

# Capital Health Plan

## MEMBER HANDBOOK

*Certificate of Coverage*

*for*

*Health Maintenance Organizations*

**State of Florida**

**Employees' Group Insurance Program**

Call CHP Member Services at (850) 383-3311 for more information  
or log on to CHP's website at [www.capitalhealth.com](http://www.capitalhealth.com).



**Capital Health**  
P L A N



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# TABLE OF CONTENTS

<b>ADMINISTRATIVE PROVISIONS.....</b>	<b>1</b>
ELIGIBILITY AND EFFECTIVE DATES.....	1
Eligibility Under Capital Health Plan.....	1
Enrollment Periods .....	3
Employee Enrollment .....	3
Employee Effective Date .....	4
Dependent Effective Date.....	4
Preexisting Condition Limitations .....	5
Coverage For Newborn Children.....	5
Coverage For Adopted Children.....	5
Coverage For Foster Children .....	6
Dependent Child As Employee.....	6
TERMINATION OF COVERAGE .....	6
Coverage Termination .....	6
Dependent Coverage Termination .....	7
Handicapped Children Coverage Termination .....	7
Termination Of Coverage For Cause .....	7
RIGHTS TO EXTENSION, CONVERSION, AND CONTINUATION .....	8
Extension Of Hospital Inpatient Benefits .....	8
Extension Of Disability Coverage And Maternity Benefits .....	8
Federal Continuation Provisions.....	8
Conversion Privilege.....	9
Requesting Conversion .....	9
COORDINATION WITH OTHER GROUP INSURANCE PLANS .....	9
How Coordination Works .....	10
For All Covered Individuals.....	10
For Eligible Dependent Children .....	11
COORDINATION WITH MEDICARE .....	11
Active Employees .....	11
Retired Employees .....	12
REIMBURSEMENT FOR NONPARTICIPATING PROVIDER SERVICES .....	12
UNUSUAL CIRCUMSTANCES.....	13
RIGHT TO RECOVER AND SUE FOR LOSSES .....	13
<b>COVERAGE PROVISIONS.....</b>	<b>15</b>
COVERAGE ACCESS RULES .....	15
CHP AND HEALTH CARE PROVIDERS.....	15
MEDICAL DECISIONS—RESPONSIBILITY OF COVERED PERSON’S PHYSICIAN, NOT CHP .....	15
ROLE OF PRIMARY CARE PHYSICIAN (PCP).....	15
SPECIALTY CARE.....	16
EMERGENCY SERVICES AND CARE .....	17
CASE MANAGEMENT .....	17
COVERED PERSON COPAYMENTS .....	17

LIFETIME MAXIMUM COVERAGE LIMIT .....	18
<b>SUMMARY OF PLAN BENEFITS .....</b>	<b>19</b>
COVERED SERVICES .....	19
<b>PRESCRIPTION DRUGS.....</b>	<b>30</b>
DRUGS THAT ARE COVERED BY CAPITAL HEALTH PLAN .....	30
DRUGS THAT ARE NOT COVERED BY CAPITAL HEALTH PLAN .....	31
<b>LIMITATIONS AND EXCLUSIONS .....</b>	<b>33</b>
FOLLOWING COVERAGE ACCESS RULES .....	33
SERVICES NOT COVERED BY CAPITAL HEALTH PLAN .....	33
<b>MEMBER RIGHTS AND RESPONSIBILITIES.....</b>	<b>38</b>
RIGHTS .....	38
RESPONSIBILITIES .....	38
<b>FILING A GRIEVANCE OR COMPLAINT .....</b>	<b>40</b>
INTRODUCTION .....	40
DEFINITIONS.....	40
INFORMAL REVIEW—COMPLAINTS .....	41
FORMAL REVIEW—GRIEVANCES .....	41
Level I Review .....	42
Standard Grievances.....	42
Request For Clinical Grievance Review.....	42
Request For Expedited Review .....	42
Level II Review .....	44
SUBSCRIBER ASSISTANCE PROGRAM .....	44
TIMEFRAMES FOR RESOLUTION OF A GRIEVANCE.....	44
GENERAL RULES .....	44
TELEPHONE NUMBERS AND ADDRESSES.....	45
<b>DEFINITIONS OF SELECTED TERMS.....</b>	<b>47</b>
<b>SCHEDULE OF COPAYMENTS .....</b>	<b>52</b>

## **ADMINISTRATIVE PROVISIONS**

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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.

### **ELIGIBILITY AND EFFECTIVE DATES**

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the State of Florida. In addition, the individual must live or work in Capital Health Plan's service area. The following sections explain eligibility and effective dates of this coverage.

#### **Eligibility Under Capital Health Plan**

To be eligible for coverage under Capital Health Plan, an individual shall be either:

1. An **employee**, which means any state officer or an individual who works for the state on a full-time or part-time basis and who is filling a salaried position, but in no case shall the term eligible employee include persons paid from other personal services (OPS) funds.
2. A **retiree**, which means any state officer or state employee who retires under a State of Florida retirement system or a state optional annuity or retirement program or is placed on disability retirement under the State of Florida retirement system and who was insured under the state group insurance program at the time of retirement and who begins receiving retirement benefits immediately after retirement from state office or employment. Eligible retiree also means a person who retired before January 1, 1976, under any of the state administered retirement systems and who is not eligible to receive any benefits under social security.
3. A **surviving spouse**, which means the following:
  - a. The widow or widower of an employee or retiree if the widow or widower was covered as a dependent under the family coverage of the employee or retiree at the time of the employee's or retiree's death;
  - b. The widow or widower of an employee or retiree who died before July 1, 1979; or

- c. The widow or widower of a person who retired before January 1, 1976, under any of the state administered retirement systems and who is not eligible to receive any benefits under social security; and
  - d. Any widow or widower shall cease to be a surviving spouse on his or her remarriage.
4. A **dependent**, which means the following:
- a. The wife or husband of the employee and any eligible children;
  - b. The wife or husband of the retiree and any eligible children;
  - c. The eligible children of a surviving spouse; and
  - d. The newborn children of an eligible child provided that the newborn children are born on or after October 1, 1984. Coverage for newborn children shall terminate 18 months after the birth of the newborn children.
5. A **child**, which means the employee's or retiree's unmarried own child, adopted child, or child placed in the employee's or retiree's home for the purpose of adoption in accordance with Chapter 63, Florida Statutes, a stepchild who the employee can claim as an exemption on his or her federal income tax return, a child for whom legal guardianship has been established under Chapter 744, Florida Statutes, a foster child, or any other unmarried child for whom the employee or retiree has been granted court-ordered temporary or other custody. A child shall be eligible for coverage as follows:
- a. From the date of birth to the end of the month in which the child's 19th birthday occurs;
  - b. From the 19th birthday to the end of the calendar year in which the child's 25th birthday occurs, if the eligible employee, retiree, or surviving spouse can claim the child as an exemption on his or her federal income tax return and the child is either living with the eligible employee, retiree, or surviving spouse or enrolled in any school, college, or university that provides training or educational activities and is certified or licensed by a state or foreign country;
  - c. A child who is mentally or physically handicapped shall be eligible to continue coverage after attainment of the above age limits and while the employee's or retiree's family coverage is in effect provided that the child is incapable of self-sustaining employment by reason of the mental or physical handicap and chiefly dependent on the employee, retiree, or surviving spouse for support and maintenance; or
  - d. A child who is over the above age limits at the time of the employee's or retiree's initial enrollment and who is mentally or physically handicapped shall be eligible for coverage if the child is incapable of self-sustaining employment by reason of the mental or physical handicap and chiefly dependent on the employee, retiree, or surviving spouse for support and maintenance; and

- e. When an eligible child marries, all coverage shall cease for that child at the end of the month in which the marriage occurs.

Capital Health Plan shall be responsible for (1) requesting, verifying, and maintaining documentation for eligible children who reach the maximum age requirements to determine school enrollment or handicap status; and (2) when a determination is made that a child no longer is eligible as a dependent, notifying the covered person, in writing, that he or she has 30 days from the date of the letter to notify his or her personnel office of this change. Additionally, Capital Health Plan shall not terminate a dependent determined not eligible until official termination is received from the Division of State Group Insurance or appropriate documentation is received verifying eligibility, however, payment of claims may be suspended.

### **Enrollment Periods**

There are three types of time periods for coverage enrollment under Capital Health Plan:

1. The **initial enrollment period** is the period of time during which an employee first is eligible to enroll, and begins on the employee's initial date of employment and ends 60 days later. If the employee is a state officer, the officer may enroll within 60 days after he or she begins a new term of office.
2. The **annual open enrollment period** is the period of time designated each calendar year during which: a) eligible employees may enroll in Capital Health Plan; or, b) eligible employees, retirees, surviving spouses, or COBRA participants may transfer from their present plan to any other plan available without application of waiting periods or exclusions based on health status as conditions of enrollment or transfer.
3. A **special enrollment period** is the period of time during which eligible employees, retirees, surviving spouses, and COBRA participants may enroll. Special enrollment periods shall be required under the following circumstances:
  - a. To permit the transfer from a defunct plan to another qualified plan; or
  - b. Legislative mandate allowing retired state employees coverage under Capital Health Plan.

### **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. Complete and submit, through his or her employing agency, a written request for coverage, using enrollment forms provided and approved by both Capital Health Plan and the State of Florida; and,
2. Agree to pay his or her portion of the required premium, if required by the State of Florida.

An employee who is a newly eligible employee shall enroll within the initial enrollment period. An employee, retiree, surviving spouse, or COBRA participant who has been covered under another health benefit plan established and maintained by the State of Florida, and who now wants to change to Capital Health Plan, shall enroll for the coverage change during an annual open enrollment period or special enrollment period.

### **Employee Effective Date**

The effective date of coverage for enrollment in Capital Health Plan shall be the first day of the month after the month in which a full month's premium has been received by the Division of State Group Insurance.

### **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 31 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, the coverage for the newborn child of a covered dependent other than the covered person's spouse shall terminate 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 shall not 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. However, covered persons with individual coverage shall convert to family coverage before the birth of the newborn child. If the newborn child is born before the conversion to family coverage, only well-baby hospital nursery services shall be eligible for 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 31 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. However, covered persons with individual coverage shall convert to family coverage before the birth or placement of the adopted child. If the adopted newborn child is born before the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. Covered services for the adopted child shall be the same as any other dependent child.

## **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. However, covered persons with individual coverage shall convert to family coverage before the placement of the foster child. If the foster newborn child is born before the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. 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.

## **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.

### **Coverage Termination**

The coverage under Capital Health Plan for any covered person shall end at 12:01 a.m., local standard time, on the earliest of the following dates:

1. The contract between the state and Capital Health Plan ends;
2. The state fails to pay the premium due;
3. The covered person otherwise fails to continue to meet each of the eligibility requirements under Capital Health Plan;
4. The covered person's membership is terminated for cause;
5. The covered person no longer resides in the Capital Health Plan service area; or
6. The covered person becomes covered under another health benefit plan established and maintained through or in connection with the state as an

alternative to Capital Health Plan.

### **Dependent Coverage Termination**

The coverage under Capital Health Plan for any covered dependent shall end automatically at 12:01 a.m., local standard time, on the earliest of the following dates:

1. The contract between the state and Capital Health Plan ends;
2. The covered person's coverage ends for any reason;
3. The dependent fails to continue to meet each of the dependent eligibility requirements under Capital Health Plan;
4. The covered dependent's membership is terminated for cause;
5. The covered dependent no longer resides in the service area with the exception of covered dependents who are full-time or part-time students outside the service area; or
6. The dependent becomes covered under another health benefit plan offered through the state as an alternative to Capital Health Plan.

### **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 mental retardation 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.

### **Federal Continuation Provisions**

Federal law permits covered persons to continue coverage under an employer established health benefit plan under certain circumstances. This law is referred to as COBRA, which stands for the "Consolidated Omnibus Budget Reconciliation Act of 1985" and includes any amendments thereto.

It shall be the state's responsibility to inform employees of their rights under COBRA. Information on employee COBRA rights also may be obtained from the United States Department of Labor.

## **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 31 days after his or her coverage under Capital Health Plan terminates. The application form to be used and information about conversion benefits shall be obtained from Capital Health Plan.

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.

## **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, or Medicare, 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 Retiree Advantage Plan. The enrollment will provide the covered person with the same benefits included in this member handbook. 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 Retiree Advantage, his or her coverage with Capital Health Plan will cease.

### **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 copayments.

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 copayments 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.

**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 PROVISIONS**

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### **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.

### **CHP AND HEALTH CARE PROVIDERS**

CHP 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 CHP 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 CHP 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 CHP**

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](http://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 shall 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.

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 without prior notification to us, subject to the copayment amount set forth in the Schedule of Copayments. 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 Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges or the charge mutually agreed to by us and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is the responsibility of the covered person to furnish to us written proof of loss in accordance with the Claims Processing section.

## **CASE MANAGEMENT**

CHP 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, CHP may use its case management program then in effect. CHP's use of the case management program with respect to any covered person shall not restrict or otherwise modify CHP's right to administer coverage and/or benefits in strict accordance with the terms of this Member Handbook with respect to the covered person, or with respect to any other covered person or other individual under any other policy or contract. Furthermore, when the cost of providing alternative or equivalent services varies, depending on whether a particular provider or supplier is used to provide the service, CHP 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.

## **COVERED PERSON COPAYMENTS**

For certain services, the covered person is responsible for paying a portion of the cost of covered services. Usually, this portion is a flat dollar amount referred to as a "copayment." The copayment requirements for Capital Health Plan are shown in the schedule of member copayments. The covered person also may call Capital Health

Plan Member Services for information on copayment amounts.

The total copayments that the covered person is responsible for in any single calendar year shall not exceed \$1,500 for individual coverage and \$3,000 for family coverage. When the covered person has paid copayments that total the annual maximum, no further copayments shall be required from that covered person for the remainder of the calendar year. The covered person is responsible for providing documentation of the amount of copayments paid.

#### **LIFETIME MAXIMUM COVERAGE LIMIT**

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

## **SUMMARY OF PLAN BENEFITS**

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### **COVERED SERVICES**

This section provides a description of services and supplies covered by Capital Health Plan. However, services and supplies not described here but mandated by state or federal law will be covered by Capital Health Plan.

Capital Health Plan pays the cost of covered care and medical supplies, less the copayment, as long as the care or supplies are: ordered by a covered provider; 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 force.

#### **Ambulance**

- Ambulance service
  - to the nearest hospital
  - 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.

#### **Anesthesia Services**

- Both inpatient and outpatient.

#### **Cancer Services**

- Diagnosis and Treatment—Includes both inpatient and outpatient diagnostic tests and treatment except for experimental or investigational treatments.

#### **Cleft Lip and Cleft Palate**

- Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology, and nutrition services only as specified by statute.

#### **Contraceptive Supplies**

- Insertion and removal of IUD
- Diaphragm
- Insertion and removal of contraceptive implants
- Contraceptive injections

#### **Cosmetic Surgery**

- Plastic & reconstructive
- Reduction mammoplasty
- Repair or alleviation of damage if treatment or surgery is the result of an accident.
- For correction of a congenital anomaly for an eligible dependent.
- Correction of an abnormal bodily function.

- For an area of the body that 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.

### **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 Consultations:
  - *For 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
    - the physicians have different specialties or have the same specialty with different sub-specialties and
    - must be authorized by 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
    - *Adult preventive medical services include:*
      - health history

- laboratory tests (e.g. urinalysis, hemoglobin, and hematocrit, stool for occult blood, sexually transmitted diseases, etc.)
- physical examination
- vision - routine (eye chart), or refractive eye exams and hearing screenings
- tuberculin skin test
- routine male and female screening exams and tests (e.g., pap smear, pelvic exam, prostate gland screening) limited to one exam per calendar year

### **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, iron lung 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

### **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.

### **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, including:
  - 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 the covered person's PCP.
  - The plan of treatment must document that home health care is medically necessary and that the services are being provided instead of hospitalization or continued hospitalization; and
  - Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility.
- Services that 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.
  - Physical therapy is subject to outpatient limitations described under rehabilitative services.

### **Hospice Care**

- In-home care
  - Physician services
  - Physical, respiratory, 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:
  - Treatment for and 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, regular plan benefits are not payable for expenses related to the terminal illness.
- These following services are **not** covered under Capital Health Plan:
  - Social work services
  - 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, for example:
  - use of operating room,
  - labor room, delivery room, and recovery room
  - use of covered drugs and medicines used by the patient
  - intravenous solutions, including glucose
  - 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**

- Breast cancer screening
- Diagnosis
- 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

### **Maternity Care**

- Pre-natal 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
- Maternity care is not covered for dependent children who become pregnant, except for certain pregnancy complications and care of the newborn. (See page 27 for a definition of complications of pregnancy)
- 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

### **Mental Health, Alcoholism and Substance Abuse Care**

- Inpatient – hospital, specialty institution, or residential facility
- Outpatient – alcoholism & substance abuse
- Treatment program must be accredited by the Joint Commission on Accreditation of Hospitals or approved by the state.
- Providers must be licensed in accordance with applicable law
- For inpatient care:
  - Alcoholism and substance abuse care is limited to a maximum of 31 days per calendar year total including detoxification.
  - Mental health and nervous disorders treatment is limited to a maximum of 31 days per calendar year total.
- For outpatient care:
  - Alcoholism and substance abuse care is limited to a maximum of 26 visits per calendar year total.
  - Mental health and nervous disorders treatment is limited to a maximum of 26

- visits per calendar year total and includes diagnostic evaluation and psychiatric treatment, and individual and group therapy.
- For learning and behavioral disabilities or mental retardation, coverage is limited to evaluation and diagnosis.
- No coverage is provided for marriage counseling, court-ordered care or testing, or required as a condition of parole or probation, testing for aptitude, ability, intelligence, or interest.

#### **Newborn Care**

- Coverage for the newborn child of an eligible dependent will be terminated 18 months after the birth of the newborn. This coverage shall include:
  - 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. The transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.
- Coverage for the newborn child of a mother who does not convert to family coverage within the prescribed time period is limited to well-baby hospital nursery 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
  - home health care services and hospice services

#### **Oral Surgery**

- Surgical treatment of nondental 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.
- Services related to an accident or injury occurring while, and as a result of, biting or chewing.

#### **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:
  - Hospital and medical expenses in accordance with the same terms and conditions as Capital Health Plan shall pay benefits for care and treatment of any other covered condition; and

- 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 from Capital Health Plan 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 noncovered 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;
  - 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 that use; and
  - 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, including glucose
  - 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 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 instead 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.

#### **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.

#### **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 Health Plan approval of a written plan of treatment
- Agreement that the covered person's condition should improve significantly within 60 days of the date on which 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
- Inpatient or outpatient basis

### **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.
- All necessary tests for the second medical opinion may be conducted by participating providers.
- 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 participating physician is selected, the only cost to the covered person will be the applicable copayment.
  - If a nonparticipating physician is selected, Capital Health Plan shall pay 60% of the usual and customary charges for those services in the community in which they were rendered as determined by Capital Health Plan, and the covered person shall be responsible for the remainder of the fee.

**Skilled Nursing Facility Care**

- Room, board, and general nursing care
- Services and supplies for necessary treatment
- PCP or Capital Health Plan approval of a written plan of treatment is required.
- Patient must require skilled care for a condition (or a related condition) that was treated in the hospital and care can be provided at a skilled nursing facility instead 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**

- Inpatient or outpatient basis

**Surgical Sterilization**

- Limited to tubal ligations and vasectomies.

## **PRESCRIPTION DRUGS**

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When a participating provider prescribes a drug, the covered person may have that prescription filled at any of Capital Health Plan's participating pharmacies, a list of which is included in Capital Health Plan's Provider Directory. Prescription drugs are subject to Capital Health Plan's preferred drug list and the provisions noted below.

To fill a prescription, the covered person simply presents his or her ID card to a pharmacist along with the prescription. The covered person will pay a copayment for up to a 30-day supply per prescription. The copayments are detailed in the Schedule of Member Copayments attached to this Handbook.

Each covered prescription drug, when purchased from a participating pharmacy, is subject to a copayment amount. The copayment amount is determined by the type of prescription drug dispensed, as follows:

- Tier I generic drugs
- Tier II Preferred Brand Drugs on Capital Health Plan's preferred drug list when no generic is available or if the covered person's doctor writes on the prescription "dispense as written" or "brand name medically necessary"\*\*\*
- Tier III Non-Preferred Brand Drugs that are not on Capital Health Plan's preferred drug list when no generic is available or if the covered person's doctor writes on the prescription "dispense as written" or "brand name medically necessary"\*\*\*

\*\* The Florida Boards of Medicine and Pharmacy, according to Chapter 465, Florida Statutes, have established a negative drug formulary. No drug substitution shall be allowed for the following:

1. Digitoxin
2. Conjugated estrogen
3. Dicumarol
4. Chlorpromazine (solid oral dosage forms)
5. Theophylline (controlled release)
6. Levothyroxine sodium
7. Pancrelipase (oral dosage forms)

### **DRUGS THAT ARE COVERED BY CAPITAL HEALTH PLAN**

Covered drugs shall include:

- Insulin
- Needles and syringes with insulin
- FDA-approved glucose strips and tablets
- Prepackaged items, such as insulin with needles or syringes, dispensed for the number of days' usage prescribed, or package quantity, whichever is greater
- Prescription refills once a usage percentage of the previous prescription, as established by Capital Health Plan, has been met based on the dosage schedule prescribed by the physician or other participating provider.

## **DRUGS THAT ARE NOT COVERED BY CAPITAL HEALTH PLAN**

Drugs that are not covered by Capital Health Plan shall include:

- Any drug, medicine, or medication that is consumed at the place where the prescription is given (provider's office or health care facility);
- Any drug, medicine, or medication that is dispensed by a physician or other participating provider (other than a pharmacy);
- Prescription refills in excess of the number specified by the physician or dispensed more than one year from the date of the original order of the physician or other participating provider who is authorized to prescribe drugs within the scope of his or her license;
- The administration of covered medication;
- Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he or she is a patient in a hospital, skilled nursing facility, convalescent hospital, inpatient hospice facility, or other facility where drugs ordinarily are provided by the facility on an inpatient basis;
- Medication that is covered by Worker's 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 Health Plan;
- 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,
- Nonfederal legend or over-the-counter drugs;
- Devices or appliances, including, but not limited to, hypodermic needles/syringes (exception: those items associated with an insulin prescription or prepackaged with other medications), support garments, and other nonmedical substances, regardless of intended use;
- Retin-A for cosmetic purposes;
- Anti-obesity drugs;
- Nicorette and similar drugs to deter smoking;

- Amphetamines and/or anorexiant for weight loss;
- Hormone treatment in preparation for sexual reassignment;
- Any costs related to the mailing, sending, or delivery of prescription drugs; and
- Prescriptions filled at a nonparticipating pharmacy, except for prescriptions required during emergency care.

See pages 33-37 for a complete listing of plan limitations and exclusions.

## **LIMITATIONS AND EXCLUSIONS**

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### **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; or services in connection with the pregnancy of eligible children; however, medically necessary services because of the following complications of pregnancy are covered by Capital Health Plan:

1. Conditions whose diagnoses are distinct from pregnancy but are affected adversely by pregnancy;
2. Conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity;
3. A non-elective cesarean section;
4. An ectopic pregnancy that is terminated; and
5. 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.

**Acupuncture services.**

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

**Autopsy or postmortem examination services,** unless specifically requested by

Capital Health Plan.

**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 that arises as a complication of a non-covered service (e.g., services or supplies to treat a complication of cosmetic surgery shall not be covered under Capital Health Plan).

**Cosmetic surgery (plastic and reconstructive surgery)**, and any other service and supply to improve the covered person's appearance or self-perception, such as electrolysis, procedures or supplies to correct baldness, or the appearance of skin (wrinkling).

**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 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, or orthognathic treatment; rapid palatal expanders; continuous passive motion (CPM) devices.

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

**Experimental or investigational treatment**, as defined in the glossary.

**Eye care**, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided in the covered services section;
2. Radial keratotomy, myopic keratomileusis, and any surgery that involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; and

3. 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.

**Hearing aids**, (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers; however, a hearing test shall be a covered service when associated with covered ear surgery.

**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 when the 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.

**Marital therapy.**

**Massage therapy.**

**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, or blood pressure kits except as specifically provided in the section on prescription drugs.

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

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

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

**Personal comfort, hygiene, or convenience items**, including services and supplies

determined to be not medically necessary by Capital Health Plan and not related directly to the care of the covered person, 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 services section, motel/hotel accommodations, air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment.

**Recreational therapy.**

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

**Services or supplies**, that are:

1. Determined not to be medically necessary;
2. Not specifically listed in the covered services section unless the services specifically are required to be covered by state or federal law. Capital Health Plan shall provide coverage on a primary or secondary basis as required by state or federal law;
3. Court-ordered care or treatment, unless otherwise covered in this Health Plan;
4. For the treatment of a condition resulting from:
  - a. War or an act of war, whether declared or not;
  - b. Participation in any act that would constitute a riot or rebellion, or commission of a crime punishable as a felony;
  - c. Engaging in an illegal occupation;
  - d. Services in the armed forces; or
  - e. Intentionally self-inflicted injuries, suicide, or attempted suicide, without regard to the mental state of the covered person.
5. Received before a covered person's effective date or received on or after the date on which a covered person's coverage terminates under this Health Plan, unless coverage is extended in accordance with extension of benefits provisions;
6. Provided by a physician or other health care provider who normally resides in the covered person's home;
7. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;
8. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

9. Supplied at no charge; or
10. Determined by Capital Health Plan not to be the most cost-effective setting, procedure, or treatment.

**Sexual reassignment, reproduction, or modification services**, including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prosthesis, genetic tests to determine paternity or sex of a child, or the insertion of penile prosthesis except when necessary in the treatment of 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 epispidas and exstrophy.

**Sleep therapy.**

**Smoking cessation programs**, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and Nicorette gum or patch.

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

**Transfusion, autologous.**

**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.

**Wigs.**

**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.

## **MEMBER RIGHTS AND RESPONSIBILITIES**

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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 CHP, 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 CHP.
- Expect CHP 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 CHP to provide treatment with courtesy, respect, and with recognition of each covered person's dignity and right to privacy.
- Communicate complaints or appeals about CHP 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 CHP policies.
- Make recommendations regarding CHP's member rights and responsibilities policies.
- Call or write us anytime with helpful comments, questions, and observations, whether concerning something 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 your care. -
- Pay copayments and provide current information concerning the covered person's CHP membership status to any CHP 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, CHP Connect, or through CHP Member Services.
- Follow the coverage access rules in the Member Handbook.

# **FILING A GRIEVANCE OR COMPLAINT**

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## **INTRODUCTION**

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

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

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

## **DEFINITIONS**

The following definitions are applicable to this Complaint and Grievance Process section:

**ADVERSE BENEFIT DETERMINATION** means any denial, reduction, or termination of coverage, benefits, or payment (in whole or in part) under this benefit document with respect to a pre-service claim or a post-service claim. Any reduction or termination of coverage, benefits, or payment in connection with a concurrent care decision, as described in this section, also shall constitute an adverse benefit determination.

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

**CLINICAL GRIEVANCE REVIEW PANEL** means a panel established by CHP to review grievances related to adverse benefit determinations made by CHP that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, does not meet the CHP requirements for medical necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of doctors who have appropriate expertise, and who were not involved in the

initial adverse benefit determination.

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

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

**GRIEVANCE** means a written expression of dissatisfaction. The covered person, a provider acting on the covered person's behalf, another person designated by the covered person, or a state agency may submit a grievance.

**HEALTH CARE SERVICE(S) OR SERVICE(S)** means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, providers.

## **INFORMAL REVIEW—COMPLAINTS**

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

**NOTE:** The covered person must give the Member Services Representative all of the facts relevant to the complaint. A failure to provide any requested or relevant information may delay CHP's review of the complaint. Consequently, the covered person is obliged to cooperate with CHP in its review of the matter.

## **FORMAL REVIEW—GRIEVANCES**

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

If the covered person needs assistance in preparing the grievance, he or she may contact CHP for assistance. Hearing impaired covered persons may contact CHP via TDD at 850-383-3534.

## **Level I Review**

### **Standard Grievances**

To begin the formal review process, the covered person must write a letter explaining the facts and circumstances relating to the grievance. The covered person should provide as much detail as possible and attach copies of any relevant documentation. The Grievance Review Panel will review the grievance in accordance with the standard grievance procedure and advise the covered person of its decision in writing. If the grievance involves a pre-service claim, CHP's decision regarding the grievance will be made within 15 days of receipt of the grievance. If the grievance involves a post-service claim, CHP's decision regarding the grievance will be made within 30 days.

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

### **Request For Clinical Grievance Review**

When a covered person has a grievance that involves an adverse benefit determination that an admission, availability of care, continued stay, or other health care service does not meet CHP's requirements for medical necessity, appropriateness of care, health care setting, level of care, or effectiveness, the covered person may request that the grievance be reviewed by a Clinical Grievance Review Panel. CHP must receive the Clinical Grievance Review Panel request within 30 calendar days from the date that the covered person received the adverse benefit determination. To request this type of review, the covered person must send a written request and supporting documentation within the 30-day time limit to the CHP address listed in the Telephone Numbers and Addresses subsection.

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

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

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

### **Request For Expedited Review**

For a grievance involving an adverse benefit determination, the covered person or a

person acting on behalf of the covered person may request that the review of the grievance be expedited. To be eligible for an expedited review, a grievance (i.e., a request for expedited review) must meet the following criteria as determined by CHP:

1. The covered person must be dissatisfied with a CHP adverse benefit determination;
2. A delay in the provision of health care services for the length of time permitted under the standard grievance procedure timeframes (approximately 30-60 working days) seriously could jeopardize the covered person's life or health or ability to regain maximum function, or in the opinion of a doctor with knowledge of the covered person's condition, would subject the covered person 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 medical service without a guarantee of coverage or payment from the covered person or CHP.

The covered person or a provider acting on behalf of the covered person 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 provided are subject to this expedited review process: (1) pre-service claims; or (2) requests for extension of concurrent care services made within 24 hours before the termination of authorization for those services.

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

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

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

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

CHP will provide written confirmation of its decision concerning a request for expedited review within two working days after providing notification of that decision. If the covered person is not satisfied with the decision, he or she may submit the grievance to the

Subscriber Assistance Panel.

## **Level II Review**

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

## **SUBSCRIBER ASSISTANCE PROGRAM**

The covered person has the right at any time to submit a complaint or grievance to the Florida Department of Financial Services, the Agency for Health Care Administration, or the Subscriber Assistance Program. (The covered person must submit the grievance to the Subscriber Assistance Program within 365 days of CHP's final decision.) Telephone numbers and addresses are listed in the Telephone Numbers and Address subsection below.

The covered person must complete the entire Complaint and Grievance Process and receive a final disposition from CHP before pursuing review by the Subscriber Assistance Program Panel. The Subscriber Assistance Program Panel may choose to investigate any complaint or grievance that it has received before CHP makes its final determination.

## **TIMEFRAMES FOR RESOLUTION OF A GRIEVANCE**

CHP will resolve grievances in a timely manner. In resolving grievances, timeframes may vary, depending on the circumstances, between the Level I and Level II review. CHP will, however, resolve a grievance within 30 days after receipt for pre-service claims or within 60 days for post-service claims.

## **GENERAL RULES**

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

1. The covered person must cooperate fully with CHP in its efforts to promptly review and resolve a complaint or grievance. If the covered person does not cooperate fully with CHP, he or she will be considered to have waived the right to have the complaint or grievance processed within the timeframes set forth above.
2. CHP will offer to meet with the covered person if the covered person believes that a meeting will help CHP resolve the complaint or grievance to the covered person's satisfaction. For the convenience of the covered person, and at his or her option, the covered person may elect to meet with CHP's representatives in person or by telephone conference call. CHP will not reimburse the covered person for travel or lodging in connection with any meeting. Appropriate arrangements will be

made to allow telephone conferencing to be held at CHP's administrative offices within the service area. CHP will make these telephone arrangements with no additional charge to the covered person. The covered person must notify CHP that he or she wishes to meet with CHP representatives concerning the complaint or grievance.

3. The timeframes set forth herein may be modified by the mutual consent of the covered person and CHP; however, any mutually agreed timeframe extension does not preclude the covered person from having CHP's decisions reviewed by the Subscriber Assistance Panel.
4. CHP will not honor a request for expedited review that relates to services that already have been performed or provided to the covered person or a request that is not eligible for expedited review in accordance with the criteria set forth in the Request for Expedited Review subsection. CHP will review any grievance, however, in accordance with the standard grievance procedure.
5. CHP must receive all grievances within one year of the date of the occurrence that initiated the grievance.
6. If the grievance involves a determination that the service did not meet CHP's medical necessity guidelines or is experimental or investigational (or a similar exclusion or limitation), the covered person may request an explanation of the scientific or clinical judgment relied on, if any, that applies the terms of this benefit document to the covered person's medical circumstances.
7. During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.
8. A covered person may ask to review pertinent documents, such as any internal rule, guideline, protocol, or similar criteria relied on to make the determination, and submit issues or comments in writing.

## **TELEPHONE NUMBERS AND ADDRESSES**

A covered person may contact a CHP Grievance Coordinator at the number listed on the membership card or the numbers listed below. If a grievance is unresolved, the covered person may, at any time, contact CHP at the telephone numbers and addresses listed on this page.

### **Capital Health Plan Member Services Department**

1545 Raymond Diehl Road, Suite 300

Tallahassee, Florida 32308

850-383-3311 (Monday through Friday, 8 a.m.–5 p.m.)

TDD: 850-383-3534 (Monday through Friday, 8 a.m.–5 p.m.)

Toll free: 1-800-390-1434 (24 hours a day, 7 days a week)

Florida State Relay: 800-955-8771 (for the hearing impaired, after business hours)

### **Mailing Address**

P.O. Box 15349, Tallahassee, Florida 32317-5349

**Website**

[www.capitalhealth.com](http://www.capitalhealth.com)

**Florida Department of Financial Services**

Division of Insurance Consumer Services

200 East Gaines Street

Tallahassee, Florida 32399-0322

1-800-342-2762

**Subscriber Assistance Program**

2727 Mahan Drive, Building 1, Room 301, Mail Stop-27A

Tallahassee, Florida 32308

850-921-5458

1-888-419-3456

**Agency for Health Care Administration**

2727 Mahan Drive, Building 1, Mail Stop 27

Tallahassee, Florida 32308

1-888-419-3456

## **DEFINITIONS OF SELECTED TERMS**

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

**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 licensed by the appropriate state agency 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 in which births are planned to occur following a normal, uncomplicated, low risk pregnancy. The facility must be licensed under state law. 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.

**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 schedule of member copayments. The copayment shall be expressed as a dollar amount.

**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 health care services and supplies, 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 27.

**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 wellbeing.

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

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

**HOME HEALTH AGENCY** means an agency or institution licensed by the appropriate state agency to provide an approved plan of service for people who are confined and convalescing at home instead of the hospital. 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 on the Accreditation of Hospitals, 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 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** shall mean the services and supplies required to identify or treat the illness, injury, or mental or nervous disorder that a doctor has diagnosed or reasonably suspects. The service must be:

1. consistent with the symptom, diagnosis, and treatment of the patient's condition;
2. in accordance with standards of good medical practice;
3. required for reasons other than convenience of the patient or the doctor;
4. approved by the appropriate medical body or board for the illness or injury in question; and
5. the most appropriate level of medical supply, service, or care that can be provided safely.

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.

**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.

**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:

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.

**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.

**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.

**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 shown in the service area attachment to Capital Health Plan, as approved by the Florida Department of Financial Services.

**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 licensed institution, or a distinct part of a hospital, 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.

**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 of the Accreditation of Hospitals (JCAH) and licensed by the Department of Children and Family Services.

**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.



# 2008 Capital Health Plan

## Schedule of Member Copayments

FOR STATE OF FLORIDA EMPLOYEES

Covered Service	Unit	Copayment
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Hospital Services		
Inpatient hospital charge	Per admission	\$ 250
Outpatient facility charge	Per surgical procedure	\$ 0
Surgeon's charge	Per surgical procedure	\$ 0

Emergency Services		
At hospital in service area	Per occurrence	\$ 50
At hospital outside service area	Per occurrence	\$ 50

Ambulatory Surgical Center Services & Other Licensed Outpatient Medical Treatment Facilities		
Facility charge	Per admission	\$ 0
Surgeon's charge	Per surgical procedure	\$ 0

Medical Services		
Ambulance services	Per trip	\$ 0
Diagnostic procedures, lab tests, X-ray exams or mammograms	Per occurrence	\$ 0
Durable medical equipment	Per device	\$ 0
Hemodialysis	Per treatment	\$ 0
Home health care	Per occurrence	\$ 0
Hospice services	Per occurrence	\$ 0
Maternity care	Per visit	\$ 25
Physician (PCP) office visit	Per visit	\$ 15
Physician (Specialist) office visit	Per visit	\$ 25
Prosthetic or orthotic devices	Per device	\$ 0
Radiation therapy	Per treatment	\$ 0
Rehabilitative services	Per visit	\$ 25
Skilled nursing facility services	Per confinement	\$ 0

Covered Service	Unit	Copayment
<b>Alcoholism and Substance Abuse Treatment</b>		
Inpatient services in a hospital or residential treatment facility	Per admission	\$ 250
Outpatient services	Per visit	\$ 25

<b>Mental and Nervous Disorders Treatment</b>		
Inpatient services in a hospital or psychiatric treatment facility	Per admission	\$ 250
Outpatient services of mental health provider	Per visit	\$ 25

<b>Prescription Drug Benefit</b>		
<b>Pharmacy Purchase:</b>		
Generic prescription drugs	30-Day supply	\$10
Brand - Preferred prescription drugs	30-Day supply	\$25
Brand - Non Preferred prescription drugs	30-Day supply	\$40
<b>Mail Order Purchase:</b>		
Generic prescription drugs (Tier 1)	90-Day supply	\$20
Brand - Preferred prescription drugs (Tier 2)	90-Day supply	\$50
Brand - Non Preferred prescription drugs (Tier 3)	90-Day supply	\$80
Oral contraceptives and supplies, including the insertion and removal of an IUD or diaphragm, contraceptive implants, and contraceptive injections	30-day supply or office visit	Prescription drug or Office visit copayment



**Capital Health**  
P L A N

[www.capitalhealth.com](http://www.capitalhealth.com)



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