Appendix A

Carlyle Place at Home

5300 Zebulon Road
Macon, GA 31210

CONTINUING CARE
MEMBER AGREEMENT

CARLYLE PLACE AND ALL OTHER CONTINUING CARE FACILITIES IN THE STATE OF GEORGIA ARE REGULATED BY CHAPTER 45 OF TITLE 33 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. A COPY OF THIS LAW IS ON FILE AT CARLYLE PLACE. THE LAW GIVES YOU OR YOUR LEGAL REPRESENTATIVE THE RIGHT TO INSPECT PROVIDER'S MOST RECENT DISCLOSURE STATEMENT BEFORE SIGNING THIS AGREEMENT.

March 2018

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CONTINUING CARE
MEMBER
AGREEMENT

THIS MEMBERSHIP AND LIFE CARE AGREEMENT (this "Agreement") is made this _____ day of _____, 20_____ by and between CENTRAL GEORGIA SENIOR HEALTH, INC. doing business as Carlyle Place, a Georgia nonprofit corporation (hereinafter referred to as "Provider") and_____ _____(hereinafter referred to jointly or individually as “Member”).

W I T N E S S E T H:

WHEREAS, Provider owns and operates a continuing care retirement community at 5300 Zebulon Road, Macon, Georgia known as CARLYLE PLACE (hereinafter referred to as “Provider”); and

WHEREAS, Provider plans to provide continuing care at home services to Member through its Carlyle Place at Home program; and

WHEREAS, Member desires to become a member of the program Carlyle Place at Home and use the facilities, programs and services provided by Provider, subject to terms and conditions of this Agreement.

WHEREAS, Member currently resides at _____ (hereinafter referred to as "Home”) and has applied for Membership in a Provider Plan as hereinafter defined; and

WHEREAS, Provider has accepted Member’s application subject to the signing of this Agreement;

NOW, THEREFORE, in consideration of the premises and the mutual covenants and agreements herein set forth, the parties, each intending to be legally bound, do hereby agree as follows:

I. TERMS AND CONDITIONS

A. SERVICES

Provider operates under the concept of continuing care at home, which recognizes the needs of a Member as varying from active independence to increased health care needs. Accordingly, a comprehensive range of services is offered to Member.

Provided that the Member accepts and pays for the Services in the manner set forth in this Agreement and abides by the rules and regulations of Provider with respect to the Services and the Facilities, Provider will provide to Member the Services described in this Agreement (as listed in Attachment I) and in the general conditions as described throughout this Agreement or the terms and conditions hereinafter set forth, in a manner consistent with the objective of enabling Member to continue to live in his/her Home for as long as is practical, or as long as the Member and the Care Coordination Team are in agreement that the plan in place supports safety and independence.

B. MEMBERSHIP CRITERIA

1. **Age** - Member must be at least sixty-two (62) years of age at the time of membership.

2. **Application** - Member shall submit for Provider's review and approval an Application for Membership together with health and financial forms within fifteen (15) days of Member's signing this Agreement. Member will provide updated medical and financial information to Provider, upon written request, should Provider determine that there may have been a material change in either status during said application period. It is Member's responsibility to provide Provider with all required information necessary to evaluate the applicant for membership within these dates.

3. **Physical and Mental Condition** - Member shall submit, within fifteen (15) days of the date of this Agreement, a report of a physical examination of Member made by a physician selected by Member and completed within six (6) months of the date of this Agreement. Such report shall include a statement by such physician that Member is in good health, is ambulatory or can move about independently and is able to take care of himself or herself in normal living activities. Provider may require Member to have a physical examination by the Medical Director at Carlyle Place or by another physician approved by

Provider at anytime deemed necessary by Provider. If the health of Member as disclosed by such physical examination differs materially from that disclosed in Member's Application for Membership, Provider shall have the right to decline admission of Member and to terminate this Agreement. Member shall permit Provider to obtain and review any medical or hospital records related to Member, and Member shall keep Provider informed of any changes in Member's physical or mental condition following completion of the Application for Membership.

4. **Financial -** To qualify for membership and remain a Member in Carlyle Place at Home, Member shall present Provider with written evidence demonstrating that Member has (and is expected to continue to have) monthly income/assets which support ongoing membership in the program. Provider will calculate/forecast estimated expenses.

5. **Discretion** - Member acknowledges and agrees that Provider has the absolute right to reject Member's Application for Membership for any reason.

6. **Summary of Representations** – Member affirms that the representations made in the Application for Membership and the medical and financial forms are true and correct and may be relied upon by Provider as a basis for entering into this Agreement.

7. **Notification** - Provider shall notify Member as early as possible of acceptance or denial of acceptance for membership, but not later than thirty (30) days after Member has completed and submitted to Provider all forms required.

C. PLAN SELECTION AND FEES

Plan options and associated fees are listed in Attachment I. Plan selected _____. The Membership Fee for the plan selected is $_____. The current Monthly Fee for the Plan selected is $_____.

The one-time Membership Fee shall not be increased or changed during the duration of the agreed upon care, except for changes required by State or Federal assistance programs.

Member may change to another Plan under all of the following conditions:

1. Member applies by completing admission documents;

2. Member’s health has not adversely changed since

Member's original application was completed;

3. Member's application to the new Plan has been approved by Provider;

4. Member enrolls in a more comprehensive plan, and

5. Member pays the difference between the pro-rated credit for the original Membership Fee and the Current Membership Fee for the more comprehensive plan

Effective upon the date of the change to the new Plan, Member shall execute a new Member Agreement and shall pay the new Monthly Fee. No change shall be retroactive as to benefits.

D. EFFECTIVE DATE OF MEMBERSHIP

The Membership Date shall be the date the Member receives the fully executed Agreement from the Provider as evidenced by the certified mail return receipt or written acknowledgment of receipt by Member. The Provider will assume none of the responsibilities of this Agreement until such effective date.

E. MEMBERSHIP FEE

Member will pay to the Provider the Membership Fee specified in Section I.C. at the time of enrollment. The Membership Fee will be utilized by the Provider in accordance with the Continuing Care Provider Regulations issued by the Department of Insurance of the State of Georgia. The Membership Fee received by the Provider may be used and applied to any proper corporate purpose of the Provider, whether or not directly related to this Agreement

F. MONTHLY FEE

Provider may adjust the amount of the Monthly Fee as necessary to reflect changes in the costs to the Provider for providing the Services. The Monthly Fee may be adjusted from time to time by the Provider as necessary to anticipate increased or decreased costs to Provider for services for which it is responsible under this Agreement.

No change in the Monthly Fee shall be effective until Member shall have received not less than sixty days advance written notice of such changes, unless such change is required by federal, state, or local law or regulations.

G. INCOME AND ASSETS TO COVER COSTS

Member represents and warrants that Member has sufficient income and assets to cover the costs needed to maintain membership in Carlyle Place at Home as outlined in this Agreement.

H. TERMINATION PRIOR TO THE EFFECTIVE DATE OF MEMBERSHIP DATE

Member may terminate the Agreement at any time prior to receipt of a fully executed copy of this Agreement by written notice of termination to the Provider. In such event, any portion of the Membership Fee already paid will be refunded to Member, without interest, within sixty (60) days.

I. SOLE RESPONSIBILITY ASSUMED BY THE PROVIDER

All legal and financial obligations assumed by the Provider in this Agreement are solely the responsibility of the Provider.

J. ENTIRE AGREEMENT

This Agreement also includes: the Application for Membership, the Disclosure Statement, the Confidential Financial Statement, and the Medical Record. These documents are hereby incorporated by reference and constitute the entire Agreement between the Provider and the Member. Knowing that the Provider will rely on Member's statements made therein, Member warrants that all such statements are true and complete.

K. NOTICES

Notices when required by the terms of this Agreement shall be given to Provider at its administrative office, and, if to Member, at the Member's address given in this Agreement. All notices must be made in writing and can be either personally delivered, mailed or faxed.

L. REGULATORY COMPLIANCE

This Agreement shall not act as a waiver of any provision of the Continuing Care Provider Registration and Disclosure Act of the State of Georgia. Further, no act, agreement or statement of a Member, or of an individual purchasing care for a Member under any agreement to furnish care to the Member, shall constitute a valid waiver of any provision of the Act intended for the benefit or protection of the Member or the individual

purchasing care for the Member. Venue for any dispute arising under this Agreement shall be in Macon-Bibb County, Georgia.

M. SEVERABILITY

Should any portion of this Agreement be ruled invalid by an authority having the power to so rule, this shall not change the validity of the rest of this Agreement.

II. FACILITIES AND SERVICES RENDERED BY THE PROVIDER

Provider is obligated by this Agreement to provide the following Services when they are Determined to be Appropriate by the Care Coordination Team:

These Services must be provided by the Provider or a Plan Participating Facility and/or a Plan otherwise approved by the Provider. The Provider agrees that the Member shall not be liable to a Plan Approved Provider for services rendered under the Member's agreement. In the event a Plan Approved Provider seeks payment from the Member, the Provider shall assume liability for payment of the Services rendered, if the Services rendered are Services which the Provider agreed to furnish to a Member in consideration of the Member's payment of Membership and Monthly Fees. Plan Approved Providers shall include persons rendering Services to a Member as employees of the Provider or of a Plan Participating Facility or Provider, on a fee-for-service basis, or otherwise. PROVIDER WILL PROVIDE THE FOLLOWING AND ONLY THE FOLLOWING SERVICES:

A. CARE COORDINATION

A Care Coordinator will be assigned to the Member. Under the direction of the assigned Care Coordinator, the Care Coordination Team, which shall consist of a representative of Administration or his/her designee, the Medical Director, Director (or his/her designee) and other clinical professionals as determined appropriate by the Care Coordinator, in consultation with the Member and/or the Member's Designated Representative, shall prepare a Care Plan to meet the Member's particular needs annually or as the Member's needs change during the term of the agreement. All decisions involving the Member's care, including Provided Services, if necessary and up to permanent transfer from the Home to Facility-Based Services, will be made by the Care Coordination Team following consultation with the Member or the Member's Designated Representative. The Member's Care Coordinator will contact the Member to assess changes in health and functional status and ensure that Services Provided are appropriate.

B. CARE COORDINATION TEAM

Provider will provide Care Coordination through a team of Professionals including Social Workers, a Medical Director, Registered Nurses, and others experienced in the field of aging and care management. Care Coordinators will contact Members regularly to determine changes in health and functional status in order to Provide Services, according to the Plan chosen to support the Member.

C. MEMBER IN-HOME FUNCTION AND SAFETY ASSESSMENT

During the first year of Membership and every second year thereafter, Provider will provide an In-Home Function and Safety Assessment for the purpose of identifying any functional and safety problems, and will make recommendations to the Member based on the assessment. Provider may require, based on circumstances of previous assessments or the Member's health status or functional capabilities, that the Member permit Provider to provide a more frequent Function and Safety Assessment at Member's Home. Any recommended changes or corrections are the Member's sole responsibility, and it is the Member's choice whether to make the recommended changes or corrections to his/her Home. Provider is not responsible for either making the changes or for covering the cost thereof; however, Provider will assist the Member by making a list of possible vendors of such goods and services. The Member assumes full responsibility for failure to make the improvements recommended in his/her Home.

D. IN-HOME SERVICES

In-Home Services will be Provided as Determined to be Appropriate by the Care Coordination Team. Member must exhibit at least one or more ADL Deficiencies to be eligible for the following In-Home Services and Member must use a Plan Approved Provider to be eligible for coverage. Provider may require an examination by the Medical Director (or his or her designee) to determine eligibility for Services. Providers and or suppliers will file appropriate insurance (Medicare, supplemental or long-term care insurance).

1. **Licensed Nursing Care** – Non-Medicare covered Home Health Services including medication administration and treatments.

2. **Home Health Aides** – For bathing, dressing, and grooming, as well as other ADL functions.

3. **Homemaker Services** – Includes cooking, light housekeeping, and chore services.

4. **Companion Services** – Visiting the Member for conversation and social time, including playing cards, games, or going for a walk; supervision of and assistance with ADLs; medication reminders; and regular telephone calls.

5. **Nutritional Support/Meals** – Meals brought to the Member's Home. The maximum number of meals that will be provided is two per-day. The cost of meals will be incurred by the Member.

6 . **Transportation Services** - If the Member is unable to drive, due to a scheduled procedure, or instructed by his/her physician not to drive, Provider will provide, with advance notice, transportation to and from medically necessary outpatient surgery or short procedures which may include, but is not limited to, cataract removal, chemotherapy and radiation treatments, and surgical biopsies.

This does ***not*** include transportation for regular physician office visits, dialysis, and routine specialist appointments. Assistance in arranging transportation for such may be handled by the Member Coordinator.

7. **Emergency Response System** - A personal emergency response system with 24-hour coverage.

8. **Hospitalization** - Provider will assist, as necessary, in arranging for inpatient hospital care for Member when prescribed in writing by a physician. The Member shall be responsible for all physician and hospital charges.

E. FACILITY-BASED SERVICES

When Determined to be Appropriate by the Care Coordination Team and prescribed by a physician, Provider will provide or cause to be provided, Facility Based Services, including Personal Care/Assisted Living and Skilled Nursing Facility Services. Member (or his or her designee) will be consulted with respect to the choice of available Facility Based Services. Provider may require an examination of Member by the Medical Director (or his or her designee) to determine eligibility for Facility Based Services. Provider will not be responsible for payment of In-Home Services for the Member while in a Personal Care/Assisted Living Facility or Skilled Nursing Facility.

1. **Personal Care/Assisted Living Facility Based Services** - As Determined to be Appropriate by the Care Coordination Team, these Services will be provided in Plan Participating Personal Care/ Assisted

Living Facilities approved by Provider. The Members Care Coordinator will assist the Member in finding a facility of the Member's choice, if a move is required. Provider will not be responsible for any ancillary charges such as laundry, prescription drugs, medical supplies, telephone, television/cable or barber/beauty.

2. **Skilled Nursing Facility Based Services** - As Determined to be Appropriate by the Care Coordination Team, these Services will be provided in Plan Participating Skilled Nursing Facilities approved by Provider. The Members Care Coordinator will assist the Member in finding a facility of the Member's choice, if a move is required. Provider will not be responsible for any ancillary charges such as laundry, prescription drugs, medical supplies, telephone, television/cable, barber/beauty, or incontinence supplies or assistance.

F. INFORMATION AND REFERRAL SERVICES

1. **Referral for Non-Health Care Services** - In addition to the Services outlined in this Agreement, a Referral Service for other services is available with associated additional charges. These may include, but not be limited to, landscape maintenance, legal, financial planning, pet sitting, home maintenance and rental of medical equipment. The Member is solely responsible for the full cost of any goods or services provided.

2. If a Member chooses to use a referral, the Member releases Provider, its officers, directors, agents and employees from any and all liability, due to any injury, damage or loss incurred in connection with the provision of or relating to the provision of any such Referral Service.

G. LIFESTYLE AND WELLNESS PROGRAMS

These programs may be offered from time to time, including but not limited to, exercise classes, arts and crafts, wellness seminars, speakers and day excursions. Members will be advised of the schedules and the cost of these programs (if any) on an as-offered basis.

H. LIMITATION OF PROVIDER PAYMENT FOR NON-INSTITUTIONAL HEALTH CARE SERVICES

Provider will limit payment for In-Home Services (skilled home health care, Home Health Aide, Homemaker, Companion, and Emergency Response System) for the Platinum Plan, Gold Plan and Silver Plan Members if the

aggregate cost of such Services for any thirty (30) day period exceeds the Average Cost of Care in a Skilled Nursing Facility for which the Member would otherwise be eligible. Provider will limit payment for such Services for The Bronze Plan (Home Care Only) Members if the aggregate cost of such services for any thirty (30) day period exceeds the Average Cost of Care in an Assisted Living Facility where the Member would otherwise be eligible. The Average Cost of Assisted Living and Skilled Nursing Care will be published by Provider annually and distributed to Members.

Members of The Platinum Plan, Gold Plan, and Silver Plan may either transfer to a Plan Participating Facility or pay to Provider the difference between the cost of In-Home Services and the Average Cost of Care in the Plan Participating Personal Care/Assisted Living or Skilled Nursing Facility where the Member would be otherwise eligible. This must be approved by the Medical Director in consultation with the Member's physician.

I. USE OF NON-PLAN PARTICIPATING PROVIDERS OF FACILITIES

1. NON-PLAN PARTICIPATING PROVIDERS

Non-Plan Participating Providers may be used within the United States under the following conditions:

a. A Plan Participating Provider is unable to provide Service as requested by Carlyle Place at Home; or

b. Individual circumstances warrant use of a Non-Plan Participating Provider; and

c. Member's Care Coordinator has approved the use of the Non-Plan Participating Provider.

Member may be responsible for arranging for the approved Services from a licensed provider, paying for such Services and submitting appropriate documentation of payment to Carlyle Place at Home, if the Services are provided outside the Designated Service Area.

2. TEMPORARY USE OF NON-PARTICIPATING PROVIDERS

If Member is receiving Services from Provider within the Designated Service Area and wishes to travel outside the Designated Service Area and continue to receive Services, this will be permitted under the following conditions:

a. After joining Provider, Member has been a resident of the Designated Service Area for a period of at least one (1) year before relocating outside the Designated Service Area:

b. Member's personal physician must certify that Member is able to undertake such travel;

c. The Care Plan in effect prior to Member's traveling outside the Designated Service Area, including the type and extent of care, will remain in effect during the period of time Member is traveling outside the Designated Service Area;

d. Member may be responsible for arranging and submitting appropriate documentation of payment to Provider for reimbursement for such services outside the Designated Service Area. Any such Services shall only be provided within the United States and its territories.

3. PERMANENT USE OF NON-PARTICIPATING PROVIDERS DUE TO RELOCATION

If Member has a change of Permanent Residence outside of the Designated Service Area, Non-Plan Participating Providers may be used under the following conditions:

a. After joining Provider, Member has been a resident of the Designated Service Area for a period of at least one (1) year before relocating outside the Designated Service Area;

b. Member is permanently residing within the United States but outside the Designated Service area;

c. Member informs Provider in writing of relocation;

d. Member may be responsible for arranging for the approved Services from a licensed provider, paying for such Services and submitting appropriate documentation of payment to Provider for reimbursement; and

e. Member agrees to pay any costs in excess of the Average Cost of Care in Designated Service Area or above the then current daily Cap.

Provider may, in its sole discretion, engage, at its expense, a geriatric care manager to access care needed and to oversee the delivery of Member's care outside the Designated Service Area.

4. NON-PLAN PARTICIPATING FACILITIES

Member may choose to enter a Non-Plan Participating Skilled Nursing Facility or Personal Care/Assisted Living Facility either within or outside the Designated Service Area with the approval of Member's Care Coordination team as long as the Non-Plan Participating Facility is licensed and in good standing. Provider will pay facility amount not to exceed the average Cost of Care within Designated Service Area or the then current daily Cap.

Provider may, in its sole discretion, engage, at its expense, a geriatric care manager to assess care needs and to oversee the delivery of Member's care outside the Designated Service Area. The Member is responsible for any additional charges.

5. RELEASE OF LIABILITY

If Member chooses to use a Non-Plan Participating Facility or Provider, Member releases Carlyle Place at Home, its officers, directors, agents, and employees from any and all liability, due to any injury, damage, death, or loss incurred in connection with the provision of or relating to the provision of any such services by a Non-Plan Participating Facility or Provider.

J. EXCLUSIONS FOR PRE-EXISTING CONDITIONS

The policy of Carlyle Place at Home is to conduct pre-admission health screenings to review the appropriateness of offering a contract to prospective Members. Prior to becoming a member, a medical application must be approved by the Care Coordination Team. The medical information shall be reviewed to determine that the applicant is an appropriate candidate for living safely in his/her own home. Membership is denied for certain pre-existing conditions or the inability to pass the medical and/or functional assessments.

Provider shall have the right to exclude from its responsibility, costs relating to Pre-Existing Conditions disclosed in the admission assessment or the Report of Member's Personal Physician. Member represents and warrants that all Pre-Existing Conditions which are known to Member have been disclosed to Provider. Those Pre-Existing Conditions to be excluded from Provider's responsibility shall be listed as an addendum to this agreement.

III. MEDICAL AND SURGICAL INSURANCE

A. MEMBER'S OBLIGATION TO CARRY MEDICAL INSURANCE

1. If Member is qualified, Member will become and remain an insured under the Social Security Amendments of 1965 (commonly referred to as "Medicare A and B") or under such programs as may be offered and/or approved by the Provider in the future. Member shall also carry a Medicare Supplemental Policy that meets Provider's required standards of coverage, or the equivalent of Plan C or a Medicare Advantage Plan. A description of the Provider's standards of coverage is attached and made part of this Agreement as Attachment II.

   If for any reason the Provider cannot apply directly for payment for medical Services, Member will apply for payment of any and all amounts payable for Services rendered to Member and for which benefits are available under Medicare or Medicare Supplemental Coverage or a program equivalent in benefits. Reimbursement from such insurance shall become the property of the Provider if the Provider has paid for these Services.

   If a Member is unable or unwilling to qualify as an insured under Medicare and Medicare supplemental coverage or a program equivalent in benefits, such as a Medicare Advantage Plan, Member will be responsible for all payments which would have been made to the Provider by such programs. Member agrees to pay for all insurance required by this Paragraph. Provider-selected Medicare Supplemental Coverage is available, at the Member's option, for an additional charge.

2. If a Member does not have the proper supplemental insurance, he/she will be required to sign an Amendment to the Continuing Care Member Agreement, Waiver of Supplemental Insurance form. The waiver is an acknowledgement of the Member's responsibility for payment in the event any medical liability incurred is not covered by Medicare. This would include, but not be limited to, hospital deductibles, physician deductibles, physician co-insurance and skilled nursing co-insurance.

3. Despite anything in this Agreement to the contrary, the Provider may, by addendum to this Agreement, require Member to carry private medical and surgical insurance, in addition to Medicare Supplemental Coverage or a program equivalent in benefits, in recognition of certain pre-existing medical conditions.

B. EXCESS COSTS

Except as specifically provided by this Agreement, Member shall be solely responsible for services not covered by Medicare Parts A and B and Medicare Supplemental Coverage and for payments exceeding Medicare and Member's Supplemental Coverage limits. Examples may include but are not limited to: hearing aids; eye glasses and refractions; dentistry; dentures; Durable Medical Equipment; organ transplants; orthopedic appliances; occupational, physical and speech therapy; podiatry; hospitalization and professional care for psychiatric disorders; treatment for alcohol or drug abuse medications; chiropractors; renal dialysis; ventilator care; incontinence supplies and assistance; extraordinary treatments; and experimental treatments as reasonably determined by Medical Director.

C. PAYMENT OF BENEFITS

Any such benefits so received by the Member (from any source) as reimbursement for Services furnished by Provider, shall be paid by Member to the Provider as reimbursement for any and all costs incurred by the Provider in furnishing said Services to Member.

D. ANNUAL PHYSICAL EXAMINATION

In order to best serve the Member, Provider requests and Member agrees to undergo an annual physical examination performed by Member's personal physician. Provider requires that a medical report be submitted by Member's personal physician to the Care Coordination Team for review.

IV. ILLNESS OR ACCIDENT

If Member is involved in an accident or suffers an illness while traveling, Member shall make every reasonable effort to notify the Provider as soon as possible. If continued medical care is required, Member shall arrange to return to Home or to Plan Participating Facility as soon as reasonably possible. If a Member has been enrolled for less than 12 months, the Provider will have no responsibility for costs resulting from such accident or illness until Member returns to Home or to Plan Participating or Approved Facilities and becomes subject to the care of Plan Approved Providers and Plan Participating Facilities. Member is entitled to reimbursement for medical costs as may be provided by Medicare supplemental coverage or a program equivalent in benefits, for the care received while away from Home or Plan Participating Facility. See Section II H for use of non-participating facilities.

V. EXCLUSIONS

In addition to the other costs to be paid by Member under Section II and except to the extent covered by Medicare or other insurance, Member will be solely responsible for payment for including but not limited to: audiological tests and hearing aids; eye glasses and refractions; hospitalization; surgeries, dentistry; dentures; dental inlays; Durable Medical Equipment; organ transplants; orthopedic appliances; occupational, physical, and speech therapy; podiatry; hospitalization and professional care for psychiatric disorders; incontinence supplies and assistance; treatment for alcohol or drug abuse; medications; chiropractors; renal dialysis; ventilator care; extraordinary treatments; experimental treatments, professional medical transportation; pharmaceuticals; physician fees; laboratory; and x-ray services. Member will also be solely responsible for all costs relating to health conditions, if any, listed on an addendum to this Agreement, except to the extent covered by Medicare or other insurance. Any such addendum, when dated and initialed by Member and the Provider, becomes part of this Agreement.

VI. DECISIONS INVOLVING PERMANENT TRANSFER FROM LIVING ACCOMMODATION

All decisions involving permanent transfer from Member's current living accommodation (including Home, Personal Care/Assisted Living Facility, Skilled Nursing Facility, Hospice, or hospital), to another accommodation will be made by the Care Coordination Team in consultation with the Member and/or the Member's Designated Representative.

VII. FINANCIAL CONDITIONS

A. MONTHLY CHARGES

1. MONTHLY FEE

From and after the Membership Date, Member will pay to the Provider each month a Monthly Fee in advance. Each member will have the opportunity to set up an automatic fund transfer to pay any charges owed to Provider monthly. The monthly charges shall be paid to the Provider within five (5) days following receipt of the Provider's monthly statement. If the Member fails to make payment on or before the 15th of the month, the Provider reserves the right to levy a late charge of 3%. If Member fails to make payment within thirty (30) days after receiving the statement the Provider may give written notice to the Member that he or she must make payment within 5 days after receiving such notice. If

Member fails to comply with such notice, the Provider may terminate this Agreement in accordance with Section IX.B.3.

2. MONTHLY STATEMENT

The Provider shall present Member a detailed monthly statement including:

a. The Monthly Fee for the current month;

b. Any credits;

c. Charges for additional services rendered during the preceding Month;

d. Any other amounts due the Provider.

3. ADJUSTMENTS TO THE MONTHLY FEE

The Monthly Service Fee rate may be adjusted by Provider from time to time on the basis of its operational experience or to reflect changes in the cost to Provider of achieving its purposes of providing Member with the Services covered by this Agreement. Provider agrees that, in the exercise of its discretion, which shall be binding on Member, it will endeavor to maintain the Monthly Fee at the lowest possible figure consistent with operating on a sound financial basis and with the maintenance of the quality of service the Provider has undertaken to furnish. Provider shall provide Member with written notice of any Monthly Service Fee rate change at least sixty (60) days prior to effective date of such increase, unless such increase is mandated by any State or Federal laws or programs, in which case no advance notice shall be required.

4. INABILITY TO PAY

a. Resident/Member Support Fund

Provider has established a Resident/Member Support Fund and shall use its best efforts to solicit and receive contributions from third parties to enhance and/or endow said Fund for the purpose of providing resources to Residents/Members who experience financial difficulties during their Membership at

Carlyle Place or their Carlyle Place at Home membership. Upon Member's presentation of written evidence to Provider of any material change to Member's financial status, which, in Provider's discretion, qualifies Member for financial assistance, then Member shall qualify for receiving either a loan or a grant from the Resident/Member Support Fund, provided sufficient resources are available. The determination of whether Member qualifies for financial assistance from the Resident/Member Support Fund and the amount of financial assistance available to Member shall be within the sole discretion of Provider.

b. Member's Responsibility

It shall be a condition of receiving a subsidy that Member shall represent that he or she has not made any gift of cash or property prior to the grant of a subsidy, and will make no such gift subsequently, which would further impair Member's ability or the ability of Member's estate to satisfy financial obligations under this Agreement. If Member's income is found to be inadequate to meet his or her responsibilities to the Provider and to pay personal incidental expenses, Member will make every effort to obtain assistance from family connections or other available sources, and if Member can qualify, to take necessary steps to obtain County, State or Federal assistance. Any Member whose Monthly Fee is subsidized wholly or partly by the Provider, shall, from time to time at the request of the Provider, supply the Provider with financial statements and copies of tax returns.

c. Recovery of Provider Subsidy

When any Member whose Monthly Fee has been subsidized wholly or partly by the Provider dies, such Member's estate, if any, shall be liable to the Provider for the full amount of the subsidy received by Member.

B. REFUNDS

1. REFUNDS PRIOR TO EFFECTIVE DATE OF MEMBERSHIP

A Member, who, through death, illness, injury or incapacity, is precluded from beginning Membership under the terms

of this Agreement, shall receive a refund, without interest, of any portion of the Membership Fee already paid.

2. SEVEN DAY ADJUSTMENT / RESCISSION PERIOD

Member may terminate this Agreement without penalty or forfeiture, by giving Provider written notice within seven (7) days after the date of signing this Agreement by Member, in which event Provider shall refund to Member the entire amount of monies paid by Member within thirty (30) days. During such 7-day period Member's monies shall be held in an escrow account.

3. TERMINATION OF AGREEMENT AFTER ADJUSTMENT/RESCISSION PERIOD OTHER THAN BY DEATH

In the case of any termination after the Adjustment/Rescission Period, the Membership Fee will be refunded, less a 4% charge and 2% per month from the Membership Date to the month of termination.

4. PERMANENT RESIDENT OF PERSONAL CARE/ASSISTED LIVING OR SKILLED NURSING FACILITY

When a Member becomes a permanent resident of a Personal Care/Assisted Living or Skilled Nursing Facility as provided in Section VI, no refund of the Membership Fee will be paid until termination or death.

5. REFUNDS OF MEMBERSHIP FEE UPON DEATH

Should death occur within the first 90 days after enrollment, the membership fee, less a 4% charge and any actual cost to the Provider for services provided to the Member, will be refunded. After the 90th day no membership fee is refunded unless a Refundable Membership fee was originally selected and noted in the agreement.

6. PAYMENT OF REFUNDS

When either the Member or the Provider terminates this agreement, any refunds of Membership Fee shall be paid to Member within sixty (60) days provided that all outstanding charges have been paid. All refunds specified in Section VII. B. shall be without interest.

VIII. RIGHTS AND OBLIGATIONS

A. RIGHT OF ENTRY

Member recognizes and accepts the responsibility of the Provider to enter Member's Home in order to carry out the purpose and intent of this Agreement. The purposes for which such entry may be made include but are not limited to:

1. Response to the Emergency Response System,

2. Entry by authorized personnel if Member is reported missing or has not responded to calls,

3. Performance of other scheduled In-Home Services and meetings with Provider Care Coordinators.

The Provider recognizes Member's right to privacy and its responsibility to limit entry to the Member's Home to legitimate emergencies and scheduled work as set forth in this Agreement.

B. RIGHT OF PROPERTY

The rights and privileges granted to Member by this Agreement do not include any right, title, or interest in any part of the personal property, land, buildings, and improvements owned or administered by the Provider. Nothing contained in this Agreement shall be construed to create the relationship of landlord and tenant between the Provider and Member. Member's rights are primarily for Services. Any rights, privileges or benefits under this Agreement shall be subordinate to any mortgage on any of the premises or interest in real property of the Provider, to all amendments, modifications, replacements or refunding, of any such mortgage, and to such reasonable rules and regulations on the use of all Provider property as shall from time to time be imposed by the Provider. Member agrees, upon request, to execute and deliver any document which is required by the Provider, or by the holder of any such mortgage, to effect such subordination or to evidence the same.

C. RESPONSIBILITY FOR DAMAGES

Any loss or damage to property of the Provider or other Plan Participating Facility or Provider caused by the negligence of Member shall be charged to and paid for by Member. If any negligence of another person results in injury or damage to Member, or damage to Member's property,

the Provider assumes no responsibility therefore, and Member hereby releases and discharges the Provider from all liability or responsibility for such injury or damage caused by the fault or negligence of other persons. Any loss or damage to Member's property caused by the fault or negligence of the Provider's employees, agents or representatives shall be charged to and paid for by the Provider.

D. RESPONSIBILITY FOR PROTECTION OF MEMBER'S PROPERTY

The Provider shall not be responsible for the loss of any property belonging to Member due to theft, fire, or any other cause, except as delineated in Section VIII C. above. Member is required, at his or her own expense, to provide insurance to protect against any such loss and liability. The Member shall insure his/her property and person against casualty and theft, in addition to having coverage for any damage to Provider or other Members that may be a result of actions caused by the Member. Provider shall not be responsible for damage or loss of any of the Member's property by casualty, theft or other cause. The Member shall provide Provider with Certificates of Insurance verifying required coverage. Polices shall be endorsed so as to provide that Provider shall receive 30 day's prior written notice of cancellation or non-renewal.

E. RIGHT TO CONFIDENTIALITY

Except as may be required by law or by the order of court, and except as may be necessary to enable Provider to obtain reimbursement or payment by insurers and other third party payors, Provider will hold all Medical Records and other information concerning the medical condition of the Member confidential and will not disclose such information or records except as directed or permitted by the Member. In addition, Provider will hold Member's Confidential Financial Statement and associated materials confidential. Provider may use aggregate information from the Medical Records and confidential financial statements of Members so long as individual Member information remains anonymous in accordance with Health Insurance Portability and Accountability Act of 1996 regulations. This right to confidentiality shall apply whether Member withdraws from the Plan or dies.

F. TRANSFER TO INDEPENDENT LIVING

Member shall have the opportunity to transfer to an Independent Living unit at Carlyle Place. Member(s) with the Bronze plan must qualify both financially and medically at the time of such transfer in order to receive Life Care benefits. Other plan members will be required to qualify financially, and upon agreement of Provider to allow such transfer to Independent Living, Provider shall credit 100% of the Membership Fee of non-Bronze Plans toward the Entrance Fee as reflected in the Member's

Purchase Agreement.

IX. TERMINATION

A. ADJUSTMENT/RESCISSION PERIOD

During the Adjustment/Rescission Period, either the Provider or Member may terminate this Agreement by giving written notice to the other of the intent to do so. On the effective date of such termination, Member's obligation to pay the Monthly Fee shall cease and Member shall be entitled to a refund as provided in Section VII.B.2.

B. AFTER ADJUSTMENT/RESCISSION PERIOD BUT PRIOR TO DEATH

1. Termination by Member

Member shall have the right at any time to terminate this Agreement by advising the Provider in writing by Certified Mail with return receipt requested at least thirty (30) days in advance of the effective date. The written notice need not cite a specific reason for the termination, but it shall state a date when the termination is to become effective. Upon the date when termination becomes effective, Member's obligation to continue to pay the Monthly Fee shall cease and Member shall be entitled to a refund of the Membership Fee subject to the limitations provided in Section VII.B.3.

2. Termination by Provider

The Provider reserves the right to terminate this Agreement for just cause which, in the judgment of the Provider, shall be good and sufficient and shall include, but not be limited to, any one or more of the following: failure on the part of the Member to abide by the rules adopted by the Provider, making of any material misrepresentation or omission in connection with application papers, including medical and financial records; a breach by Member of any other material terms of this Agreement or for other reasons set forth in this Agreement which Member has not cured to the satisfaction of Provider within 30 days of written notice from Provider of intent to terminate. Provider shall then serve a second written notice of termination specified to be effective on a date no less than 60 days or more than 120 days after the date of the second written notice. Upon the effective date, Member's obligation to continue to pay the Monthly Fee shall cease and Member may be entitled to receive a refund of a portion of the Membership Fee subject to the limitations provided in Section VII.B.3. minus a charge of 4% of the Membership Fee for processing. A Member may request a hearing with the Executive

Director and a representative of the Board of Directors of Provider to contest the Provider's decision in this matter.

3. Termination for Non-Payment of Charges
Notwithstanding Section VII.A.4.a., non-payment of charges shall be considered just cause for termination of this Agreement.

C. TERMINATION FOR INABILITY TO PAY CHARGES

Member's Agreement shall not be terminated for inability to pay the charges until the entire Membership Fee has been earned by the Provider. For purposes of this paragraph only, the Membership Fee will be earned at 2% of the Membership Fee per month for each month of in-home occupancy, 3% of the Membership Fee per month for each month of occupancy in a Personal Care/Assisted Living Unit and 4% of the Membership Fee per month for each month of occupancy in a Skilled Nursing Facility plus a one-time charge of 4% of the Membership Fee for processing. If Member is unable to and fails to pay the required charges, if the Membership Fee is exhausted and if the Provider elects to terminate this Agreement, Member will be given 90 days notice of such termination. In no event will the Member be required to withdraw from enrollment from Provider within 90 days of the date the Member failed to pay the monthly charges.

D. TERMINATION BY DEATH

Unless previously terminated by its own provisions, this Agreement shall terminate at the death of Member, whereupon all obligations of the Provider under this Agreement, other than those relating to payment of refund, if any, shall cease.

E. RELEASE UPON TERMINATION

Upon termination of this Agreement, the Provider is released from any further obligations to provide services as outlined in this Agreement, to Member or Member's estate except for the payment of any refund which may be due under the Agreement.

X. OTHER CONDITIONS

A. ARRANGEMENTS FOR GUARDIANSHIP

If Member becomes unable to care properly for himself/herself or his/her

property and has made no other designation of a person or legal entity to serve as guardian or trustee, or under a power of attorney, then Member hereby authorizes the Provider to refer Member to the Area Agency on Aging in the county in which the Member resides to serve as legal guardian when approved by a court as provided by law.

B. MEMBER'S OBLIGATION TO THE PROVIDER FOR ARRANGEMENTS CONCERNING DEATH

A Member who has become a Permanent Resident of a Plan Participating Facility agrees to furnish the facility with the following information prior to the admission date: name and address of funeral director, location of will, name and address of lawyer, executor, names and addresses of any banks, trust officers, agent, etc.; information necessary to complete a death certificate and whom to notify, and persons to whom Member's tangible property is to be delivered. Member is encouraged to complete and file with Provider an Advance Directive (Living Will) within 60 days of Membership Date.

C. LIMITATION OF LIABILITY IN CASE OF REFUSAL TO LEAVE HOME SITE

If the Care Coordination Team reasonably determines that it would be injurious to the health or safety of the Member to remain in his/her Home and that therefore the Member should become a resident in a Plan Participating Facility, and Member refuses to make such move, or if a Member refuses any other reasonable recommendation of the Care Coordination Team, Provider shall have no responsibility or liability for the consequences of such refusal. Provider has the right to terminate Agreement pursuant to Section IX.B.2.

D. DELEGATION BY DIRECTOR OR MEDICAL DIRECTOR

It is understood that any authority or responsibility given by this Agreement to the Director or Medical Director may be delegated by him or her to any one or more Members of the Provider's staff.

E. NONDISCRIMINATION POLICY

It is understood and agreed that neither race nor color nor religion nor sex nor national origin nor marital status nor any other grounds which are prohibited by law, shall have any bearing upon the acceptance or rejection of candidates for Membership in Plan.

F. RULES ADOPTED BY THE PROVIDER

The Provider reserves the right to adopt policies, procedures and rules regarding Membership consistent with the provisions of this Agreement, and Member agrees to observe such policies, procedures and rules.

G. MARITAL STATUS CHANGE

Should there be a change in marital status, in order to qualify for Membership a new spouse will have to meet the current financial and health requirements for Membership in Carlyle Place at Home; however, the current Membership fee will be adjusted to reflect the discount given to couples upon acceptance of the new spouse into Provider for both partners.

H. REQUIRED NOTICE OF RELOCATION FROM HOME

Member shall not relocate from the Home without notifying Provider in writing.

I. RIGHT OF SUBROGATION

In case of injury to the Member by a third party, Provider shall have the right to subrogation for all its costs and expenses incurred by reason of such injuries, and shall have the right, in the name of the Member or otherwise, to take all necessary steps and procedures to enforce the payment of the same by the person responsible for said injury.

J. APPEAL PROCESS

1. MEMBER'S RIGHT TO APPEAL

The Member has the right to appeal decisions in connection with Section # (Facilities and Services Rendered by Provider) including Subsection # (Decisions Involving Permanent Transfer from Living Accommodation) and Section # (Right of Subrogation) in accordance with the procedures set forth in this Section #.

2. WHO MAY APPEAL

The Member or Member's Designated Representative has the right to appeal. The family members of a Member may advocate for or encourage the Member to appeal, but cannot themselves appeal, except where the family member has been appointed the Member's Designated Representative. The Care Coordinator may act as an advocate for the Member or may facilitate the appeal, but the Care Coordinator cannot appeal him/herself.

3. APPEAL PROCESS — LEVEL I

a. The Care Coordinator shall record all requests to appeal.

b. The Member shall promptly initiate appeal procedures by telephoning the Member's Care Coordinator; or

c. Informing Provider in writing of the Member's desire to appeal.

d. The Program Director of Provider shall perform a prompt, independent review of the case, and shall notify the Member of the review decision within ten business days.

4. APPEAL PROCESS — LEVEL II

If the Member promptly notifies the Program Director of Provider in writing of the desire to appeal the review decision, the case will be reviewed promptly by the Care Coordination Team. The Program Director of Provider shall notify the Member of the Care Coordination Team's decision within 30 calendar days.

5. APPEAL PROCESS — LEVEL III

If the Member promptly notifies the Program Director of Provider in writing of the desire to appeal the Care Coordination Team's decision, the case will be reviewed promptly by the Program Director, the Medical Director, a representative of the Board of Directors of Provider, and a representative designated by the Member. The Program Director of Provider shall notify the Member of the Level III decision in writing within 30 calendar days.

6. NO FURTHER APPEAL

The Member shall have no right to appeal a Level III decision.

PROVIDER RESERVES THE RIGHT TO MODIFY THE TERMS OF THE MEMBERSHIP AGREEMENTS PROSPECTIVELY. ANY SUCH MODIFICATION WILL NOTADVERSELY AFFECT EXISTING MEMBER AGREEMENTS.

Date:_____ By:_____
Director or other authorized signatory

NOTICE TO THE MEMBER: YOU HAVE THE RIGHT TO CANCEL THIS AGREEMENT BY SENDING OR DELIVERING WRITTEN NOTICE OF CANCELLATION TO THE PROVIDER BY MIDNIGHT OF THE SEVENTH CALENDAR DAY FOLLOWING THE DAY ON WHICH IT WAS EXECUTED BY BOTH PARTIES. SUCH CANCELLATION IS WITHOUT PENALTY AND ALL DEPOSITS MADE BY YOU SHALL BE PROMPTLY REFUNDED (WITHOUT INTEREST) EXCEPT FOR EXPENSES INCURRED BY THE PROVIDER AT YOUR REQUEST.

Member

Date:_____ _____
Signature

_____ _____
Witness Address

ATTACHMENT I
LEVELS OF COVERAGE

Type of Service	Platinum Plan 10% Co-Pay	Gold Plan 25% Co-Pay	Silver Plan 50% Co-Pay	Bronze Plan Home Care Only
Care Coordination	100%	100%	100%	100%
HOME SERVICES				
Licensed Nurse Visits	90%	75%	50%	100%
Companion/Homemaker	90%	75%	50%	100%
24-Hour Live-In Companion	90%	75%	50%	100%
Home Health Aide	90%	75%	50%	100%
Emergency Response	90%	75%	50%	100%
Transportation Coordination	100%	100%	100%	100%
FACILITY SERVICES				
Personal Care/ Assisted Living				
First 100 Days	90%	75%	50%	-------
Over 100 Days	90%	75%	50%	-------
Skilled Nursing* **				
First 100 Days	90%	75%	50%	-------
Over 100 Days	90%	75%	50%	-------

** Excludes services rendered during the applicable waiting period or until the Member meets his/her financial responsibility.
*** Excludes Medicare skilled nursing care coverage or that of other third party payor.
Coverage subject to Average Cost of Care as defined in Section III G of Member Agreement

ATTACHMENT II

Carlyle Place at Home
Medicare and
Supplemental Insurance
Requirements

The following represents the basic insurance benefits required by Provider. If a Member's insurance does not meet these requirements, an addendum to the Agreement must be signed. Most of these requirements can be met by various insurance plans, such as Medicare and a Supplemental Plan, an HMO or Medicare Advantage Plan that contracts with Carlyle Place, Plan Participating facilities or a major medical plan.

Medicare Parts A and B and Supplemental Insurance:

Hospitalization: Semi-private room and board, general nursing and miscellaneous services and supplies for 365 days each year paid for at a minimum of 100% of the current Medicare fee schedule.

Medical Expenses: All outpatient or hospital services such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, paid for at minimum of 100% of the current Medicare fee schedule.

Skilled Nursing Facility Care: Up to one hundred days of skilled nursing care paid for at a minimum of 100% of the current Medicare fee schedule.

Homeowners or Renters Insurance: Policy covering protection liability, contents, and physical damage to the property.

ATTACHMENT III
Definitions

I. **DEFINITIONS** – Except as otherwise defined by this Agreement the terms set forth below shall have the following meanings ascribed thereto:

The Act means the Official Code of Georgia Annotated Title 33 Chapter 45 Paragraph 10 (33-45-10).

Activities of Daily Living (ADLs)
The ability to perform routine activities of daily living is used as a basis for determining functional independence for Provider. Following is a list of those activities:

Bathing
Dressing/Grooming
Eating
Toileting/ Continence
Mobility/Transferring

ADL Deficiencies means an inability to perform activities of daily living (bathing, dressing/grooming, eating, toileting/continence and mobility/transferring) without assistance or at all, as determined by the Care Coordination team.

Admissions Documents are those documents required in connection with Member's admission to the Plan. Admissions Documents include:

- **Application for Membership** means the Membership Application completed by the Applicant.

- **Confidential Financial Statement** means the personal financial statement of Applicant, disclosing such information as Provider requires to ensure Applicant's income and assets are sufficient for Applicant to participate in the program.

- **Applicant's Self-Assessment** means the Applicant's assessment of his or her physical and emotional health completed by Applicant.

- **Report of Applicant's Personal Physician** means the information and history obtained by Provider from Applicant's personal physician.

- **Report of Plan Medical Director** means the report of the Plan's Medical Director of the medical evaluation of Applicant.

- **Pre-admission Functional Review -** the assessments completed by Provider to understand the Applicant's level of independence.

Adjustment/Rescission Period means the seven (7) day period immediately following the Membership Date (as defined in paragraph II C hereof) during which Member can rescind this Agreement under the conditions outlined throughout this Agreement.

Agreement means the Continuing Care at Home Agreement**.**

Application Fee means the non-refundable fee paid by the prospective Member to Provider in connection with Member's application for membership in the Plan.

Average Cost of Care in a Skilled Nursing Facility means the average daily, monthly or yearly cost of care in a Plan Participating Skilled Nursing Facility as calculated and published annually by Provider.

Average Cost of Care in a Personal Care/Assisted Living Facility means the average daily, monthly or yearly cost of care in a Plan Participating Personal Care/Assisted Living Facility as calculated and published annually by Provider.

Cap means the maximum daily amount paid by the Provider for services covered under the agreement.

Care Coordination Team means the persons appointed by Provider for Member, comprised of the Care Coordinator (or his or her designee), a representative of administration, and, in the case of medical health care services, the Plan's Medical Director (or his or her designee), and other clinical professionals as deemed appropriate, in consultation with the Member and/or Member's designee. The Care Coordination Team may, at Provider's sole discretion, change from time to time both as to titles and personnel.

Care Coordinator means the person(s) appointed by Provider to be responsible for handling needs of the Member for Services and for conducting specific needs assessments and making recommendations for Services, subject to review and final determination of the Member's eligibility for Services by the Care Coordination Team.

Care Plan means the written plan of long-term care Services, including type of Service, start date, quantity, frequency, duration of Service, name of Plan Participating Provider or Facility and any special considerations, which is developed and approved by the Care Coordination Team for the Member based on a comprehensive needs assessment. The Care Plan is agreed to and signed by the Member.

Co-Payment means the amount a Member would pay toward services based upon the Plan level selected.

Companion means a person designated by the Provider to provide companion services to a Member at the Member's Home..

Companion Services means those services provided by a companion which may include visiting a Member for conversation and social time, including playing cards, games or going for a walk, supervision of and assistance with activities of daily living, medication reminders, and regular telephone calls.

Designated Service Area means Provider's area of coverage for Services, as defined by Provider. The Designated Service Area may be altered from time to time at the sole discretion of Provider. No change in the Designated Service Area by Provider will adversely affect this Agreement.

Determined to be Appropriate means that the Care Coordination Team, utilizing industry standards and accepted standards of healthcare practice, has assessed a Member's medical and functional status and concluded that Services are necessary and will be provided by the Provider.

Disclosure Statement means the Disclosure Statement of the Provider provided pursuant to the Act.

Durable Medical Equipment means items which can withstand repeated use, are primarily and customarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, are appropriate for use in the home, and do not serve as comfort/convenience items. Many such items are paid for by third party health coverage, many are not.

Emergency Response System means an in-home 24-hour electronic alarm system activated by a signal to a central switchboard at a responder organization. This system allows Members to secure immediate help in the event of a medical, physical, emotional or environmental emergency. The Member agrees to allow Provider's contracted or designate responders, to have access to the home in the event of an emergency.

Facility-Based Services means services provided in a facility other than the home, including Personal Care/Assisted Living and Skilled Nursing Facilities as defined below.

> **Personal Care Home** means a facility licensed in accordance with State of Georgia Department of Community Health regulations applicable to Personal Care Homes which provides assistance with personal hygiene and tasks of daily living and medications, as well as social services, independent and group activities, dietary services and limited nursing services, (e.g. Stafford Suites, Cambridge Court).

Assisted Living Facility means a facility licensed in accordance with State of Georgia Department of Community Health regulations applicable to an Assisted Living Facility, which provides assistance with personal hygiene and tasks of daily living and medications, as well as social services, independent and group activities, dietary services and limited nursing services.

Skilled Nursing Facility means a facility which meets the Medicare definition of a Skilled Nursing Facility and provides long term care and skilled level nursing care services in accordance with State of Georgia Department of Health regulations applicable to Skilled and Long Term Care Nursing Facilities, (e.g. Harrington House.)

Health Insurance Portability and Accountability Act (HIPAA) is a law that creates a national standard to protect individual's medical records and other personal health information.

Home means the primary residence exclusive of Personal Care/Assisted Living or Skilled Nursing Facility.

Home Health Services means services of Registered or Licensed Nurses and certified home health aides provided by an agency operating in accordance with State of Georgia Department of Health regulations applicable to Home Health Care Agencies and the Centers for Medicare and Medicaid Services (CMS) regulations applicable to Medicare Certified Home Health Care Agencies.

Home Health Aide means a qualified person to provide assistance with personal care and designated by the Provider to provide Home Health Aide Services to a Member at the Member's Home.

Home Health Aide Services may include assistance with bathing and dressing, an established activity regimen such as range of motion exercises, nutritional needs such as feeding assistance and simple maintenance of the Member's environment.

Homemaker means a person designated by the Provider to provide Homemaker Services to a Member at the Member's Home

Homemaker Services are services provided by a Homemaker which may include assistance with day-to-day chore activities in the Home such as cooking, dishwashing, laundry, light housekeeping and errands.

Hospice is a provider, licensed by the state, primarily engaged in providing end of life care to individuals. Hospice is a Medicare benefit.

In-Home Function and Safety Assessment means the evaluation conducted by an occupational or physical therapist to assess the Member's functioning and safety within

the Home and to make recommendations for appropriate adaptations. The cost of any home adaptation is the Member's sole responsibility.

In-Home Services means Services provided by the Plan in a Member's place of residence indicated in this Agreement.

Medical Director means a physician duly licensed to practice medicine appointed by Provider to review the provision of medical and health care services provided to Members. Any designee of the Medical Director must meet these licensure qualifications.

Medical Record means all records relating to Member's medical history and condition, which may be maintained by Provider or by a facility or provider, as outlined in HIPAA standards.

Medicare means the Health Insurance for the Aging Act, title XVIII of the Social Security Amendment of 1965, as amended and Regulations promulgated there-under or any subsequent legislation or regulations dealing with the same or similar subject matter.

Medicare Covered Services means all hospital, skilled nursing, home healthcare, medical and other services eligible for payment by Medicare Parts A and B for persons 65 years of age or older or those under 65 whose disabilities or end-stage renal disease have been approved for Medicare coverage.

- **Part A** - Helps pay for inpatient hospital admissions, skilled nursing facilities, hospice care and some home health care. Part A is paid for through Social Security Taxes.

- **Part B** – Helps pay for doctor's services, outpatient hospital care, and some other medical services that Part A does not cover such as the services of physical and occupational therapists and some home health care. Medicare Part B pays for these services and supplies when they are medically necessary. In order to receive Part B benefits, the eligible individual must sign up upon reaching age 65 or when enrolling for Social Security and Part A benefit.

- **Medicare Advantage Plan** means a Medicare certified managed care organization which provides all Medicare covered hospital, skilled nursing, home care and primary care and medical services for those Members enrolled in such a program.

- **Medicare Supplemental Coverage (Medigap)** means a private health insurance plan which is certified by the Secretary of Health and Human Services as meeting federal requirements for Medicare supplemental policies. In general, Medicare Supplemental Insurance, also known as Medigap

Insurance or Secondary Insurance pays some of the balance of the costs of care covered by Medicare Parts A and B when full costs are not paid by Medicare. It pays for certain deductibles and co-payments.

Member or you: The person who executes this Agreement as Member.

Member's Designated Representative means any person appointed by Member to represent Member's interests including Member's agent or guardian appointed by a court.

Member's Health Status Confirmation means confirmation by Member at the time of signing of the Agreement that his or her health has not changed since the Membership Application was completed.

Membership Date means the date the Member receives the fully executed Agreement from the Provider as evidenced by the certified mail return receipt or written acknowledgement of receipt by Member. The Provider will assume none of the responsibilities of this Agreement until such effective date.

Membership Fee means the one-time fee paid by Member to Provider upon signing of this Agreement.

Monthly Fee means the amount billed by Provider (in accordance with the Plan selected by Member upon enrollment) to Member on a monthly basis.

Monthly Statement means the bill presented by Provider to Member each month outlining all amounts due to Provider, which includes the monthly fee and co-payments or other charges due to Provider.

Nutritional Support means assistance accessing nutritional resources including meals.

Permanent Resident means a Member who has resided in a Personal Care/ Assisted Living or Skilled Nursing Facility for 100 consecutive days, and has been determined to be a Permanent Resident with respect to such Facility by the Care Coordination Team.

Plan means the option which Member selected upon enrollment.

Plan Participating Facility means a Personal Care/Assisted Living and Skilled Nursing Facility having an agreement with Provider to supply Facility Based Services according to the definition of Facility Based Services to Members.

Plan Participating Provider means a health care provider having an agreement with Provider to provide health care and in-home services to Members and which is not a Plan Participating Facility.

Non-Plan Participating Provider means a health care provider not having an agreement with Provider to provide health care services to Members.

Non-Plan Participating Facility means any Skilled Nursing Facility or Personal Care/Assisted Living Facility not having an agreement with Provider.

Plan Participating Personal Care Home means a facility owned, leased or contracted with by Provider which provides assistance with personal hygiene and tasks of daily living and medications, as well as social services, independent and group activities, dietary services, and nursing services provided for in accordance with State of Georgia Department of Community Health regulations applicable to Personal Care Homes.

Plan Participating Assisted Living Facility means a facility owned, leased or contracted with by Provider which provides assistance with personal hygiene and tasks of daily living and medications, as well as social services, independent and group activities, dietary services, and nursing services provided for in accordance with State of Georgia Department of Community Health regulations applicable to Assisted Living Facilities.

Plan Participating Skilled Nursing Facility means a facility owned, leased or contracted with by Provider, which meets the Medicare definition of a Skilled Nursing Facility and provides skilled nursing care services in accordance with the State of Georgia Department of Health regulations applicable to Skilled Care Nursing Facilities.

Pre-existing Condition means a disease, illness, sickness, mental or physical condition for which medical care, advice or treatment was recommended by or received from a physician, within the five (5) year period preceding the date of Member's admission to the Plan.

Promptly, as appears in the Appeal Procedure, means no more than seven (7) business days absent unusual circumstances.

Provide means that Provider will directly or through a Plan Participating Provider or Facility make services available at Provider cost, subject to applicable co-payments, deductibles and limitations.

Prevailing Rate for a Plan Participating Facility means the current per diem rate charged by a particular Plan Participating Facility.

Referral Service means a service whereby Provider, acting as an intermediary between Member and third party vendors of such services, makes referrals to

Member for such services as Member may choose, at costs payable in full by Member. Provider makes no warranties as to the suitability of such a service provider and assumes no liability for the actions of any such providers.

Services means any assistance, including care coordination, Member in-home functional assessment, In-Home Services (including Skilled Nursing, Homemaker Services, Companion Services, and Emergency Response System), Facility Based Services (including Personal Care/Assisted Living and Skilled Nursing Facility), transportation coordination services, referral services and lifestyle and wellness programs, that are provided to Members of Provider at Provider's cost, subject to applicable plan co-payments and deductibles.

Skilled Nursing Facility Care means care in a licensed nursing home for someone with a medical condition that is generally paid for by medical insurance and often requires physical, speech, occupational, IV therapies or other highly technical services.