physician care (surgical assistance provided by another physician) and consultations.
- Child health supervision services
- Adult preventive medical services
- Allergy treatment – including testing, desensitization therapy and allergy immunotherapy, which includes hypo-sensitization serum when administered by a health care provider
- Diagnostic procedures, lab tests or x-rays, including their interpretation, for the treatment of a covered condition
- For concurrent physician care and surgical assistance:
    - The additional physician must participate actively in the treatment and:
    - the condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; and
    - the physicians have different specialties or have the same specialty with different sub-specialties; and
    - must be authorized by the covered person's PCP or Capital Health Plan.
  - *For Consultations:*
    - PCP must request the consultation;
    - Consulting physician shall prepare a written report.
  - *For child health supervision services:*
    - Medical services and supplies include:
      - newborn's first examination in the hospital
      - periodic examinations, which shall include a history and physical examination, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child
      - oral and/or injectable immunizations
      - laboratory tests normally performed for a well child
      - evaluation and management counseling and/or risk factor reduction intervention for covered dependents without symptoms or established illnesses

        - hearing screenings
        - vision screenings
    - These services shall conform with prevailing medical standards and shall not be less than 18 visits at approximately the following age intervals:
        - Birth
        - 2, 4, 6, 9, 12, 15 and 18 months
        - 2, 3, 4, 5, 6, 8, 10, 12, 14, and 16 years
    - For Child health supervision services and Adult preventive medical services will be defined by the patient Protection and Affordable Care Act, which includes:
        - Evidence-based items or services that have in effect a rating of “A” and/or “B” in the current recommendations of the United States Preventive Services Task Force;
        - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individuals involved:
        - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
        - With respect to women, such additional preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Durable Medical Equipment

- For the care and treatment of a condition covered under this Health Plan, Capital Health Plan shall either rent or purchase, at its option, medical equipment and supplies including, but not limited to:
    - Trusses, braces, walkers, canes, crutches, casts, and splints
    - Occlusal guards, bite or dental splints, repositioning devices, and TMJ models for the treatment of temporomandibular joint (TMJ) syndrome
    - Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products
    - Oxygen and rental of equipment for the administration of oxygen, ventilator or other mechanical equipment for the treatment of respiratory paralysis or insufficiency
    - Ambulatory home uterine activity monitoring devices (AHUM)
    - Wheelchairs, hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment
    - Other medical equipment and supplies as determined to be medically necessary
- Durable Medical Equipment:
    - Shall not serve as a comfort, hygiene, or convenience item.
    - Shall not be used for the sole purpose of exercise.
    - Shall not be used by any other party.
    - Shall have been manufactured specifically for medical use.

  - Shall not include shoe buildups, shoe orthotics, shoe braces, or shoe supports unless the shoe is attached to a brace.
  - Shall not include water therapy devices, modifications to motor vehicles and/or homes, or similar items.

Emergency Care
- Coverage without prior authorization, for screening and stabilization based on determination by either a participating or non-participating provider.

Eye Care
- Routine or refractive eye examinations as part of the adult preventive medical care or child health supervision services benefit
- For treatment of a covered condition:
  - Aphakic patients and soft lenses or sclera shells
  - Following an injury, disease, or accident.
- For eyeglasses or contact lenses
  - Limited to the first pair following an accident to the eye or cataract surgery.
  - Includes the examination for the prescribing or fitting thereof.

Family Planning Services
- Includes counseling and information on birth control, sex education, and the prevention of sexually transmitted diseases.

Hearing Tests
- Only when associated with a covered ear surgery, in accordance with child and adult preventive health care benefits, or for the diagnosis of a covered condition.

Hemodialysis for Renal Disease
- Includes equipment, training, and medical supplies for home dialysis and dialysis centers.

Home Health Care
- Services by a home health care agency for a covered person confined and convalescing at home for a covered condition,
- Home health care services include:
  - Part-time, intermittent, or continuous nursing care by registered nurses, or licensed practical nurses, nurse registries, or home health agencies;
  - Physical, speech, occupational and respiratory therapy; and infusion therapy
  - Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by the treating physician and other covered services provided by or for a home health agency, through a licensed nurse registry, or by an independent nurse licensed under Chapter 464, Florida Statutes, to the extent that they would have been covered if the covered person had

been confined in a hospital.

- For approval of home health care services by the covered person's PCP or Capital Health Plan:
  - The treating physician must submit a home health care plan of treatment to your PCP; and
  - The plan of treatment must document that home health care is medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and
  - Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility.
- Services which shall not be covered under this benefit include:
  - Any service that would not have been covered had the covered person been confined in a hospital.
  - Services that are solely for the convenience of the covered person.

Therapy is subject to outpatient limitations described under rehabilitative services.

Hospice Care

- In-home care
  - Physician services
  - Physical, respiratory, massage, speech, and occupational therapy if approved by Capital Health Plan
  - Medical supplies, drugs, and appliances
  - Home health aide services
  - Part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) or private duty nursing service
  - Oxygen
  - Infusion therapy
- Hospice inpatient care
  - Room and board and general nursing care
  - Inpatient care services same as inpatient hospital care
  - Same covered services as in-home and outpatient hospice care
  - Includes care for pain control or acute chronic symptom management
- Hospice outpatient care includes:
  - Physician services
  - Laboratory, x-ray, and diagnostic testing
  - Ambulance service
  - Same covered services as in-home hospice care
- Hospice treatment program shall:
  - Meet the standards outlined by the National Hospice Association;
  - Be recognized as an approved hospice program by Capital Health Plan;
  - Be licensed, certified, and registered as required by Florida law; and
  - Be directed by the covered person's PCP or Capital Health Plan and coordinated by a registered nurse with a treatment plan that provides an organized system of hospice facility care, uses a hospice team, and has

around-the-clock care available.

- For hospice care:
  - Counseling of terminally ill patients whose doctor has certified that they have less than one year to live
  - Primary care physician (PCP) must submit a written hospice care plan or program; and
  - PCP must submit a life expectancy certification.
  - All hospice care expenses shall be approved in writing by Capital Health Plan
  - While in the hospice program, plan benefits for expenses related to the terminal illness are covered by the hospice provider.
  - Limited to 210 calendar days per lifetime
- These following services are **not** covered under Capital Health Plan:
  - Social work
  - Bereavement and pastoral
  - Financial
  - Legal
  - Dietary counseling
  - Day care
  - Homemaker and chore services
  - Funeral services

Hospital Inpatient Care

- Hospital room, board, and general nursing care for a semi-private room unless Capital Health Plan determines that a private room is medically necessary
- Room, board, and treatment in an intensive, progressive, cardiac or neonatal care unit
- Other necessary services and supplies, including but not limed to:
  - use of operating room, labor room, delivery room, and recovery room
  - Drugs and medicines used by the patient
  - intravenous solutions
  - dressings, ordinary casts, splints, and trusses
  - anesthesia and related supplies
  - transfusion supplies and services including blood, blood plasma, and serum albumin, if not replaced
  - respiratory therapy, including oxygen
  - diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms
  - basal metabolism examinations
  - x-ray, including therapy
  - diathermy
  - all covered rehabilitative services
- Services and supplies must be furnished at a network hospital and must be authorized by the primary care physician or Health Plan to be covered.

Exceptions to this include emergency services and other special circumstances, as approved by Capital Health Plan.
- Excludes services and supplies provided when the covered person is admitted to a hospital or other facility primarily to provide rehabilitative services.

Immunizations
- Includes flu shots

Mammograms
- Screening
- Diagnostic service
- One baseline mammogram for women age 35 through 39
- One mammogram every two years – ages 40 through 49
- One mammogram every year – age 50 and over
- At any age if determined to be medically necessary (diagnostic).

Maternity Care
- Prenatal and post-natal care and monitoring of the mother
- Delivery in a hospital or birth center
- Postpartum care
- Newborn care and assessment, including initial exam from pediatrician
- Medically necessary clinical tests and immunizations
- Routine well-baby nursery services
- Midwife services
- Breastfeeding support, supplies and counseling
- Covered hospital stays for the mother and newborn child will be no less than
  - 48 hours for a normal delivery
  - 96 hours for a Cesarean-section delivery unless agreed to by the provider and the patient
  - With respect to Women's Preventive Services, coverage for breast feeding supplies is:
    - Limited to one breast pump per birth

Mental Health, Alcoholism and Substance Abuse Care
- Inpatient
- Outpatient
- Treatment program must be accredited by the Joint Commission or approved by the state.
- Providers must be licensed in accordance with applicable law
- For inpatient care:
  - Alcoholism and substance abuse care includes detoxification.
- For outpatient care:
  - Mental health and nervous disorders treatment includes diagnostic evaluation and psychiatric treatment, and individual and group therapy.
  - For learning and behavioral disabilities orintellectual disabilties coverage

is limited to evaluation and diagnosis.
NOTE: Please refer to pages 61-65 which provides a thorough description of Capital Health Plan's Mental Health and Addiction Treatment Program.

Newborn Care

- Coverage for the newborn child of an eligible dependent will be terminated 18 months after the birth of the newborn. Coverage includes,
    - coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity;
    - the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.
- Coverage for the unenrolled newborn child of a covered eligible subscriber or dependent is limited to well-baby hospital nursery services.
- Newborn must be enrolled in the Health Plan within 60 days of the birth to be covered for other services.

Nutrition Counseling

Nursing Services

- Nursing care by a registered nurse (RN) or licensed practical nurse (LPN)
    - Includes inpatient private duty nursing when authorized by Capital Health Plan
    - Includes home health care services and hospice services

Oral Surgery

- Surgical treatment of non-dental injury to teeth, fractured or dislocated jaw, excision of tumors, cysts, abscesses and lesions of the mouth, and surgical treatment of temporomandibular joint (TMJ) syndrome.
- Does not include care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes.
- Treatment of bones or joints of the jaw or facial region as required by section 641.31094, Florida Statutes when medically necessary as determined by the health plan for conditions caused by congenital or developmental deformity, disease or injury.

Organ Transplants

- Services, care, and treatment received for or in connection with the approved transplantation of the following human tissue and organs:
    - Heart
    - Heart/lung
    - Lung

- Liver
- Kidney
- Kidney/pancreas
- Bone marrow
- Cornea
- Covered services include:
  - Organ acquisition and donor costs. However, donor costs shall not be payable under Capital Health Plan if they are payable in whole or in part by any other insurance health plan, organization, or person other than the donor's family or estate.
- Transplantation includes pre-transplant, transplant, and post-discharge services, and treatment of complications after transplantation.
- To have a transplant covered:
  - Prior approval for the transplant must be obtained by the covered person's PCP in advance of the covered person's initial evaluation for the procedure.
  - Capital Health Plan shall be given the opportunity to evaluate the clinical results of the evaluation. This evaluation and approval shall be based on written criteria and procedures established by Capital Health Plan.
  - The facility in which the pre-transplant services, transplant procedure, and post-discharge services will be performed must be licensed as a transplant facility and authorized by Capital Health Plan.
- For bone marrow transplants:
  - Includes the harvesting, transplantation, and chemotherapy components.
  - Donor costs are covered in the same way as costs for the covered person, including limitations and non-covered services, as specified in Florida Statutes.
- Transplant services shall not be covered when:
  - Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not the funding was applied for or received;
  - The expense relates to the transplantation of any nonhuman organ or tissue;
  - The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ, and a total artificial heart used as destination therapy;
  - The organ is sold rather than donated to the covered person;
  - The expense relates to the donation or acquisition of an organ for a recipient who is not covered by Capital Health Plan except in the case of the donor costs for bone marrow transplants; or
  - A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of the transplant.
- The following services and supplies shall not be covered:
  - Artificial heart devices used as a bridge to transplant;
  - Drugs used in connection with diagnosis or treatment leading to a transplant when the drugs have not received FDA approval for such use;

or

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

Outpatient Care

- Treatment as an outpatient in a hospital, a health care provider's office, an ambulatory surgical center, or other licensed outpatient health care facility
- Clinical laboratory services
- Services for outpatient surgery and outpatient treatment of an injury
- Includes medically necessary supplies provided or used by the facility during the surgery or treatment, such as:
  - use of operating room and recovery room
  - use of covered drugs and medicines used by the patient
  - intravenous solutions, dressings, ordinary casts, splints, and trusses
  - anesthesia, related supplies, and their administration
  - transfusion supplies and services, including blood, blood plasma, and serum albumin, if not replaced
  - respiratory therapy, including oxygen
  - diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms
  - basal metabolism examinations
  - x-ray, including therapy
  - diathermy
  - services provided by a birthing center licensed under sections 383.30-383.335, Florida Statutes
  - other covered medically necessary services and supplies

Pathologist services

- Both inpatient and outpatient

Pre-admission tests

- Tests shall be ordered or authorized by the covered person's PCP; and
- Tests shall be performed in a facility accepted by the hospital and Capital Health Plan in lieu of the same tests that normally would be done while hospital-confined.

Pregnancy Complications and Care of the Newborn

- Maternity care in connection with the pregnancy of eligible children because of the following complications of pregnancy are covered by Capital Health Plan:
  - conditions whose diagnoses are distinct from pregnancy but are affected adversely by pregnancy;

- conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity;
- a non-elective cesarean section;
- an ectopic pregnancy that is terminated; and
- a spontaneous termination of pregnancy that occurs before the twenty-second (22nd) week of gestation.

- **NOTE:** Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Preventive Services

- Preventive medical services will be as defined by the Patient Protection and Affordable Care Act, which include:
    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
    - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health resources and Services Administrations
    - With respect to Women's Preventive Health Services, coverage is provided to the extent mandated by federal law.

Prostheses and Orthotic Devices

- Initial placement of the most cost-effective prosthetic or orthotic device, fitting, adjustments, and repair.
- Replacements covered if because of growth or change and approved by Capital Health Plan as medically necessary.
- Shoe orthotics shall be covered only when attached to a brace.
- Penile prosthesis shall be covered only when necessary to treat organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, postprostatectomy, postpriapism, and epispadias and exstrophy.
- Total artificial hearts used as destination therapy are an excluded benefit (See **ORGAN TRANSPLANT** section within this **SUMMARY OF PLAN BENEFITS** section.)

Radiologist Services

- Both inpatient and outpatient

Rehabilitative Services

- Spine and back disorder treatment
- Manipulative services
- Physical therapy
- Speech therapy
- All services shall be provided by licensed therapists, chiropractors and physicians for the purpose of aiding in the restoration of normal physical function.
- Requires Capital Health Plan approval of a written plan of treatment, including documentation that the covered person's condition should improve significantly within 60 days of the date therapy begins.
- Outpatient rehabilitative services limited to 60 visits per injury; inpatient rehabilitative services limited to the duration of hospital confinement
- Rehabilitative services shall not be covered when:
  - The covered person was admitted to a hospital or other facility primarily for the purpose of providing rehabilitative services; or
  - The services or supplies maintain rather than improve a level of physical function, or when it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60-day period.

Respiratory Therapy

- Services of respiratory or inhalation therapists
- Oxygen
- Both Inpatient or outpatient

Second Medical Opinions

- May be requested by the covered person or Capital Health Plan for:
  - Elective surgery
  - When the appropriateness or necessity of a covered surgical procedure is questioned
  - Serious injury or illness
- The covered person
  - must provide prior notice to Capital Health Plan.
  - may obtain the opinion from any licensed physician within Capital Health Plan's service area. The use of second medical opinions in connection with a particular diagnosis or treatment may be restricted to a maximum of three per calendar year.
- Capital Health Plan shall review the second medical opinion, once rendered, and determine the treatment obligations of Capital Health Plan. That judgment shall be controlling. Any treatment obtained that is not authorized by Capital Health Plan shall be at the covered person's expense.

- Covered expenses for the second opinion:
  - If a network physician is selected, the only cost to the covered person will be the applicable copayment amount

If a non-network physician is selected, the member may be required to pay for up to 40 percent of the usual and customary charges for those services in the community where they were rendered as determined by the Health Plan.

Skilled Nursing Facility Care

- Room, board, and general nursing care.
- Services and supplies for necessary treatment.
- PCP or Capital Health Plan shall approve a written plan of treatment
- Patient must require skilled care for a condition (or a related condition) which was treated in the hospital and such care can be provided at a skilled nursing facility in lieu of hospitalization or continued hospitalization
- Patient shall be admitted to the facility immediately following discharge from the hospital.
- Skilled nursing care or services are provided on a daily basis.
- Limited to 60 days of confinement per calendar year.
- Services shall be ordered by and provided under the direction of a physician.

Surgical Procedures

- Both Inpatient or outpatient

Surgical Sterilization

- Limited to tubal ligations and vasectomies.

Wigs

- Covered only when hair loss is caused by chemotherapy, radiation therapy, or cranial surgery. Coverage is limited to a maximum payment of $40 for one wig and fitting in the 12 months following treatment or surgery.

AUTISM SPECTRUM DISORDER

Definitions:

- (a) "**Applied behavior analysis**" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

- (b) "**Autism spectrum disorder**" means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:
  1. Autistic disorder.
  2. Asperger's syndrome.
  3. Pervasive developmental disorder not otherwise specified.
  4. Childhood Disintegrative Disorder.

General Rules:

1. Autism Spectrum Disorder services are provided to an Eligible Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

   a. Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.
   b. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section 393.17 of the Florida Statutes or licensed under Chapters 490 or 491 of the Florida Statues; and
   c. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

2. The coverage is subject to the following requirements:

   a. Coverage may be subject to general exclusions and limitations, including, but not limited to, coordination of benefits, participating provider requirements, and utilization review of

health care services, including the review of medical necessity, case management, and other managed care provisions.

Exclusions:

Any services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this endorsement.

Note: In order to determine whether Autism Spectrum Disorder services are covered under this Endorsement, we reserve the right to request a formal written treatment plan signed by a trained Network psychologist in accordance with our *Clinical Practice Guideline for the Assessment and Treatment of Children with Autism Spectrum Disorders*. The Treatment Plan will address communication, social interactions, and family function. The proposed treatment type(s) will include frequency and duration of the treatment along with the outcomes stated as goals. Once a treatment plan has been established and approved by your Primary Care Physician (PCP) it is important that close follow-up occur to evaluate the progress and efficacy of treatment. The Network psychologist will reassess the child diagnosed with Autism Spectrum Disorder on an annual basis to assess for improvements and to rule out the development of co-morbid conditions. The Treatment Plan will be adjusted based on an annual assessment and new goals established for treatment over the following twelve months.

Prior coverage Authorization/Pre-Service Notification for Autism Spectrum Disorder

Out-of-Network Providers

It is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network provider **before** Autism Spectrum Disorder Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such services.**

Once the necessary medical documentation has been received from you and/or the provider, Capital Health Plan will review the information in accordance with our Utilization Management process and make a prior coverage authorization decision, based on Capital Health Plan's established criteria then in effect and approved by the Medical Director. You will be notified of the prior coverage authorization decision.

For additional details on how to obtain prior coverage authorization for Autism Spectrum Disorder services, please call the customer service phone number on the back of your ID card.

MENTAL HEALTH AND ADDICTION TREATMENT PROGRAM DESCRIPTION

OVERVIEW

Capital Health Plan provides members with high quality mental health and addiction services that are medically necessary, and take place in the least restrictive environment necessary to assist members with resolving their issues. This program treats medically necessary mental health and addiction issues in compliance with State and Federal regulations by ensuring that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than the predominant treatment limitations placed on substantially all medical/surgical benefits.

Mental Health and Addiction Services

Capital Health Plan defines Mental Health and Addiction Services as treatment provided for a member with selected mental health disorder(s) which must be diagnosed by either the member's Primary Care Physician or a network Behavioral Health Specialist. The disorder(s) must be included in the most recent *Diagnostic and Statistical Manual of Mental Disorders-IV TR* and not be one of the diagnoses excluded from coverage (see Diagnosis Exclusion List).

Behavioral Health Network

Capital Health Plan's Behavioral Health Network is that group of credentialed professionals licensed by the State of Florida which specializes in the treatment of mental health and substance use disorders and who are contracted with Capital Health Plan to provide services to plan members. Capital Health Plan's behavioral health network includes specialists trained as Psychiatrists, Psychologists, and Therapists who work with members experiencing problems from mental health and/or substance use disorders.

Least Restrictive Environment

Least restrictive environment is the appropriate level of care provided to the member for treating their mental health and/or addiction disorder. Capital Health Plan offers a continuum of care for its members from the least restrictive form of treatment (outpatient therapy) to the most restrictive form of treatment (inpatient crisis intervention and stabilization). Capital Health Plan ensures members receive the level of mental health and addiction care required to help them resolve their current problem. Levels of care from least restrictive to most restrictive are as follows:

- Outpatient counseling

- Intensive outpatient treatment (addiction treatment)
- Partial hospitalization
- Residential treatment
- Acute inpatient hospitalization

Limited Access Prior to Preauthorization

Outpatient Counseling

Capital Health Plan defines outpatient counseling as those services provided in the office of a network credentialed Behavioral Health practitioner for the treatment of a mental health and/or addiction problem. The services are provided by a practitioner with a current Florida license, such as a Psychiatrist, Psychologist, or Therapist. Outpatient services include individual, group and family therapy; and psychiatric and psychological evaluation and assessment and medication management.

Members may access outpatient behavioral health services for up to a total of 15 sessions per calendar year without prior authorization. After the 15th session in the calendar year, Capital Health Plan requires an assessment by a network psychiatrist to determine whether the member is experiencing a mental health and/or substance abuse problem with co-morbid conditions, or a problem that would be more effectively treated with the combination of medication and therapy. It is up to the member and the therapist to keep track of the number of outpatient sessions provided. A consultation with a psychiatrist for a psychiatric evaluation should be scheduled between sessions ten and fifteen each year. Once the psychiatrist has made an assessment and diagnosis with treatment recommendations, the physician will send a report to the member's PCP and therapist. The member will need to contact their PCP with a request for authorization for counseling sessions beyond the initial 15 sessions. The member's PCP will submit a referral requesting authorization of addition sessions for treatment of the issue diagnosed in the psychiatrist's letter. However, if the consulting psychiatrist indicates further sessions are not necessary, no further sessions will be authorized. The member's therapist is expected to submit subsequent claims based on the psychiatrist's recommended treatment plan and diagnostic codes.

Access Requiring Preauthorization

Partial Hospitalization

Capital Health Plan defines partial hospitalization as mental health or addiction services provided in a hospital setting with treatment that lasts 7 hours per day, with the member leaving the treatment facility in the evenings. Partial hospitalization is used either as a step-down transition level from inpatient care to outpatient care, or to avoid a hospital admission. The member may qualify for

partial hospitalization if he or she does not meet criteria for an inpatient stay, but the treating psychiatrist believes the member requires more structure than traditional outpatient therapy would provide. Admission for partial hospitalization treatment requires there be a benefit for partial hospitalization, a review of medical records and a PCP referral. A Capital Health Plan Medical Director will review the records and make a determination about coverage prior to the start of services.

Residential Treatment

Residential treatment involves a sub-acute level of care provided in a treatment center or facility that specializes in the treatment of addictions or eating disorders. Limitations on length of stay for residential treatment facilities are the same as limitations of length of stay placed on Skilled Nursing Facility (SNF) programs. Approval for admission to a residential treatment facility requires that all clinical criteria for the requested program are met, and the Medical Director has approved the admission. All residential treatment is preauthorized for two weeks and then continuation of treatment requires re-authorization, including review of clinical records. The treating facility must maintain a residential treatment license and current accreditation with an appropriate accreditation body, such as the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission.

No Preauthorization Required

Acute Inpatient Hospitalization

Inpatient services are approved for emergent care when the patient's condition prevents similar services from being provided in a practitioner's office, the outpatient department of a hospital or a non-residential facility.

Capital Health Plan defines an acute inpatient hospitalization as services requiring emergent medically necessary care as determined by a psychiatrist through evaluations in the office or in an Emergency Department. In Florida, patients are admitted to an acute inpatient facility under a Baker Act either voluntarily (Ba-40) or involuntarily (Ba-52 or Ba-1). Admission to a psychiatric hospital indicates the member has either thoughts of harming self or others or has acted on these thoughts to harm self or others by overdosing, cutting, or threatening self or others with a gun or other deadly weapon. The purpose of an acute inpatient hospitalization is for crisis management and stabilization. Once the member no longer meets criteria for hospitalization, i.e., Baker Act Status, as determined by the attending psychiatrist, the member is discharged back to a less restrictive level of service.

Intensive Outpatient Treatment

Capital Health Plan defines intensive outpatient treatment (IOP) as care provided 3-4 days a week that lasts 3 hours per day, over a period of at least 4 weeks. These services also include an ongoing aftercare program. The purpose of an IOP Program is to focus on addiction treatment and the prevention of relapse. Services are provided within the Capital Health Plan Behavioral Health Network by licensed clinicians.

Diagnoses Exclusion List:

Inpatient Treatment

- Specific Anxiety disorders including: Agoraphobia, specific phobias (insects, spiders, heights etc.), and social phobia.

Inpatient and Outpatient Treatment

- All relationship problems with the exception of bereavement.
- Assessment and treatment of all sexual and gender identity disorders, specifically all diagnoses in the Sexual and Gender Identity Disorders section of the *Diagnostic and Statistical Manual of Mental Disorders-IV TR*, which are categorically excluded regardless of medical necessity.
- Treatment specific to, and solely for, learning, communication and motor skills disorders, intellectual disabiltities, academic or career counseling.
- Feeding and eating disorders of infancy or early childhood including: pica and rumination disorder.
- Other disorders of infancy, childhood or adolescence, such as separation anxiety disorder, selective mutism and reactive attachment disorder.
- Services for nicotine/caffeine abuse or addiction, except as covered under the State of Florida's prescription drug benefit.
- All Personality Disorders without a primary diagnosis of a covered mental health or substance abuse disorder.

The following Treatment modalities are not covered:

- Scholastic/Educational Testing, Intelligence, and Learning Disability testing and evaluations. These tests should be requested and conducted by the child's school district.
- Court-ordered counseling or treatment, as a condition of release or probation, such as residential substance abuse treatment, intensive outpatient counseling and individual or family counseling.
- Work or school ordered assessment and treatment in the absence of a clinical need.
- Counseling for marital and relationship enhancement and religious purposes including counseling provided by a religious counselor.

- Experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, methadone maintenance, neurofeedback, light boxes for phototherapy and outward bound or other wilderness type therapies.
- Cognitive remediation.
- Elective therapies such as Gestalt, Transactional Analysis, Transcendental Meditation, Z-therapy, Mind expansion therapy and Erhard Seminar Training (EST).
- Transcranial Magnetic Stimulation.
- Applied Behavioral Analysis (except for State mandated treatment for specific diagnoses meeting Capital Health Plan clinical criteria and approved by the Medical Director).
- Custodial Care or basic care provided in a residential, institutional or assisted living setting. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aides, and personal care designed to help the member in activities of daily living or to keep the member from continuing unhealthy activities.
- Transitional living centers, non-licensed programs, therapeutic boarding schools, and services typically provided by community mental health services program settings.

Section 5: List of UM Criteria and Clinical Practice Guidelines

Capital Health Plan has placed all Clinical Practice Guidelines and all UM Clinical Criteria can be found at www.capitalhealth.com and on CHP*Connect* for credentialed practitioner use and review. Notification of changes or revision to the documents below occurs through electronic distribution of the Network News to all credentialed practitioners.

PRESCRIPTION DRUGS (Administered by Express Scripts #1-877-531-4793)

If you are enrolled in one of the State Employees' HMO Plans, except retiree Medicare Advantage plans, you automatically participate in the State Employees' Prescription Drug Plan. The drug Plan features a network of participating retail pharmacies and a mail order program.

Drugs That Are Covered by the Prescription Drug Plan (PDP)

Covered drugs shall include, but are not limited to:

1. Federal legend drugs
2. State restricted drugs
3. Compound medications
4. Smoking cessation drugs requiring a prescription
5. Insulin and other covered injectable medication;
6. Needles and syringes for insulin and other covered injectable drugs;
7. FDA-approved glucose strips, tablets and lancets;
8. Prepackaged items, such as insulin with needles or syringes, dispensed for the number of days' usage prescribed, or package quantity, whichever is greater;
9. Those items associated with an insulin prescription or prepackaged with other medications;
10. Prescription refills once a usage percentage of the previous prescription, as established by the PDP, has been met based on the dosage schedule prescribed by the physician or other participating provider.
11. Zostavax (however, the medical provider's charge to administer this vaccine is not covered under the Prescription Drug Program).

Drugs That Are Covered by the HMO

Covered drugs shall include, but are not limited to:

1. Any drug, medicine, medication or immunization that is consumed or provided at the place where the prescription is given (medical provider's office or health care facility);
2. Any drug, medicine or medication that is dispensed or administered by a physician or other participating provider (other than a pharmacy) including, but not limited to, outpatient facilities;
3. Any prescriptions to be taken by or administered to the covered person, in whole or in part, while a patient in a hospital, skilled nursing facility, convalescent hospital, inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis.

Drugs That Are Not Covered by the Medical or Prescription Drug Plan

- Prescription refills in excess of the number specified by the physician or dispensed more than one year from the date of the participating provider's original order;
- Medication that is covered by Workers Compensation or Occupational Disease Laws or by any state or governmental agency;
- Prescriptions ordered or received in excess of any maximums covered under this benefit and not covered under any other provision in this PDP;
- Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use." Any experimental drug or drug used for non-FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the covered person;
- Immunizing agents such as flu shots (except Zostavax);
- Non-Federal legend or over-the-counter drugs;
- Devices or appliances including, but not limited to, hypodermic needles/syringes, and other non-medical substances, regardless of intended use;
- Retin-A for cosmetics purposes;
- Anti-obesity drugs;
- Non-prescription smoking cessation aides (i.e., gums, patches, lozenges)
- Amphetamines and/or anorexiants for weight loss;
- Hormone treatment in preparation for sexual reassignment;
- Any costs related to the mailing, sending or delivery of prescription drugs;
- Prescriptions filled at a non-participating pharmacy, except for prescriptions required during emergency care; and
- Prescription medications that are not on the formulary
- Infertility and fertility drugs
- Viagra and similar drugs for psychosexual disorders for females, and males under age 18;
- Enteral formulas exceeding $2500 per calendar year, or for individuals 25 years of age or older;
- Growth hormones for the diagnosis of idiopathic short statute;
- Overlapping therapies within the same drug classifications, even if used for different conditions. For example, an erectile dysfunction drug for the treatment of benign prostate hyperplasia (BPH) and an erectile dysfunction drug for treatment of erectile dysfunction, as both are in the same drug classification of erectile dysfunction drugs.

Purchasing Prescriptions at Retail Pharmacies

When your Doctor prescribes you a medication, you may have your prescription filled at any network pharmacy. Participating pharmacies include most major drug chains, with over 50,000 pharmacies nationwide. There is no paperwork when you use your prescription drug program card at a participating pharmacy. The

claim will be submitted electronically. To find out if your pharmacy participates, call (877) 531-4793 or visit www.Express-Scripts.com. For New enrollees, a list of the nearest pharmacy locations will be included in your prescription drug welcome kit. You can also use this toll-free number or www.Express-Scripts.com to locate a participating pharmacy if you are traveling anywhere in the United States.

Using a Participating Pharmacy
When you take your prescription to a participating pharmacy, simply present your prescription drug Plan card. You will pay a copayment or coinsurance for up to a 30-day supply of each covered prescription:

- Standard HMO Option
    - $7 for a generic drug
    - $30 for a preferred brand name drug
    - $50 for a non-preferred brand name drug
    - The copayment plus the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

- Health Investor HMO Option
    - 30% for a generic drug (subject to Calendar Year Deductible)
    - 30% for a preferred brand name drug (subject to Calendar Year Deductible)
    - 50% for a non-preferred brand name drug (subject to Calendar Year Deductible)
    - The calendar year deductible and/or coinsurance plus the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

Using the Mail Order Program
- To order up to a 90-day supply, you:
- Complete a mail order form available from Express Scripts at (877) 531-4793 or www.Express-Scripts.com
- Be sure to have at least a 14-day supply on hand when ordering; generally, refills will be mailed within 5 days of a request and new prescriptions will be mailed within 8 days of receipt of all necessary information
- Your medication will arrive usually within eight (8) days after your order is received by Express Scripts
- The Copayment or Coinsurance will be based on the date the prescription is filled, not on the date the prescription is received by Express Scripts
- Order online at www.Express-Scripts.com or call Express Scripts at (877) 531-4793 and Express Scripts will contact your physician to get a mail order prescription for you.

- Ask your doctor to call Express Scripts at (888) 327-9791 to call in your prescription or to obtain instructions on how to fax your prescription directly to Express Scripts.

Automatic Refill and Renewal Options at Mail Order
If you are taking long-term or maintenance medications, Worry Free Fills® provides easy anc convenient refill and/or renew options through mail order for many but not all medications.

If you sign up for this program (and have refills remaining), Express Scripts will automatically fill and mail your medications at the appropriate refill date saving you time from ordering onine or by phone.

Also, Experss Scripts will contact your Physician and request a new prescription automatically after you last available refill. Express Scripts will alert you in advance by email or phone.

For additional information on this program or to sign up go to www.Express-Scripts.com or call (877) 531-4793.

- Standard HMO Option
    - $14 for a generic drug
    - $60 for a preferred brand name drug
    - $100 for a non-preferred brand name drug
    - The copayment plus the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

- Health Investor HMO Option
    - 30% for a generic drug (subject to Calendar Year Deductible)
    - 30% for a preferred brand name drug (subject to Calendar Year Deductible)
    - 50% for a non-preferred brand name drug (subject to Calendar Year Deductible)
    - The calendar year deductible and/or coinsurance plus the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

What if you Request a Brand Name at a Participating Pharmacy
If your prescription is filled with a generic, you pay only the applicable Copayment or Coinsurance. If a generic equivalent is not available, or if your Doctor writes on the prescription "dispense as written" or "brand name medically necessary," you pay the applicable Copayment or Coinsurance for the brand name. However, if you request a brand name instead of an available generic equivalent, you will pay the lesser of:

1. The brand name Copayment or Coinsurance, plus the difference between the Plan's cost for the brand name drug and the Plan's cost for the generic drug; or
2. The actual retail price of the brand drug.

How You Save With Mail Order
If you use a drug regularly, you will save on Copayments (Coinsurance for Health Investor Health Plan) through mail order. For instance, if your drug is a preferred brand name, under the HMO Standard plan ($60 copayment):

Mail Order	**Participating Retail Pharmacy**
...up to a 90-day maximum supply	…up to a 30-day maximum supply
$60 Copayment applies	$30 Copayment applies
You pay $60 for 90 days of medicine and order once (you save $30)	You pay $90 for 90-day supply and make three trips to the pharmacy (you save nothing)
IMPORTANT: Ask your Physician to prescribe a 90-day supply to send to the mail order pharmacy. Otherwise, if your prescription is only for 30-days (or up to), you still owe $60 for that 30-day mail order, which is more than had you gone to a retail pharmacy and paid $30 for the same 30-day supply.	

What are Generics?

Generic drugs are similar to brand name drugs but can save you money. Here are some important facts about generic drugs:

- Generic equivalent drugs have the same active ingredients as the brand name, but they are less expensive because the brand name manufacturer makes the initial investment for product research and development
- The Food and Drug Administration (FDA) Doctors and pharmacists review generic products regularly to make sure they are safe and effective.

Important Information about the Prescription Drug Program

1. The Preferred Drug List (PDL) is updated and subject to change on a semi-annual basis. Contractually, Express Scripts has full authority over the development of the PDL; therefore, DSGI cannot require that specific drugs be included.
2. Generic substitution: Prescriptions written for brand name drugs that have a generic equivalent will be automatically substituted unless the prescribing Physician writes "dispense as written" or "DAW" on the prescription. Generally, even if the prescription includes "DAW," Express Scripts will still contact the Physician to ask if the generic equivalent may be substituted.

3. Certain medications, including most biotech and/or Specialty Drugs, are only available through Express Scripts's Specialty Pharmacy, Accredo. Generally, these drugs are for chronic or genetic disorders including, but not limited to, multiple sclerosis, growth hormone deficiency and rheumatoid arthritis and may require special delivery options, such as temperature control. Your prescribing physician may contact Accredo at (800) 803-2523.
4. For mail order, Express Scripts may contact the prescribing Physician when a prescription for a non-preferred brand name drug is submitted and a therapeutically equivalent preferred drug is available. If the Physician or an authorized agent of the Physician authorizes a change to the preferred drug, Express Scripts will dispense the alternative drug and provide written notification of the change to the member.
5. Express Scripts will contact the prescribing Physician if the prescribed dosage differs from the dosage recommended by the FDA or the manufacturer's guidelines. Dosage is the number of units, the strength of such units, and the length of time to take the medicine. If the Physician or an authorized agent of the Physician authorizes a change to the dosage, Express Scripts will change the dosage amount, dispense the new dosage, and provide written notification of the change to the member.
6. During the prescription review process, your mail order and retail pharmacy prescription history, age, self-reported allergies, and self-reported disease states are reviewed along with the FDA drug interactions and manufacturer's guidelines to determine if there are any interactions, side effects, and/or contraindications. Express Scripts will contact the prescribing Physician if any questions, conflicts or issues are identified. Express Scripts may contact the prescribing Physician if any indication of fraud or excessive usage is identified. If the Physician or an authorized agent of the Physician authorizes any changes, Express Scripts will change the prescription accordingly, dispense the drug accordingly, and provide written notification of the change to the member.
7. For mail order, Express Scripts will contact the prescribing Physician to verify the prescription if the prescription is illegible, written in different pen and/or penmanship, or altered in any way. If Express Scripts cannot reach the Physician or an authorized agent of the Physician, the prescription will be returned to the member unfilled.
8. Prescriptions for treatment of Conditions for unapproved indications or "off-label" use will not be filled if not proven safe and effective for the treatment of the Condition based on the most recently published medical literature of the United States, Canada or Great Britain, using generally accepted scientific, medical or public health methodologies or statistical practices.
9. Approximately 75% of the previous prescription must be utilized, if used as prescribed, before a request for a refill will be processed.
10. Requests for mail order refills that are received within 90 days of the "too soon to fill" date (based on the previous paragraph) will be held and filled

when eligible to be filled. You may check your medication label for the next available refill date, or if the prescription was filled through mail order, you may log onto www.Express-Scripts.com for the next available mail order refill date.

11. As part of the Accredo specialty services, Express Scripts will administer the Specialty Management Program for this Plan. This program is intended to optimize outcomes and promote the safe, clinically appropriate and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for this program during the coverage review will result in denial of medication coverage for the Plan participant and discontinuation of medication coverage for the Plan participant..

The Specialty Management Program is a process by which authorization for a specialty medication is obtained based on the application of currently acceptable medical guidelines and consensus statements for the appropriate use of the medication in a specific disease state. Therapies reviewed under this Program include, but are not limited to: multiple sclerosis, oncology, allergic asthma, human growth hormone deficiency, hepatitis C, psoriasis, rheumatoid arthritis, and respiratory syncytial virus. Additional therapies may be added. For additional information on specialty medications or to see if your medication is in this category call Member Services tool-free at (877) 531-4793.

COVERAGE REVIEW AND/OR PRIOR AUTHORIZATION OF DRUGS

Some medications require coverage review and/or prior authorization before your prescription can be filled and some medications may be subject to quantity limits. Your pharmacist will let you know if your prescription requires coverage review and/or prior authorization and whether it is subject to quantity limits. If your prescription requires coverage review and/or prior authorization and/or is subject to quantity limits, Express Scripts will work with your Physician to determine medical necessity. Approval or denial of coverage will be determined within 72 hours after contacting your Physician and receiving all required information and/or documentation. Various drug classifications require coverage review and/or prior authorization and/or are subject to quantity limits; for example, drugs for the diagnosis of erectile dysfunction require coverage review and/or prior authorization and are limited to eight doses per month.

Most prior authorizations are valid for one year and must be renewed after expiration; however, prior authorizations may be as brief as one month.

FOLLOWING COVERAGE ACCESS RULES

If the covered person does not follow the coverage access rules described in this document, he or she risks having Capital Health Plan not cover the services and supplies that he or she receives. The covered person then would be responsible for reimbursing Capital Health Plan.

Also, covered persons shall understand that the ordering of a service by a physician does not in itself make that service medically necessary or a covered service.

SERVICES NOT COVERED BY CAPITAL HEALTH PLAN

The following services and supplies are excluded from coverage under Capital Health Plan unless a specific exception is noted. Exceptions may be subject to certain coverage limitations.

Abortion: elective abortions performed at any time during a pregnancy

Acupuncture services: Services, supplies, care or treatment in connection with acupuncture (except when used in lieu of an anesthetic agent for covered surgery)

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

Autologous transfusion, in which blood is removed from a donor and stored before it is returned to the donor's circulation

Autopsy.

Biofeedback services, and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, mind expansion, elective psychotherapy such as Gestalt Therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard Seminar Training (EST).

Complications of non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service

Cosmetic surgery/services, including plastic and reconstructive surgery (except as noted as a covered service), and any other service and supply to improve the covered person's appearance or self-perception,

Costs incurred by Capital Health Plan, related to:

1. Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent that the services are payable under any medical expense provision of any automobile insurance policy; and

2. Telephone, internet, or other technological consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services, and respite care.

Dental care or any treatment relating to the teeth, jaws, or adjacent structures (e.g., periodontium), including but not limited to: extraction or cleaning of the teeth; implant, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic; rapid palatal expanders; continuous passive motion (CPM) devices,

Dietary regimens, treatments, food, food substitutes, vitamins or exercise programs for reducing or controlling weight.

Experimental/Investigational or Not Medically Necessary treatment, with the exception of routine care in connection with a cancer clinical trial, pursuant to the Florida Clinical Trial Compact.

Eye care, including:

- The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided in the covered benefits section;
- Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or astigmatic error; and
- Training or orthoptics, including eye exercises.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease, injury, or accident. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by Capital Health Plan to be medically necessary.

Gender reassignment or modification services and supplies.

Genetic tests to determine paternity or sex of a child.
Hearing aids, (external or implantable) or the examination, including hearing

tests, for the prescription or fitting of hearing aids, including tinnitus maskers.

Human Growth Hormone for idiopathic short stature.

Hypnotism, medical hypnotherapy, or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such immunizations and examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

Infertility treatment and supplies, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in these or similar procedures.

Marriage counseling.

Massage therapy.

Mental Health and Addiction Treatment as outlined in the section titled **Mental Health and Addiction Treatment Program Description** in this Member handbook.

Military service-connected medical care, for which the covered person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the covered person.

Nonprescription drugs and supplies, including any nonprescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods, blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.,.

Obesity and weight reduction treatment, including surgical operations and medical procedures for the treatment of morbid obesity, such as intestinal or stomach bypass surgery and a weight loss program required by the covered person's primary care physician prior to surgery, unless determined to be medically necessary, as determined by Capital Health Plan’s medical management team.

Occupational therapy, unless provided as a home health care service or

hospice service or as treatment for Autism Spectrum Disorder

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

Oversight of a medical laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion includes but is not limited to the oversight of; 1) the laboratory to assure timeliness, reliability, and/or usefulness of test results, 2) the calibration of laboratory machines or testing of lab equipment, 3) the preparation , review, and/or updating of any protocol or procedure created or reviewed by a Physician or other heatlh care provider, and 4) lab equipment or lab personnel for any reason.

Personal comfort, hygiene, or convenience items, including but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than medically necessary ambulance services that are specified in the covered benefits section, motel/hotel or other housing accommodations (even if approved by a physician), air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment. Also excluded are services not directly used to provide treatment.

Prescription drugs. (Prescription drug benefits are administered by Express Scripts #1-877-531-4793).

Recreational therapy.

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

Sexual deviations, disorders or psychosexual dysfunctions services and supplies.

Sleep therapy.

Smoking cessation products, including but not limited to Nicorette gum, patches, lozenges, inhalers or vapor and e-cigarettes.

Training and educational programs, including programs primarily for pain management, or vocational rehabilitation unless specifically provided by law.

Transportation services, that is non-emergency transportation between institutional care facilities, or to and from the covered person's residence.

Volunteer services, or services that normally would be provided free of charge to a covered person.

Weight control/loss programs, including, but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

Work-related condition services, to the extent that the covered person is covered or required to be covered by a workers' compensation law. If the covered person enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, Capital Health Plan shall not cover past or future medical services that are the subject of or related to that settlement. In addition, if the covered person is covered by a workers' compensation program that limits benefits if other than specified health care providers are used and the covered person receives care or services from a health care provider not specified by the program, Capital Health Plan shall not cover the balance of any costs remaining after the program has paid.

Additional exclusions include, but are not limited to:

- Services or supplies that are not medically necessary as determined by the Health Plan and/or the Prescription Drug Plan clinical staff and the state.
- Court ordered care or treatment, unless otherwise covered in this Health Plan, including testing required as a condition of parole or probation; testing for aptitude, ability, intelligence or interest.
- Treatment of a condition resulting from:
    - War or an act of war, whether declared or not;
    - Participation in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony;
    - Engaging in an illegal occupation;
    - Services in the armed forces;
- Services or supplies received prior to a covered person's effective date or received on or after the date a covered person's coverage terminates under this Health Plan, unless coverage is extended in accordance with extension of benefit provisions;
- Services rendered from a medical or dental department maintained by or on behalf of a public health entity;
- Non-medical conditions related to hyperkinetic syndromes, learning disabilities, intellectual disabilties, or impatient confinement for environmental change;
- Services or supplies supplied at no charge, or determined by the Health Plan not to be the most cost-effective setting, procedure or treatment.
- The following services:
    - Social work
    - Bereavement and pastoral
    - Financial
    - Legal
    - Dietary counseling
    - Day care

- Homemaker and chore
- Funeral

MEMBER RIGHTS AND RESPONSIBILITIES

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

RIGHTS

Each covered person has the right to:

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

RESPONSIBILITIES

Each covered person has the responsibility to:

- Seek all non-emergency care through the covered person's primary care physician (PCP), obtain a referral from his or her PCP for medical services by a specialist, and cooperate with those providing care and treatment.
- Be courteous; respect the rights, needs and privacy of other patients, office staff, and providers of care.
- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care.
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that the covered person has agreed to with his or her practitioners.
- Ask questions and seek clarification to enable the covered person to participate fully in his or her care.
- Pay copayments or coinsurance and deductible and provide current information concerning the covered person's Capital Health Plan membership status to any Capital Health Plan participating practitioner or provider.
- Follow established procedures for filing a complaint, appeal, or grievance concerning medical or administrative decisions that the covered person feels are in error.
- Review and understand the benefit structure, both covered benefits and exclusions, as outlined in the Member Handbook. Cooperate and provide information that may be required to administer benefits.
- Seek access to medical and member information through the covered person's Primary Care Physician, CHPConnect, or through Capital Health Plan Member Services.
- Follow the coverage access rules in the Member Handbook.

COMPLAINT, GRIEVANCE and APPEAL PROCESS

Capital Health Plan has established a process for reviewing Member complaints, grievances and appeals. The purpose of this process is to facilitate review of, among other things, any Member's dissatisfaction with Capital Health Plan, Capital Health Plan administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent contracting provider. The Complaint, Grievance and Appeal Process also permits the Member, or his or her physician, to expedite Capital Health Plan review of certain types of appeals. The process described below must be followed if the Member has a complaint, grievance or appeal.

Under the Complaint, Grievance and Appeal Process, a complaint will be handled informally in accordance with the Informal Review subsection set forth below. An appeal or grievance will be handled formally in accordance with the Formal Review subsection described below. A request to review an adverse benefit determination of a pre-service claim, post-service claim, or a concurrent care decision will be handled in accordance with the terms of this section.

Capital Health Plan encourages the Member to attempt informal resolution of any dissatisfaction by calling Capital Health Plan Member Services at 850-383-3311 (toll-free 1-877-247-6512); TTY 850-383-3534 (toll-free 1-877-392-1532); Florida Relay 1-800-955-8771 or 711. If Capital Health Plan is unable to resolve the matter on an informal basis, the Member may submit his or her formal request for review in writing.

Definitions

Adverse Benefit Determination means a determination by Capital Health Plan that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Adverse benefit determinations also include rescissions of coverage.

Appeal means a written request for Capital Health Plan to review and overturn a previous decision to deny coverage or payment for health care services, supplies or drugs. A Member, a Member's representative, a provider acting on behalf of a Member, or a state agency may submit an appeal. To submit or pursue an appeal on behalf of a Member, a health care provider must previously have been directly involved in the treatment or diagnosis of the Member. Expedited appeals may be submitted verbally.

Appeal Review Panel means a panel established by Capital Health Plan to review appeals related to denial decisions made by Capital Health Plan based on

plan benefit design.

Clinical Appeal Panel means a panel established by Capital Health Plan to review appeals related to adverse benefit determinations made by Capital Health Plan. This panel includes physicians who have appropriate expertise, and who were not involved previously in the initial adverse benefit determination.

Complaint means an oral (i.e., non-written) expression of dissatisfaction.

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

As defined herein, a concurrent care decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the case management subjection as described in the Member Handbook.

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

External Review means a process through which a Member can request a review of a Capital Health Plan appeal denial from an independent external review entity. This external review is performed by the Federally Authorized External Review Process.

Grievance means a written expression of dissatisfaction which does not involve a previous CHP decision. The Member, a provider acting on his or her behalf, another person designated by the Member, or a state agency may submit a grievance.

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

Medically Necessary or Medical Necessity means, for coverage and payment

purposes, that a medical service or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of Capital Health Plan:

1. 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.

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 Capital Health Plan in a format acceptable to Capital Health Plan.

Pre-Service Claim means any request or application for coverage or benefits for a service that has not yet been provided to the Member and with respect to which the terms of the Member Handbook condition payment for the service, (in whole or in part) on approval by Capital Health Plan of coverage or benefits for the service before the Member receives the service. A pre-service claim may be a claim involving urgent care. As defined herein, a pre-service claim shall not include a request for a decision or opinion by Capital Health Plan regarding coverage, benefits, or payment for a service that has not actually been rendered to the Member if the terms of this Member Handbook do not require approval by Capital Health Plan of coverage or benefits (or condition payment) for the service before it is received.

Informal Review – Complaints

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

below.

Important Note:

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

Formal Review –Grievances and Appeals

The Member, a provider acting on behalf of the Member, a state agency, or another person designated by the Member, may submit a grievance or appeal. The Member must give written permission for another person to represent him or her in an appeal. To submit or pursue an appeal on behalf of a Member, a health care provider previously must have been directly involved in treatment or diagnosis of the Member. A letter must be mailed to the Capital Health Plan address listed in the Telephone Numbers and Addresses subsection.

If the Member needs assistance in preparing the grievance or appeal, he or she may contact Capital Health Plan for assistance. Hearing impaired Members may contact Capital Health Plan via TTY at 850-383-3534 (1-877-392-1532 toll-free) or the Florida Relay at 1-800-955-8771 or 711.

1. Formal Grievance and Appeal Review

    a. Grievances

    To begin the formal review process, the Member must write a letter explaining the facts relating to the grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation. Capital Health Plan will review the grievance and advise the Member in writing of the outcome of its research. Capital Health Plan's response is provided to the Member within 30 calendar days of its receipt.

    b. Standard Appeals

    To begin the appeal process, the Member must write a letter explaining the facts related to the appeal. The Member should provide as much detail as possible and attach copies of any relevant documentation. The Appeal Review Panel or the Clinical Appeal Panel, as appropriate, will review the appeal and advise the Member of the decision in writing. If the appeal involves a pre-service claim, Capital Health Plan's decision regarding the appeal

will be made within 15 calendar days of receipt of the appeal. If the appeal involves a post-service claim, Capital Health Plan's decision regarding the appeal will be made within 30 calendar days of receipt of the appeal.

In standard appeal cases, the following information will be provided to the Member or authorized representative as soon as possible after CHP's receipt of the appeal so that they have enough time to respond to Capital Health Plan prior to the final adverse determination deadline:

- new or additional evidence considered, relied upon, or generated by Capital Health Plan in connection with the appeal, and

- new or additional rationale on which the final adverse determination will be based.

If the Member provides additional information in response to the above, such information shall be presented to the Panel for a final decision.

If the Member remains dissatisfied with the decision of the Appeal Review Panel, he or she may request a reconsideration of the decision by an External Review Program.

c. Request for Clinical Appeal Review

When a Member has an appeal that involves an adverse benefit determination that an admission, availability of care, continued stay, or other health care service does not meet the Capital Health Plan requirements for medical necessity, appropriateness of care, health care setting, level of care, or effectiveness, the grievance will be reviewed by the Clinical Appeal Panel.

The Clinical Appeal Panel will include health care professionals, including at least one physician who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the condition, process, or treatment that the Member or the provider is asking to be reviewed.

If the appeal involves a pre-service claim, the Capital Health Plan decision regarding the appeal will be made within 15 calendar days of receipt of the appeal. If the appeal involves a post-service claim, the Capital Health Plan decision regarding the appeal will be made

within 30 calendar days of receipt of the appeal.

The Clinical Appeal Panel will review the appeal and make a decision based on medical records, additional information, and input from health care professionals in the same or similar specialty as typically manages the condition, procedure, or treatment under review. Capital Health Plan will advise the Member of its decision in writing.

In standard clinical appeal cases, the following information will be provided to the Member or authorized representative as soon as possible after CHP's receipt of the appeal so that they have enough time to respond to Capital Health Plan prior to the final adverse determination deadline:

- new or additional evidence considered, relied upon, or generated by Capital Health Plan in connection with the appeal, and

- new or additional rationale on which the final adverse determination will be based.

If the Member provides additional information in response to the above, such information shall be presented to the Panel for a final decision.

If the Member remains dissatisfied with the decision of the Clinical Appeal Panel, he or she may request a reconsideration of the decision by an External Review Program.

d. Request for Expedited Review

For an appeal involving an adverse benefit determination, the Member, or a person acting on behalf of the Member, may request that the review of the appeal be expedited. To be eligible for an expedited review, an appeal (i.e., a request for expedited review) must meet the following criteria as determined by Capital Health Plan:

(1) The Member must be dissatisfied with a Capital Health Plan adverse benefit determination;

(2) As determined by Capital Health Plan, a delay in the provision of health care services for the length of time permitted under the standard appeal procedure timeframes

(approximately 15 calendar days) seriously could jeopardize the Member's life or health or the Member's ability to regain maximum function, or in the opinion of a physician with knowledge of the Member's condition, would subject the Member to severe pain that cannot be managed adequately with the care or treatment that is the subject of the claim; and

(3) The health care provider involved has refused to or will not provide the needed health care service without a guarantee of coverage or payment from the Member or Capital Health Plan.

Expedited appeals may be submitted in writing or verbally. The Member, the Member's authorized representative, or a provider acting on behalf of the Member, specifically must request an expedited review. For example, this request may be made by saying, "I want an expedited review." Only the following services that have yet to be rendered are subject to this expedited review process: (a) pre-service claims; or (b) requests for an extension of concurrent care services made within 24 hours before the termination of authorization for those services.

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

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

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

If the Member's request for expedited review arises out of a utilization review determination by Capital Health Plan, that a

continued hospitalization or continuation of a course of treatment is not medically necessary, coverage for the hospitalization or course of treatment will continue until the Member has been notified of the determination.

Capital Health Plan will provide written or verbal confirmation of its decision concerning an expedited review within 24 hours of receipt of the request. If the decision is given verbally, written confirmation will be sent within two working days after providing notification of the decision. If the Member is not satisfied with the decision, he or she may submit the grievance to an External Review Program.

Independent Review by Outside Agencies

The Member has the right at any time to submit a complaint or appeal to the Florida Department of Financial Services or the Agency for Health Care Administration. The Member has the right at any time to submit an appeal to the Federally Authorized External Review Program. The Member must submit the appeal to the Federally Authorized External Review Program within four months of the final Capital Health Plan decision. Telephone numbers and addresses are listed in the Telephone Numbers and Addresses subsection below.

Ordinarily, the Member must complete the entire appeal process and receive a final disposition from Capital Health Plan before pursuing review by an external review program. However, in the case of an expedited appeal related to an adverse benefit determination, a Member may file concurrent appeals with Capital Health Plan and the Federally Authorized External Review Program.

Timeframes for Resolution of an Appeal

Capital Health Plan resolved appeals in a timely manner. In resolving appeals, timeframes may vary, depending on the medical needs of the Member. Capital Health Plan will; however, resolve the Member's appeal within 15 calendar days after receipt for pre-service claims, or within 30 calendar days for post-service claims.

General Rules

General rules regarding the Capital Health Plan Complaint, Grievance and Appeal Process include the following:

1. The Member must cooperate fully with Capital Health Plan in its effort to promptly review and resolve a complaint, grievance, or appeal. If the Member does not cooperate fully with Capital Health Plan, he or she will

be considered to have waived his or her right to have the complaint, grievance, or appeal processed within the timeframes set forth above.

2. The timeframes set forth herein may be modified by the mutual consent of Capital Health Plan and the Member; however, any mutually agreed timeframe extension does not preclude the Member from asking the Federally Authorized External Review Program to review a Capital Health Plan decision at any time.

3. Capital Health Plan will not honor a request for expedited review that relates to services that have already been performed or provided to the Member or a request that is not eligible for expedited review in accordance with the criteria set forth in the Request for Expedited Review subsection. Capital Health Plan will handle non-expedited reviews in accordance with the Standard Appeal Procedure.

4. Capital Health Plan must receive all grievances within one year of the date of the occurrence that initiated the grievance.

5. If the appeal involves a determination that the service did not meet the Capital Health Plan medical necessity guidelines or is experimental or investigational (or a similar exclusion or limitation), the Member may request an explanation of the scientific or clinical judgment relied on, if any, that applies the terms of the Member Handbook to the Member's medical circumstances.

6. During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination. The members of the Capital Health Plan Appeal Panels will not have been involved in a previous denial of the request for coverage or payment, nor will they be a subordinate of an individual who was involved previously in the denial of the request.

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

8. If an appeal has been denied by Capital Health Plan and the denial has been upheld by the External Review Program, and nothing regarding the matter has changed (i.e., the benefits, employer, medical condition are unchanged), Capital Health Plan will not be required to reopen the appeal.

Telephone Numbers and Addresses

The Member may contact a Capital Health Plan Member Service Representative at the number listed on the membership card or the numbers listed below. If a complaint, grievance or appeal is unresolved, the Member may, at any time, contact Capital Health Plan at the telephone numbers and addresses listed on this page.

Capital Health Plan Member Services
1545 Raymond Diehl Road, Suite 300
Tallahassee, FL 32308
Office hours: Monday – Friday, 8 a.m. to 5 p.m.
850-383-3311 (M-F, 7 a.m. – 7 p.m.)
Toll-free: 877-392-1532 (24 hours a day, 7 days a week)
TTY: 850-383-3534 (M-F, 8 a.m. – 5 p.m.)
TTY Toll-Free: 1-877-870-8943
For expedited reviews, fax to 850-383-3413
Florida State Relay: 800-955-8771 or 711 (for the hearing impaired, after business hours)

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

Website: http://www.capitalhealth.com

Florida Department of Financial Services
Office of Insurance Regulation
Division of Insurance Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0322
1-877-693-5236 (toll free)

Agency for Health Care Administration
2727 Mahan Drive, Building 1, Mail Stop 26
Tallahassee, FL 32308
1-888-419-3456 (toll free)

Federally Authorized External Review Program
Mail: Disputed Claims
P.O. Box 791
Washington, DC 20044
Fax: 202-606-0036
Phone: 877-549-8152
Email: DisputedClaim@opm.gov

DEFINITIONS OF SELECTED TERMS

ACCIDENT means accidental bodily injury sustained by the covered person that results in and is the direct cause of medical expenses independent of illness.

ACCIDENTAL DENTAL INJURY means an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional and unexpected event or force. It shall include injuries caused by biting or chewing.

AMBULANCE means any private or publicly owned land, air, or water vehicle licensed under Chapter 401, Part III, Florida Statutes, or for services rendered outside Florida, other states' applicable laws, that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, air, land, or water transportation of persons who are in need of medical or surgical attention.

AMBULATORY SURGICAL CENTER means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes to provide surgical care, to which a patient is admitted and discharged within the same working day, and that is not a part of a hospital. A facility existing mainly for performing abortions, an office maintained by a doctor for the practice of medicine, or an office maintained for the practice of dentistry is not an ambulatory surgical center.

BIRTH CENTER means any facility, institution, or place, licensed pursuant to Chapter 383 of the Florida Statutes, in which births are planned to occur following a normal, uncomplicated, low risk pregnancy. A facility is not considered a birth center if it is an ambulatory surgical center, a hospital, or part of a hospital.

CALENDAR YEAR means a period of one year that starts on January 1 and ends December 31.

COINSURANCE means those amounts payable by the covered person, at the time of service, after the deductible is met, as specifically set forth in the Summary of Benefits for the Health Investor HMO Plan. The coinsurance amount shall be expressed as a percentage amount. *(Coinsurance and deductibles are only applicable to the Health Investor HMO Plan.)*

CONDITION means any disease, illness, injury, accident, bodily dysfunction, pregnancy, drug addiction, alcoholism, or mental or nervous disorder. For any preventive care benefits provided in Capital Health Plan, condition shall include the prevention of sickness.

CONFINEMENT means an approved medically necessary covered stay as an inpatient in a hospital that is due to a condition, and authorized by a licensed

medical health care provider with admission privileges. Each "day" of confinement includes an overnight stay for which a charge customarily is made.

COPAYMENT means those amounts payable by the covered person, at the time of service, as specifically set forth in the Summary of Benefits. While this amount may vary depending on, among other things, the contracting status of the health care provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Summary of Benefits for the service. *(Copayments are only applicable to the Standard HMO Plan.)*

COVERED PERSON means eligible employees, retirees, surviving spouses, COBRA participants, or any eligible dependents included for coverage under Capital Health Plan.

COVERED SERVICES OR SUPPLIES means those Medically Necessary health care services and/or supplies, described in the Covered Services sections, including pharmaceuticals and chemical compounds that are medically necessary or preventive medical services and child health supervision services not otherwise excluded by Capital Health Plan.

CUSTODIAL CARE means care or services that

- are maintenance in nature;
- can be provided by or taught to home caregivers;
- do not require the skill of a registered nurse;
- are designed to help the covered person with daily living activities, such as help walking, getting in and out of bed, bathing, dressing, eating, or taking medicine; and
- are not expected to improve the covered person's medical condition.

Care or services that meet this definition are not covered by Capital Health Plan. See exclusion on page 73.

In determining whether a person is receiving custodial care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

DEDUCTIBLE means the amount you must pay for covered services before our plan begins to pay its share, except for some preventive care. Expenses that will not count toward the deductible amount include (i) expenses related to services that are not covered and (ii) expenses exceeding the allowed amount. *(Deductibles are only applicable to the Health Investor HMO Plan.)*

DEPENDENT means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility under Capital Health Plan for Dependent(s) subsection, is properly enrolled hereunder through submission of applicable forms by his/her Subscriber and is eligible to enroll as a Covered Dependent, and for whom, or on whose behalf, prepayment fees and any supplemental charges have been received by Capital Health Plan.

DURABLE MEDICAL EQUIPMENT

- At the option of Capital Health Plan, the rental or purchase of medical equipment and medical supplies for the care and treatment of a condition covered under Capital Health Plan, which includes:
  - Trusses, braces, walkers, canes, crutches, casts, and splints
  - Occlusal guards, bite or dental splints, repositioning devices, and TMJ study models for the treatment of temporomandibular joint (TMJ) syndrome
  - Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products
  - Oxygen and rental of equipment for the administration of oxygen, ventilator or other mechanical equipment for the treatment of respiratory paralysis
  - Ambulatory home uterine activity monitoring devices (AHUM)
  - Wheelchairs, hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment
  - Other medical equipment and supplies as determined to be medically necessary
- Durable Medical Equipment:
  - Shall not serve as a comfort, hygiene, or convenience item.
  - Shall not be used for the sole purpose of exercise.
  - Shall not be used by any other party.
  - Shall have been manufactured specifically for medical use.
  - Shall not include shoe buildups, shoe orthotics, shoe braces, or shoe supports unless the shoe is attached to a brace.
  - Shall not include water therapy devices, modifications to motor vehicles and/or homes, or similar items.

ELECTIVE ADMISSION means a hospital admission that is not of an urgent or emergency nature and can be scheduled in advance and at a time that is convenient for the covered person and the covered person's physician without risking the covered person's well being.

ELIGIBLE DEPENDENT means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility under Capital Health Plan for Dependent(s) subsection, is properly enrolled hereunder through submission of applicable forms by the dependent’s parent (employee, retiree or

surviving spouse), and is eligible to enroll as a Covered Dependent, and for whom, or on whose behalf, prepayment fees and any supplemental charges have been received by Capital Health Plan.

ELIGIBLE EMPLOYEE means an individual who meets and continues to meet all of the eligibility requirements set forth in the Eligibility Requirements for Subscribers(s) subsection, is properly enrolled hereunder through submission of applicable forms by his/her employer and is eligible to enroll, and for whom, or on whose behalf, prepayment fees and any supplemental charges have been received by Capital Health Plan.

ELECTIVE SURGERY means surgery of a nonemergency nature in which the covered person can elect when, or if, surgery can be done.

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

1. a medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    (a) serious jeopardy to the health of a patient, including a pregnant woman or fetus;
    (b) serious impairment of bodily functions; or
    (c) serious dysfunction of any bodily organ or part.

2. with respect to a pregnant woman:
    (a) that there is inadequate time to affect safe transfer to another Hospital prior to delivery;
    (b) that a transfer may pose a threat to the health and safety of the patient or fetus; or
    (c) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES AND CARE means medical screening, examination, and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if any 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.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT means any evaluation, treatment, therapy, or device that:

1. cannot be marketed lawfully without approval of the United States Food and Drug Administration or the Florida Department of Health if approval for marketing has not been given at the time that the service is provided to the covered person;

2. is the subject of ongoing Phase I or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or is under study to determine the maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the condition;

3. generally is regarded by experts as requiring more study to determine maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the condition;

4. has not been proven safe and effective for the treatment of the condition based on the most recently published medical literature of the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

5. is not accepted in consensus by practicing doctors as safe or effective for the condition; or

6. is not used regularly by practicing doctors to treat patients with the same or similar conditions.

HOME HEALTH AGENCY means a properly licensed agency or organization which provides health services for people who are confined and convalescing at home instead of the hospital pursuant to Chapter 400 of the Florida Statutes. A home health agency may operate independently or as part of a hospital.

HOSPICE means a licensed, autonomous, centrally administered, nurse-coordinated program providing home, outpatient and inpatient care for a covered person who is terminally ill and members of that person's family. At a hospice, a team of health care providers assists in providing palliative and supportive care to meet the special needs arising during the final stages of illness and during dying and bereavement. The team of providers includes a doctor and nurse, and also may include a social worker, a clergy member or counselor, and volunteers.

HOSPITAL means a licensed institution providing medical care and treatment to a patient as a result of illness, accident, or mental or nervous disorder on an inpatient/outpatient basis at the patient's expense and that meets all the following:

1. It is accredited by the Joint Commission the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities. Licensed institutions in rural, sparsely populated geographic regions, however, may not be accredited.

2. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed doctors. A facility may be considered a hospital if it does not have major surgical facilities but provides primarily rehabilitative services for treatment of physical disability.

3. It continuously provides 24 hours a day nursing service by or under the supervision of registered nurses.

The term “hospital’ does not include a specialty or residential facility, or a U.S. Government hospital or any other hospital operated by a governmental unit, unless a charge is made by such hospital that the patient legally is required to pay without regard to insurance coverage.

ILLNESS means physical sickness or disease, pregnancy, bodily injury, or congenital anomaly.

INTENSIVE CARE UNIT means a specialized area in a hospital in which an acutely ill patient receives intensive care or treatment. Included in the hospital's charge, in the intensive care unit, are the services of specially trained professional staff, nurses, supplies, the use of any and all equipment, and the patient's board. A coronary care unit also is considered an intensive care unit.

MANIPULATIVE SERVICES means a term of physical medicine involving the skillful and trained use of the hands to treat diseases or symptoms resulting from misalignment of the spine. Manipulative services do not include massage therapy.

MEDICAL DIRECTOR OF CAPITAL HEALTH PLAN means a Physician serving as the Medical Director in the Service Area of Capital Health Plan in which the Member is enrolled.

MEDICAL SUPPLIES OR EQUIPMENT shall mean supplies or equipment that are:

1. ordered by a physician;
2. of no further use when medical need ends;
3. usable only by the covered person;
4. not primarily for the patient's comfort or hygiene;
5. not for environmental control;

6. not for exercise;
7. manufactured specifically for medical use.

MEDICALLY NECESSARY means for coverage and payment purposes, that a medical service, drug, or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of Capital Health Plan:

1. consistent with the symptom, diagnosis, and treatment of the member's condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based on scientific evidence;
3. universally accepted in clinical use such that omission of the service 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, or the prescriber; and,
7. the most appropriate level of service, care or supply which can safely be provided to the Member.

The fact that a service is prescribed by a doctor does not necessarily mean that the service is medically necessary or a covered service. Capital Health Plan determines whether a service or supply is medically necessary.

MEDICALLY NECESSARY LEAVE OF ABSENCE means for the purposes of continued coverage in accordance with Michelle’s Law, a leave of absence from a post-secondary educational institution or any change in enrollment of an eligible dependent child at the institution, that:

1. begins while the eligible dependent child is suffering from a serious illness or injury on such date as determined by the dependent child’s treating provider.

2. is medically necessary, as determined and evidenced by written certification provided by the eligible dependent child’s treating provider to CAPITAL HEALTH PLAN; and

3. causes the eligible dependent child to lose student status for purposes of coverage under this plan.

MEMBER means an individual who meets and continues to meet all of the eligibility requirements set forth in the Eligibility under Capital Health Plan section, is properly enrolled hereunder through submission of applicable forms and is eligible to enroll, and for whom, or on whose behalf, prepayment fees and any supplemental charges have been received by Capital Health Plan.

MEMBERSHIP means an Eligible Employee or Dependent who meets and continues to meet all applicable eligibility requirements of the Eligibility under Capital Health Plan section, who enrolls hereunder, and for whom the payment(s) required by Capital Health Plan has been received.

MEMBERSHIP CARD means the identification card issued by Capital Health Plan to Members. The Membership Card is the property of Capital Health Plan, and is not transferable to another person. Possession of such Membership Card in no way verifies that a particular individual is eligible for or covered under the Group Plan.

MENTAL HEALTH PROFESSIONAL means a person properly licensed to treat mental health problems pursuant to Chapter 491 of the Florida Statutes. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination or sect who provide counseling services.

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

MIDWIFE means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes.

NETWORK PROVIDER or CONTRACTED PROVIDER see Participating Provider definition.

NON-CONTRACTING PROVIDER means any health care institution, facility, pharmacy, Physician, or other health care provider with whom Capital Health Plan does not have a contract in effect at the time the health care services are provided.

NURSING SERVICES means services that are provided by an advanced registered nurse practitioner (A.R.N.P.), registered nurse (R.N.), or a licensed practical nurse (L.P.N.), who is licensed under Chapter 464, Florida Statutes, and is:

1. acting within the scope of that person's license;
2. authorized by a physician; and
3. not a member of the covered person's immediate family.

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

OCCUPATIONAL THERAPIST means a person properly licensed to practice occupational therapy pursuant to Chapter 468 of the Florida Statutes.

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

OUTPATIENT HEALTH CARE FACILITY means a licensed facility other than a doctor's, physical therapist's, or midwife's office, that provides medically necessary outpatient services for treatment of an illness or injury other than mental or nervous disorders, drug addiction, or alcoholism.

PALLIATIVE CARE means the reduction or abatement of pain and other troubling symptoms through services provided by members of the hospice team of health care providers.

PARTICIPATING PROVIDER means a hospital, doctor, pharmacy, medical laboratory, or other health care provider who has entered into a contractual agreement with Capital Health Plan to provide services to covered persons at a negotiated rate.

PHYSICAL THERAPY means the treatment of disease or injury by physical or mechanical means. Such therapy may include traction, active or passive exercises, or heat therapy.

PHYSICAL THERAPIST means a person properly licensed to practice physical therapy pursuant to Chapter 486 of the Florida Statutes.

PHYSICIAN means any individual who is properly licensed by the State of Florida, as a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Chiropractic, Doctor of Dental Surgery or Dental Medicine, or Doctor of Optometry.

PRIMARY CARE PHYSICIAN (PCP) means a participating doctor who has been chosen by the covered person to be responsible for providing, prescribing, directing, and authorizing all care and treatment of the covered person.

PROSTHETIC DEVICE means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

PSYCHIATRIC FACILITY means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For coverage purposes, a psychiatric facility is not a Hospital, as defined herein.

PSYCHOLOGIST means a person properly licensed to practice psychology

pursuant to Chapter 490 of the Florida Statutes.

SEMI-PRIVATE ROOM means a hospital room with two bed accommodations in which an inpatient receives board and general nursing care included in the hospital's charge for that room.

SERVICE AREA means the geographic area(s) that Capital Health Plan is licensed to service, as approved by the Agency for Health Care Administration and, if applicable, the Florida Department of Financial Services and Centers for Medicare and Medicaid Services (CMS). This includes the following Florida counties: Calhoun, Franklin, Gadsden, Jefferson, Leon, Liberty, and Wakulla.

SKILLED NURSING CARE means care furnished by, or under the direct supervision of, licensed registered nurses (under the general direction of the physician) to achieve the medically desired result and to ensure the covered person's safety. Skilled nursing care may include providing direct care when the ability to provide the service requires specialized and/or professional training, observation and assessment of the covered person's medical needs, or supervision of a medical treatment plan involving multiple services when specialized health care knowledge must be applied to attain the desired medical results.

SKILLED NURSING FACILITY means a institution or part thereof which is licensed as a skilled nursing facility by the State of Florida, accredited as a skilled nursing facility by the Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare and primarily engaged in providing to inpatients:

1. skilled nursing care by, or under the supervision of, licensed registered nurses;
2. rehabilitative services by, or under the supervision of, licensed physical therapists; and
3. other medically necessary related health services.

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

SPECIALTY INSTITUTION OR RESIDENTIAL FACILITY means a licensed facility providing an inpatient rehabilitation program for the treatment of alcohol or drug abuse or mental or nervous conditions. The program must be accredited by the Joint Commission and licensed by the Department of Children and Family Services.

SPEECH THERAPY means the treatment of speech and language disorders by a qualified health care provider including language assessment and language restorative therapy services.

SPEECH THERAPIST means a person properly licensed to practice speech therapy pursuant to Chapter 468 of the Florida Statutes.

SUBSCRIBER means an Eligible Employee who meets and continues to meet all applicable eligibility requirements of the Eligibility Requirements for Subscribers subsection, who enrolls hereunder, and for whom the payment(s) required by Capital Health Plan has been received.

SUBSTANCE DEPENDENCY means a condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

TERMINALLY ILL means that a person has a life expectancy of one year or less because of a chronic, progressive illness that is incurable according to the person's doctor.

WELL-BABY NURSERY SERVICES means those covered services and supplies associated with the care of a healthy newborn child.