

State Employees' PPO Plan

Group Health Insurance Plan Booklet
and Benefits Document

Effective January 1, 2019



State Employees' PPO Plan Group Health Insurance

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This Plan Booklet and Benefits Document replaces any other brochure or booklet printed prior to January 1, 2019, relative to the Plan and shall remain in effect until further notice. The State Employees' PPO Plan is further subject to federal and State of Florida laws and rules promulgated pursuant to law, including, but not limited to, Chapter 60P of the Florida Administrative Code.

In any instance of conflict, the provisions of this Plan Booklet and Benefits Document shall take precedence over provisions of law, so far as legally permitted. Any clause, section or part of this Plan Booklet and Benefits Document that is held or declared invalid for any reason shall be eliminated, and the remaining portion or portions shall remain in full force and be valid, as if such invalid clause or section had not been incorporated herein.

This Plan contains a deductible provision. Details on deductible dollar amounts and when deductibles may be applied can be found in sections 1 and 2, depending on the Plan you choose.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED.
You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 16-6 for more details.

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Important Information About the Plan

Plan Administrator

Division of State Group Insurance
P.O. Box 5450
Tallahassee, FL 32314-5450
(850) 921-4600; (800) 226-3734

The Division of State Group Insurance (DSGI), within the Department of Management Services, has been designated by the Florida Legislature as the entity responsible for administering state employee benefits, including the State Employees' PPO Plan (PPO Plan or Plan).

DSGI is authorized to provide health insurance coverage through fully insured or self-insured plans. This preferred provider organization (PPO) Plan is a self-insured plan. This means that claims are paid from a fund established by the State of Florida (State). Because this Plan is self-insured, the Plan does not have to pay typical insurance company fees, such as retention, reinsurance, premium taxes and other insurance-related charges.

DSGI has full and final decision-making authority concerning eligibility, coverage, benefits, claims, and interpretation of the Plan's Benefits Document.

Final decisions concerning the existence of coverage or benefits under the Plan shall not be delegated or deemed to have been delegated by DSGI. DSGI and the Medical and Prescription Drug Program Third Party Administrators hired by DSGI are responsible for processing claims in accordance with the terms of the Benefits Document.

Medical Claim Administrator

Florida Blue
P.O. Box 2896
Jacksonville, FL 32232-0079
(800) 825-2583
www.floridablue.com or
www.floridablue.com/state-employees

Florida Blue is a trade name for Blue Cross and Blue Shield of Florida, Inc. (BCBSF). Florida Blue provides claim processing services, customer service, provider network access, medical coverage guidelines, and utilization and benefit management services. Benefits are available through Florida Blue's Preferred Patient CareSM PPO, which is a network of preferred providers established by Florida Blue.

Florida Blue does not assume any financial risk or obligation with respect to claims.

Prescription Drug Program Claim Administrator

CVS Caremark
(888) 766-5490
www.Caremark.com

CVS Caremark provides prescription drug utilization and benefit management services. CVS Caremark also provides prescription drug claims payment services, retail pharmacy access, mail order services and clinical management services.

Plan Documents

The descriptions contained in this document are intended to provide a summary explanation of your benefits. Easy-to-read language has been used as much as possible to help you understand the terms of the Plan.

Your insurance coverage is limited to the express written terms of this Benefits Document. Your coverage cannot be changed based upon statements or representations made to you by anyone, including employees of DSGI, Florida Blue, CVS Caremark, People First or your employer.

Rights to Employment

The existence of this Plan does not affect the employment rights of any employee or the rights of the State to discharge an employee.

Rights to Amend or Terminate the Plan

The State has arranged to sponsor this Plan indefinitely, but reserves the right to amend, suspend, or terminate it for any reason. Plan fee schedules, allowed amounts, allowances, Physician and pharmacy network participation status, medical policy guidelines, prescription Preferred Drug List (PDL), maintenance medication list, Specialty (drug) Management Program guidelines and premium rates are subject to change at any time without the consent of Plan participants. You will be given notice of any changes that affect your benefit levels as soon as administratively possible.

NOTICE: As prohibited by the terms of the Plan, the following acts will be treated as fraud or misrepresentation of material fact:

- Falsifying dependent information;
- Falsely certifying ineligible persons as eligible;
- Falsifying dependent documentation;
- Falsely enrolling ineligible persons in Coverage;
- Falsifying the occurrence of QSC Events;
- Falsifying QSC Event documentation.

Such acts will require you to reimburse the Plan for any fraudulent claims incurred or, if still within the COBRA election window, for paying COBRA premiums for any months ineligible persons were covered.

Introduction

This booklet describes the coverage and benefits available to employees, retirees, COBRA participants, the surviving spouses of active State employees or retirees, and eligible covered dependents, under the State Employees' PPO Plan. In this booklet, the PPO Plan may also be referred to as "this Plan" or "the Plan." If you have questions about your coverage after reading this booklet, you may call any of the telephone numbers listed on page 3 and talk with a member service representative.

The PPO Plan is designed to cover most major medical expenses for a covered illness or injury, including Hospital and Physician services. However, you will be responsible for any:

1. deductibles;
2. Copayments;
3. Coinsurance (as applicable, a percentage of the Network Allowed Amount or Non-Network Allowance for the service provided);
4. admission fees;
5. non-covered services;
6. amounts above the Plan's allowance for non-network services, except when provided in an emergency or an in-network facility;
7. amounts above the Plan's limitations; and
8. penalties for not certifying most Hospital admissions or stays in a non-network Hospital.

This booklet describes enrollment and eligibility, covered services, what the Plan pays, amounts that are your responsibility, and services that are not covered.

This Plan contains a deductible provision. Details on deductible dollar amounts and when deductibles may be applied can be found in sections 1 and 2, depending on the Plan you chose.

Important enrollment and eligibility information can be found in section 10 of this booklet, including information on:

1. who is eligible to participate in this Plan;
2. how to enroll for coverage;
3. when coverage begins and ends; and
4. when coverage may be continued, including continuation coverage through COBRA.

Medical Necessity

In order to be covered under this Plan Document, the service, prescription drug, or supply must meet all of the requirements of a Covered Service and Supply, including being Medically Necessary, as defined by this Plan Document.

It is important to remember that any time we review whether services, prescription drugs, or supplies are Medically Necessary, it is solely for the purpose of determining coverage, benefits, or payment under the terms of this Plan Document and not for the purpose of recommending or providing medical care. When we review whether services, prescription drugs, or supplies are Medically Necessary, we may review specific medical facts or information about you. Any such review, however, is strictly for the purpose of determining, whether the service, prescription drug, or supply provided or proposed is Medically Necessary as defined in this Plan Document. In applying the definition of Medically Necessary to a specific service, prescription drug, or supply we may apply our coverage and payment guidelines then in effect.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, prescription drug, or supplies are solely your responsibility and that of your treating providers. You and your providers are responsible for deciding what medical care you should have and when that care should be provided. Florida Blue, CVS Caremark, and DSGI are solely

responsible for determining whether expenses incurred for that medical care are Covered Services and Supplies under this Plan Document. In making coverage decisions, Florida Blue, CVS Caremark, and DSGI will not be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care providers.

Whether or not a service, prescription drug, or supply is specifically listed as an exclusion, the fact that a provider may prescribe, recommend, approve, or furnish a service, prescription drug, or supply does not mean that the service, prescription drug, or supply is Medically Necessary (as determined by Florida Blue, CVS Caremark, and DSGI and as defined in this Plan Document) or a Covered Service and Supply. You are free to obtain a service, prescription drug, or supply even if we deny coverage because the service, prescription drug, or supply is not Medically Necessary; however, you will be solely responsible for paying for the service, prescription drug, or supply. Please refer to Section 15 for the definition of "Medically Necessary".

Who to Call for Information

If you need information about...	Contact...
Medical benefits or claims under the PPO Plan, or finding a medical Network Provider within the State of Florida	Florida Blue P.O. Box 2896 Jacksonville, FL 32232-0079 (800) 825-2583 www.floridablue.com or www.floridablue.com/state-employees
PPO Plan Pre-Admission Hospital Certification	(800) 955-5692
Finding a PPO Network Provider outside the state of Florida, Puerto Rico or the U.S. Virgin Islands – BlueCard® PPO Program	(800) 810-2583 or www.bluecares.com
Finding a provider outside the U.S. - BlueCard® Worldwide	(877) 547-2903 if calling within the U.S., or (collect) at (804) 673-1177, if calling outside the U.S.
Healthy Addition® Prenatal Program	(800) 955-7635, option 6, or www.floridablue.com or www.floridablue.com/state-employees
Health Dialog®	(877) 789-2583 (TTY (877) 900-4304)
Prescription drug program information	CVS Caremark www.Caremark.com Customer Care Team (888) 766-5490 For paper claims only: CVS Caremark P.O. Box 52010 MC003 Phoenix, AZ 85072-2010 General correspondence, Customer Care Correspondence: P.O. Box 7074 Lee's Summit, MO 64064-7074
Enrollment, eligibility, or changing coverage	People First (866) 663-4735 https://peoplefirst.myflorida.com
Medicare eligibility and enrollment	The Social Security Administration office in your area

Section 1: Standard PPO Option Summary of Benefits

This summary provides an overview of the Standard PPO Option. For further information on the coverage and benefits of this Plan, as well as applicable limitations and exclusions, please refer to sections 3 (Covered Services), 5 (Exclusions), 7 (Additional Required Provisions) and 15 (Definitions) of this booklet. **If you are enrolled in the PPO High Deductible Health Plan Option, please refer to section 2, entitled "PPO High Deductible Health Plan Option Summary of Benefits."**

Benefit Description	Network	Non-Network*
	Calendar Year Deductible/Copays/Limits	
Calendar Year Deductible (CYD) Per person Family aggregate	\$250 \$500	\$750 \$1,500
Coinsurance Maximum (OOP) Per person Family aggregate		\$2,500 \$5,000
Global Network (OOP) Maximum Per Person Family Aggregate	\$7,900 \$15,800	N/A
Emergency Room (ER) Facility Services Copay (per visit)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Urgent Care Center	\$25 PVF	\$25 PVF
Per Admission Deductible (PAD) Inpatient Hospital	\$250 per admission	\$500 per admission
Physician Office Per Visit Fee (PVF) Primary Care Physician (PCP) Specialist Convenient Care Center	\$15 PVF \$25 PVF \$15 PVF	Coinsurance only; no CYD or PVF
Hospital Services		
Room and Board (R&B) (semi-private) Admission Certification/ Hospital Stay Certification (AC/ HSC) required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Intensive/Progressive Care AC/HSC required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Emergency Room	100% of Allowed Amt after ER copay	100% of Allowance after ER copay
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, operating room, etc.)	80% of Allowed Amt after PAD	60% of Allowance after PAD
Outpatient Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Partial Hospitalization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physician Services		
Emergency Room	80% of Allowed Amt after CYD	80% of Allowance after CYD
Hospital Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Office Visit	100% of Allowed Amt after applicable PVF	60% of Allowance (no PVF/CYD)
Outpatient Services (outpatient visits, consultations, maternity care, etc.)	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Physician Services		
Pathology/Radiology/ Anesthesiology	80% of Allowed Amt after CYD	60% of Allowance after CYD
Preventive Care-Adult (Screening mammograms are included in Preventive Adult Care)	100% of Allowed Amt	100% of Allowance
Preventive Care-Children	100% of Allowed Amt	100% of Allowance
Surgery (Inpatient/Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Urgent Care Center	100% of Allowed Amt after \$25 PVF	100% of Allowance after \$25 PVF
Other Covered Facility Services		
Ambulatory Surgical Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Birthing Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Osteopathic Hospital (Inpatient)	80% of Allowed Amt after PAD	60% of Allowance after PAD
AC/HSC required except for physical rehab admissions	80% of Allowed Amt after CYD	60% of Allowance after CYD
Outpatient Facility	80% of Allowed Amt after CYD	60% of Allowance after CYD
Rehab Hospital (Inpatient) AC/HSC not required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Rehab Hospital (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Skilled Nursing Facility	70% of Allowed Amt	70% of Allowance
Not subject to PAD; AC/HSC not required	70% of Allowed Amt	70% of Allowance
Specialty Facility (Inpatient) AC/HSC required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Specialty Facility (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Home Health Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Residential Treatment Services	80% of Allowed Amt after PAD	60% Allowance after PAD
Other Covered Services		
Acupuncture	80% of Allowed Amt after CYD	60% of Allowance after CYD
Ambulance	100% of Allowed Amt	100% of Covered Charge
Autism	80% of Allowed Amt after CYD	60% of Allowance after CYD
Cleft Lip and Cleft Palate	80% of Allowed Amt after CYD	60% of Allowance after CYD
Contraceptives, supplies and related services	Paid according to the type of service rendered as noted above for Preventive Adult Care, Physician office visits, other Physician services, Durable Medical Equipment, and prescription drugs.	
Dental Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Durable Medical Equipment (DME)/Supplies	80% of Allowed Amt after CYD	60% of Allowance after CYD
Eye Glasses or Contacts	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Other Covered Services		
Limited Fertility Testing and Treatment	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hearing Tests	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mammograms (diagnostic and/or medical)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Manipulative Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mastectomy and Reconstructive Surgery	80% of Allowed Amt after CYD	60% of Allowance after CYD
Maternity Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Midwife Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physical/Massage/Occupational Therapy	80% of Allowed Amt after CYD	60% of Allowance after CYD
Prescription Drugs (CVS Caremark) Participating Retail Pharmacy (30-day supply) Participating Retail Pharmacy (90-day supply) Mail Order Pharmacy (90-day supply)	Generic/Preferred Brand/ Non-Preferred Brand \$7 / \$30 / \$50 \$14 / \$60 / \$100 \$14 / \$60 / \$100	You pay in full and file claim (see section 9 for reimbursement information)
Prostheses	80% of Allowed Amt after CYD	60% of Allowance after CYD
Surgical Sterilization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Transplants	80% of Allowed Amt after CYD	60% of Allowance after CYD
Weight Loss Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Wigs	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hospice Care		
Hospice Inpatient	70% of Allowed Amt	70% of Allowance
Hospice Outpatient/Home	80% of Allowed Amt	80% of Allowance

Note: Certain categories of Network Providers may not currently be available in all geographic regions. Additionally, certain providers (e.g., radiologists, anesthesiologists, pathologists, emergency room Physicians, Hospitalists) rendering care at network facilities may not be Network Providers and are, therefore, subject to non-network benefits unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

These are the benefits provided the coverage is active (i.e., in effect) when the services are rendered. Oral and written statements cannot modify the coverage or benefits described in this Plan Booklet and Benefits Document.

*** The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance, except when provided in an emergency or an in-network facility.**

Plan Maximums

Hospice Care days per person per lifetime	210
Lifetime Benefit Maximum per person per lifetime	Not Applicable
Manipulative Services per person per calendar year	26 treatments
Massage and/or Physical Therapy (excluding physical therapy for the treatment of Autism Spectrum Disorder and Down syndrome)	
Treatments per day; and	4
Days per 6-month period	21
Occupational Therapy (excluding occupational therapy for the treatment of Autism Spectrum Disorder, Down Syndrome, and under hospice and home health care services)	
Days per 6-month period	21
Skilled Nursing Facility days per person per calendar year	60
Weight Loss Services (non-surgical) per person per 12-month period	\$150
Wigs per person per event	\$40

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Office Visits

For office visits, the amount you pay depends on whether you use a network or non-network physician or other health care provider. You pay a set copayment per visit for network Physicians or other health care providers, while Coinsurance applies for most office visits to non-network physicians or other health care providers.

If you use non-network physicians or other health care providers, you will be under an obligation to pay any amount above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. See page 1-7 for more information about the Network Allowed Amount and the Non-Network Allowance.

Copayments for office visits do not count toward meeting the Plan's calendar year deductible or the calendar year coinsurance maximum. An office visit includes all services provided on the same day as the office visit, by the same health care provider. Therefore, the copayment you pay for the office visit applies to all covered services rendered in that office visit and does not count toward meeting the calendar year deductible.

Emergency Room Visits

For emergency room (ER) visits, the amount you pay depends on whether you use a network or non-network facility:

1. Facility
You pay a set Copayment per visit for the facility charges. This Copayment is waived if you are admitted to the Hospital directly from the emergency room. The per visit ER Copayment does not count toward meeting the Plan's calendar year deductible or the calendar year coinsurance maximum.
2. ER Physician or Other Health Care Provider
You pay a percentage of the Network Allowed Amount or Non-Network Allowance after you meet the calendar year deductible. It is not uncommon to receive ER Physician or other health care provider services from a Non-Network Provider within a network facility.

Deductible for Hospital Stays (Per Admission Deductible)

The calendar year deductible does not apply to covered facility services for inpatient Hospital stays, but there is a separate Hospital stay deductible that applies to each Hospital stay. This means that you must meet the Hospital stay deductible each time you are admitted as an inpatient before the Plan pays benefits for covered facility services. The calendar year deductible does apply to Physician or other professional services provided during your inpatient Hospital stay.

Deductible for Most Other Covered Care

You must meet a calendar year deductible before this Plan pays benefits for most covered expenses. Please refer to the summary of benefits chart on pages 1-1 through 1-3 for information on services that are not subject to the calendar year deductible (e.g., services requiring a Copayment or per admission deductible). The calendar year deductible applies each January 1 to December 31. The deductible will not roll over to the following year.

Once the calendar year deductible is met, this Plan pays a percentage of the Network Allowed Amount for Network Providers and a percentage of the Non-Network Allowance for Non-Network Providers. Please refer to page 1-7 for more information regarding your share of expenses for Non-Network Providers.

The amount of the calendar year deductible depends on whether you use Network or Non-Network Providers. Amounts applied to the deductible for network-covered services will count toward satisfying the non-network deductible, and vice versa.

If you have individual coverage, this Plan begins paying a percentage of your eligible expenses after you meet your individual deductible.

If you have family coverage, you can meet the family deductible in one of two ways:

1. two family members can each meet the individual calendar year deductible; or
2. all family members can combine their covered expenses to meet the family deductible.

How the Deductible Works

Assume Joe and his family had the following covered medical expenses during the first three months in a calendar year. All the expenses are for care from Network Providers and are not office visits.

Joe	\$ 200
Wife	\$ 125
Daughter	\$ 100
Son	+ \$ 75
network family deductible	\$ 500

In this example, the family members' combined covered expenses meet the network family deductible.

Once your family satisfies the family deductible, this Plan begins paying a percentage of covered expenses for you and all your covered dependents for the rest of the calendar year. If one person in your family meets the individual deductible, the Plan begins paying a percentage of covered expenses for that person for the rest of the calendar year.

Calendar Year Coinsurance Maximum

There is a limit on the amount of Coinsurance you pay out of your pocket toward covered expenses in any one calendar year for network and non-network care combined. Once your share of out-of-pocket Coinsurance expenses reaches the annual limit, this Plan begins paying 100 percent of the Network Allowed Amount for care from Network Providers and 100 percent of the Non-Network Allowance for care from Non-Network Providers, after any required Copayments or deductibles, for the rest of the calendar year. You meet the family out-of-pocket Coinsurance maximum (if applicable) when the Coinsurance expenses of two of your covered family members or a combination of covered

family members adds up to the family coinsurance maximum.

Both your network and non-network covered expenses count toward the out-of-pocket coinsurance maximum. The following expenses, however, do not count toward the out-of-pocket coinsurance maximum:

1. calendar year and inpatient Hospital deductibles;
2. Copayments for office visits, urgent care visits and emergency room visits;
3. charges for services and supplies that are not covered by this Plan;
4. charges greater than the Non-Network Allowance for Non-Network Providers;
5. charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment; and
6. pre-admission certification or other penalties.

Global Network Out-Of-Pocket Maximum

There is a limit on the amount you will pay out-of-pocket toward covered expenses during any calendar year for network Covered Services and Supplies and prescription drugs. Under individual coverage, once your share of network out-of-pocket expenses reaches the global network out-of-pocket maximum, this Plan begins paying 100 percent of the Network Allowed Amount for network Covered Services and Supplies and prescription drugs for the remainder of the calendar year for you. You meet the family global network out-of-pocket maximum when two covered family members or a combination of covered family members meet the family global network out-of-pocket maximum. Only expenses for network Covered Services and Supplies and prescription drugs count toward the global network out-of-pocket maximum; expenses that apply to this maximum include:

1. Network expenses that applied to the annual calendar year deductible;
2. Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Network emergency room Copays;
4. Network hospital per admission deductibles;
5. Network office visit Copays; and
6. Network prescription drug Copays.

Expenses that do not apply to the global network out-of-pocket maximum include:

1. Non-Network expenses that applied to the annual calendar year deductible;
2. Non-Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Non-Network emergency room Copays;
4. Non-Network hospital per admission deductibles;
5. Non-Network office visit Coinsurance;
6. Charges for services, supplies and prescription drugs that are not covered by this Plan;
7. Charges for Covered Services and Supplies and prescription drugs that are greater than Plan limits for dollar amounts, number of treatments, or number of days of treatment;
8. Charges and/or penalties for not obtaining pre admission certification and/or exceeding approved days of hospital stay certification;
9. Non-Network prescription drugs;
10. Specialty drugs that are denied by the Specialty Guideline Management Program;
11. Specialty drugs that would have been denied or would have been outside clinical treatment guidelines by the Specialty Guideline Management Program if you had tried to get the drug approved but did not go through the proper approval process; and,
12. The difference between the cost of a generic drug and a brand name drug when the prescribing physician does not indicate "dispense as written" or "brand name medically necessary" and you request the brand name drug.

The Plan Pays a Share of Covered Expenses

Benefits are paid at two different levels. The level you receive depends on whether your care is provided by Network Providers or Non-Network Providers.

This Plan pays benefits for covered services based on the Network Allowed Amount for network care and the Non-Network Allowance for non-network care. The Network Allowed Amounts are preferred rates Florida Blue has negotiated with Network Providers, and Network Providers are not allowed to charge you for any amounts above the Network Allowed Amounts. When you use Network Providers, you take advantage of the preferred rates of the Network

Allowed Amounts and the Plan pays the highest level of benefits, keeping your cost down.

When you receive services from Non-Network Providers by choice or even if you have no choice in the selection of the Non-Network Provider, this Plan pays benefits based on the Non-Network Allowance, not the providers' billed charges. If your provider charges more than the Non-Network Allowance, you are responsible for any amounts above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. In addition, because the Plan often pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

In selecting Florida Blue as the Medical Claim Administrator for the State Employees' PPO Plan, DSGI agreed to accept the Non-Network Allowance schedule used by Florida Blue to make payment for specific health care services submitted by Non-Network Providers.

In the case of a Non-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Non-Network Provider for the specific Covered Services provided to you, the Non-Network Allowance will be the lesser of that Non-Network Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to:

- payment for such Covered Services under the Medicare and/or Medicaid programs;
- payment often accepted for such Covered Services by that Non-Network Provider and/or by other providers, either in Florida or in other comparable market(s), that Florida Blue determines are comparable to the Non-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Non-Network Provider and/or by other providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations);

- payment amounts which are consistent, as determined by Florida Blue, with our provider network strategies (e.g., does not result in payment that encourages providers participating in a Florida Blue network to become non-participating); and/or,
- the cost of providing the specific Covered Services.

In the case of a Non-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard® Program, the Non-Network Allowance for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the services were provided at the amount such organization would pay Non-Network Providers in its geographic area for such services.

In no event will the Non-Network Allowance be greater than the amount the Non-Network Provider actually charges.

If a particular Covered Service is not available from any provider that is in PPCSM, as determined by Florida Blue, the Non-Network Allowance, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar providers in a geographical area established by Florida Blue.

You may get an estimate of the Non-Network Allowance or the Network Allowed Amount for particular services by calling Florida Blue Customer Service toll-free at 1-800-825-2583. The fact that Florida Blue or DSGI may provide you with such information does not mean that the particular service is a Covered Service. All terms and conditions included in this Plan Booklet and Benefits Document apply. Please refer to Section 1 (Standard PPO Option Summary of Benefits), Section 2 (PPO High Deductible Health Plan Option Summary of Benefits), Section 3 (Covered Services), and Section 5 (Exclusions) for more detailed information on the Plan and member cost share amounts, covered services, and exclusions.

Keep in mind that you will receive benefits at the non-network level whenever you use Non-Network Providers.

See section 6 for more information about the PPCSM network.

The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

Section 2: PPO High Deductible Health Plan Option Summary of Benefits

This summary provides an overview of the PPO High Deductible Health Plan Option. For further information on the coverage and benefits of this Plan, as well as applicable limitations and exclusions, please refer to sections 3 (Covered Services), 5 (Exclusions), 7 (Additional Required Provisions) and 15 (Definitions) of this booklet. **If you are enrolled in the Standard PPO Option, please refer to section 1, entitled "Standard PPO Option Summary of Benefits."**

Benefit Description	Network	Non-Network*
	Calendar Year Deductible/Copays/Limits	
Calendar Year Deductible (CYD) Individual Purchaser	CYD \$1,350	\$2,500
Family Purchaser	\$2,700	\$5,000
Coinsurance Maximum (OOP) Individual Purchaser	\$3,000	\$7,500
Family Purchaser	\$6,000	\$15,000
Global Network (OOP) Maximum Individual Purchaser	\$4,350	N/A
Family Purchaser	\$8,700 (no one person shall exceed \$6,750)	
Emergency Room (ER) Facility Services Copay (per visit)	No copay, subject to CYD	
Per Admission Deductible (PAD) Inpatient Hospital	No PAD; subject to CYD	\$1,000 after CYD
Physician Office Convenient Care Center Urgent Care Center	Subject to Coinsurance and CYD	
Hospital Services		
Room and Board (R&B) (semi-private)		
Admission Certification/ Hospital Stay Certification (AC/ HSC) required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Intensive/Progressive Care AC/HSC required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Emergency Room	80% of Allowed Amt after CYD	80% of Allowance after CYD
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, operating room, etc.)	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Outpatient Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Partial Hospitalization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physician Services		
Emergency Room	80% of Allowed Amt after CYD	80% of Allowance after CYD
Hospital Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Office Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Outpatient Services (outpatient visits, consultations, maternity care, etc.)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Pathology/Radiology/ Anesthesiology	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Physician Services		
Preventive Care-Adult (Screening mammograms are included in Preventive Adult Care)	100% of Allowed Amt	100% of Allowance
Preventive Care-Children	100% of Allowed Amt	100% of Allowance
Surgery (Inpatient/Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Urgent Care Center	80% of Allowed Amt after CYD	80% of Allowance after CYD
Other Covered Facility Services		
Ambulatory Surgical Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Birthing Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Osteopathic Hospital (Inpatient) AC/HSC required except for physical rehab admissions	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Outpatient Facility	80% of Allowed Amt after CYD	60% of Allowance after CYD
Rehab Hospital (Inpatient) AC/HSC not required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Rehab Hospital (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Skilled Nursing Facility Not subject to PAD; AC/HSC not required	70% of Allowed Amt after CYD	70% of Allowance after CYD
Specialty Facility (Inpatient) AC/HSC required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Specialty Facility (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Home Health Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Residential Treatment Services	80% of Allowed Amt after PAD	60% Allowance after PAD and CYD
Other Covered Services		
Acupuncture	80% of Allowed Amt after CYD	60% of Allowance after CYD
Ambulance	100% of Allowed Amt after CYD	100% of Covered Charge after CYD
Autism	80% of Allowed Amt after CYD	60% of Allowance after CYD
Cleft Lip and Cleft Palate	80% of Allowed Amt after CYD	60% of Allowance after CYD
Contraceptives, supplies and related services	Paid according to the type of service rendered as noted above for Preventive Adult Care, Physician office visits, other Physician services, Durable Medical Equipment, and prescription drugs.	
Dental Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Durable Medical Equipment (DME)/Supplies	80% of Allowed Amt after CYD	60% of Allowance after CYD
Eye Glasses or Contacts	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Other Covered Services		
Limited Fertility Testing and Treatment	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hearing Tests	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mammograms (diagnostic and/or medical)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Manipulative Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mastectomy and Reconstructive Surgery	80% of Allowed Amt after CYD	60% of Allowance after CYD
Maternity Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Midwife Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physical/Massage/Occupational Therapy	80% of Allowed Amt after CYD	60% of Allowance after CYD
Prescription Drugs (CVS Caremark) Participating Retail Pharmacy (30-day supply) Participating Retail Pharmacy (90-day supply) Mail Order Pharmacy (90-day supply)	Generic/Preferred Brand/ Non-Preferred Brand 30% / 30% / 50% 30% / 30% / 50% 30% / 30% / 50% (after In-Network CYD)	You pay in full and file claim (see section 9 for reimbursement information)
Prostheses	80% of Allowed Amt after CYD	60% of Allowance after CYD
Surgical Sterilization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Transplants	80% of Allowed Amt after CYD	60% of Allowance after CYD
Weight Loss Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Wigs	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hospice Care		
Hospice Inpatient	70% of Allowed Amt after CYD	70% of Allowance after CYD
Hospice Outpatient/Home	80% of Allowed Amt after CYD	80% of Allowance after CYD

Note: Certain categories of Network Providers may not currently be available in all geographic regions. Additionally, certain providers (e.g., radiologists, anesthesiologists, pathologists, emergency room Physicians, Hospitalists) rendering care at network facilities may not be Network Providers and are, therefore, subject to non-network benefits unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

These are the benefits provided the coverage is active (i.e., in effect) when the services are rendered. Oral and written statements cannot modify the coverage or benefits described in this Plan Booklet and Benefits Document.

* The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance except when provided in an emergency or an in-network facility.

Plan Maximums

Hospice Care days per person per lifetime	210
Lifetime Benefit Maximum per person per lifetime (includes prescription drugs)	Not Applicable
Manipulative Services per person per calendar year	26 treatments
Massage and/or Physical Therapy (excluding occupational therapy for the treatment of Autism Spectrum Disorder, Down Syndrome)	
Treatments per day; and	4
Days per 6-month period	21
Occupational Therapy (excluding physical therapy for the treatment of Autism Spectrum Disorder and Down syndrome and under hospice and home health care services)	
Days per 6-month period	21
Skilled Nursing Facility days per person per calendar year	60
Weight Loss Services (non-surgical) per person per 12-month period	\$150
Wigs per person per event	\$40

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Office Visits

For office visits, the amount you pay depends on whether you use a network or non-network physician or other health care provider. You pay a percentage of the Network Allowed Amount for Network Providers and a percentage of the non-Network Allowance for non-Network Providers, after the calendar year deductible is satisfied.

If you use non-network Physicians or other health care providers, you will pay any amount above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. See page 2-6 for more information about the network Allowed Amount and the Non-Network Allowance.

Emergency Room Visits

For emergency room (ER) visits, the amount you pay depends on whether you use a network or non-network facility:

1. Facility
The Plan pays a percentage of the Network Allowed Amount or Non-Network Allowance after you meet the calendar year deductible you pay the remaining coinsurance percentage.
2. ER Physician or Other Health Care Provider
The Plan pays a percentage of the Network Allowed or Non-Network Allowance, after you meet the calendar year deductible. You are responsible for your share of the Coinsurance. It is not uncommon to receive ER Physician or other health care provider services from a Non-Network Provider in a network facility.

Deductible

Before this Plan pays benefits for covered expenses, you must meet a calendar year deductible. Both health and prescription expenses are applied to the calendar year deductible on the PPO High Deductible Health Plan Option. The calendar year deductible applies each January 1 to December 31. The deductible will not roll over to the following year.

Once the calendar year deductible is met, this Plan pays a percentage of the Network Allowed Amount for Network Providers and a percentage of the Non-

Network Allowance for Non-Network Providers. Please refer to page 2-6 for more information regarding your share of expenses for Non-Network Providers.

The amount of the calendar year deductible depends on whether you use Network or Non-Network Providers. Amounts applied to the deductible for network-covered services will count toward satisfying the non-network deductible, and vice versa.

If you have individual coverage, this Plan begins paying a percentage of your eligible expenses after you meet your individual deductible.

If you have family coverage, you can meet the individual/family deductible in one of two ways:

1. one family member can meet the individual calendar year deductible, after which the Plan begins paying a percentage of that family member's eligible expenses; or
2. all family members can combine their eligible expenses to meet the family deductible, after which the Plan begins paying a percentage of all family members' eligible expenses

How the Deductible Works

Assume Joe and his family are covered under the PPO High Deductible Health Plan Option, and had the following covered medical expenses during the first three months in a calendar year. All the expenses are for care from Network Providers.

Joe	\$1,200
Wife	\$1,125
Daughter	\$ 300
Son	+ \$ 75
network family deductible	\$2,700

In this example, the family members' combined covered expenses meet the network family deductible.

The calendar year deductible on the PPO High Deductible Health Plan Option applies to all services you receive under the policy, except for preventive care.

Calendar Year Coinsurance Maximum

There is a limit on the amount of Coinsurance you pay out of your pocket toward covered expenses in any one calendar year for network and non-network care

combined. Under an individual contract/policy, once your share of out-of-pocket Coinsurance expenses reaches the individual annual coinsurance maximum, this Plan begins paying 100 percent of the Network Allowed Amount for care from Network Providers and 100 percent of the Non-Network Allowance for care from Non-Network Providers, for the rest of the calendar year. Under a family contract/policy, you meet the family aggregate out-of-pocket Coinsurance maximum (if applicable) when the Coinsurance expenses of one, or a combination of your covered family members, add up to the family maximum.

Both your network and non-network covered expenses count toward the out-of-pocket maximum. The following expenses, however, do not count toward the out-of-pocket maximum:

1. calendar year and inpatient Hospital deductibles;
2. charges for services and supplies that are not covered by this Plan;
3. charges greater than the Non-Network Allowance for Non-Network Providers;
4. charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment; and
5. pre-admission certification or other penalties

Global Network Out-of-Pocket Maximum

There is a limit on the amount you will pay out-of-pocket toward covered expenses during any calendar year for network Covered Services and Supplies and prescription drugs. Under individual coverage, once your share of network out-of-pocket expenses reaches the global network out-of-pocket maximum, this Plan begins paying 100 percent of the Network Allowed Amount for network Covered Services and Supplies and prescription drugs for the remainder of the calendar year for you. You meet the family global network out-of-pocket maximum when two covered family members or a combination of covered family members meet the family network out-of-pocket maximum. However, no one family member shall exceed \$6,750. Only expenses for network Covered Services and Supplies and prescription drugs count toward the global network out-of-pocket maximum; expenses that apply to this maximum include:

1. Network expenses that applied to the annual calendar year deductible;
2. Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Network emergency room Coinsurance;

4. Network hospital per admission deductibles and Coinsurance;
5. Network office visit Coinsurance; and
6. Network prescription drug Coinsurance.

Expenses that do not apply to the global network out-of-pocket maximum include:

1. Non-Network expenses that applied to the annual calendar year deductible;
2. Non-Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Non-Network emergency room Coinsurance;
4. Non-Network hospital per admission deductibles and Coinsurance;
5. Non-Network office visit Coinsurance;
6. Charges for services, supplies, and prescription drugs that are not covered by this Plan;
7. Charges for Covered Services and Supplies and prescription drugs that are greater than Plan limits for dollar amounts, number of treatments, or number of days of treatment;
8. Charges and/or penalties for not obtaining pre admission certification and/or exceeding approved days of hospital stay certification;
9. Non-Network prescription drugs;
10. Specialty drugs that are denied by the Specialty Guideline Management Program;
11. Specialty drugs that would have been denied or would have been outside clinical treatment guidelines by the Specialty Guideline Management Program if you had tried to get the drug approved but did not go through the proper approval process; and,
12. The difference between the cost of a generic drug and a brand name drug when the prescribing physician does not indicate "dispense as written" or "brand name medically necessary" and you request the brand name drug.

The Plan Pays a Major Share of Covered Expenses

Benefits are paid at two different levels. The level you receive depends on whether your care is provided by Network Providers or Non-Network Providers.

This Plan pays benefits for covered services based on the Network Allowed Amount for network care and the Non-Network Allowance for non-network care. The Network Allowed Amounts are preferred rates Florida Blue has negotiated with Network Providers, and Network Providers are not allowed to charge

you for any amounts above the Network Allowed Amounts. When you use Network Providers, you take advantage of the preferred rates of the Network Allowed Amounts and the Plan pays the highest level of benefits, keeping your cost down.

When you receive services from Non-Network Providers by choice or even if you have no choice in the selection of the Non-Network Provider, this Plan pays benefits based on the Non-Network Allowance, not the provider's billed charges. If your provider charges more than the Non-Network Allowance, you are responsible for any amounts above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. In addition, because the Plan often pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

In selecting Florida Blue as the Medical Claim Administrator for the State Employees' PPO Plan, DSGI agreed to accept the Non-Network Allowance schedule used by Florida Blue to make payment for specific health care services submitted by Non-Network Providers.

In the case of a Non-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Non-Network Provider for the specific Covered Services provided to you, the Non-Network Allowance will be the lesser of that Non-Network Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to:

- payment for such Covered Services under the Medicare and/or Medicaid programs;
- payment often accepted for such Covered Services by that Non-Network Provider and/or by other providers, either in Florida or in other comparable market(s), that Florida Blue determines are comparable to the Non-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Non-Network Provider and/or by other providers as participating providers in other provider networks of third-party payers which may

include, for example, other insurance companies and/or health maintenance organizations);

- payment amounts which are consistent, as determined by Florida Blue, with our provider network strategies (e.g., does not result in payment that encourages providers participating in a Florida Blue network to become non-participating); and/or,
- the cost of providing the specific Covered Services.

In the case of a Non-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard® Program, the Non-Network Allowance for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the services were provided at the amount such organization would pay Non-Network Providers in its geographic area for such services.

In no event will the Non-Network Allowance be greater than the amount the Non-Network Provider actually charges.

If a particular Covered Service is not available from any provider that is in PPCSM, as determined by Florida Blue, the Non-Network Allowance, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar providers in a geographical area established by Florida Blue.

You may get an estimate of the Non-Network Allowance or the Network Allowed Amount for particular services by calling Florida Blue Customer Service toll-free at 1-800-825-2583. The fact that Florida Blue or DSGI may provide you with such information does not mean that the particular service is a Covered Service. All terms and conditions included in this Plan Booklet and Benefits Document apply. Please refer to Section 1 (Standard PPO Option Summary of Benefits), Section 2 (PPO High Deductible Health Plan Option Summary of Benefits), Section 3 (Covered Services), and Section 5 (Exclusions) for more detailed information on the Plan and member cost share amounts, covered services, and exclusions.

Keep in mind that you will receive benefits at the non-network level whenever you use Non-Network Providers.

See section 6 for more information about the PPCSM network.

The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

Section 3: Covered Services

Covered Service Categories

Acupuncture

Services must be provided by a medical Doctor, a Doctor of Osteopathy, a chiropractor certified in Acupuncture, or a certified Acupuncturist.

Ambulance

Ground ambulance services must be Medically Necessary to transport a patient:

1. from a Hospital unable to provide care to the nearest Hospital that can provide the Medically Necessary level of care;
2. from a Hospital to a home or nearest Skilled Nursing Facility that can provide the Medically Necessary level of care; or
3. from the place of an emergency medical Condition to the nearest Hospital that can provide the Medically Necessary level of care.

Air, helicopter, and boat ambulance services are covered to transport a patient from the location of an emergency medical Condition to the nearest Hospital that can provide the Medically Necessary level of emergency care, when:

1. the pick-up point is inaccessible by ground;
2. speed in excess of ground speed is critical; or
3. the travel distance by ground is too far to safely treat the patient.

Autism Spectrum Disorder and Down Syndrome

Treatment for Autism Spectrum Disorder and Down syndrome is covered for an individual that was diagnosed as having a Developmental Disability at eight years or younger and is either; 1. Under 18 years of age, or 2. Eighteen years of age or older and in high school. Coverage includes well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder and Down syndrome, speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis. Applied Behavioral Analysis is covered when provided by Applied Behavioral Analysts, psychologists, clinical social workers, and others within the scope of their license. Coverage is limited to treatment prescribed by the treating physician in accordance with a treatment plan.

The PPO Plan covers Autism Spectrum Disorder and Down syndrome in accordance with s. 627.6686, Florida Statutes.

Cleft Lip and Cleft Palate

Treatment is covered for children less than 18 years of age, including medical, dental, speech therapy, audiology and nutrition services.

Clinical Trials

Routine patient care for Covered Services and Supplies provided in direct connection with your participation in an Approved Clinical Trial including the Florida Clinical Trial Compact may be covered when:

1. You are deemed eligible to participate in such Approved Clinical Trial, and
2. A Network Provider has indicated such Approved Clinical Trial is appropriate for you, or
3. You provide Florida Blue with medical and scientific information establishing that your participation in such Approved Clinical Trial is appropriate.

Routine patient care includes all Medically Necessary Services and Supplies that are otherwise covered under this Plan, such as doctor visits, prescription drugs, lab tests, x-rays and scans and hospital stays related to treatment of your covered Condition. Your cost share will be the same for this routine patient care as it would have been if such routine patient care had not been provided in connection with an Approved Clinical Trial.

Contraceptives

Medical services and supplies related to contraceptive management are covered under the medical component administered by Florida Blue. For contraceptive prescription coverage, please refer to the prescription drug program section.

With respect to Women's Preventive Services only, and to the extent required by federal law, contraceptive coverage is limited to at least one form of contraception in each of the eighteen methods identified in the FDA's most current Birth Control Guide and limited to generic products when available. Other contraceptives may be covered

based on medical necessity. The Plan will pay 100 percent of the network allowed amount or 100 percent of the non-network allowance. You will be responsible for the total amount above the non-network allowance.

Cosmetic Services

Cosmetic services, including any service to improve the appearance or self-perception of an individual, if the service is:

1. a result of a covered Accident and the surgery or treatment is performed while the person is covered by this Plan;
2. for correction of a Congenital Anomaly for an eligible dependent and performed while the dependent is covered by this Plan;
3. a Medically Necessary procedure to correct an abnormal bodily function;
4. for reconstruction to an area of the body that has been altered by the treatment of a disease;
5. for breast reconstructive surgery and the prosthetic devices related to a mastectomy; or
6. for hair loss related to a covered medical condition or covered immune related disorder.

“Mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician, and “breast reconstructive surgery” means surgery to re-establish symmetry between the two breasts.

Cosmetic services that are not identified in paragraphs 1-6 above are excluded under Section 5: Exclusions of this Plan.

Dental

Dental care is limited to the following:

1. Care and treatment rendered within 120 days of an **Accidental Dental Injury**, unless an extension is requested and approved in writing by Florida Blue, provided such services are for the treatment of damage to sound natural teeth. Services must be provided within 120 days of the Accidental Dental Injury unless a written explanation from the dentist or Physician stating any extenuating circumstances requiring treatment over a longer period of time is received and approved, in writing, by Florida Blue as Medically Necessary within 120 days. In no instance will any services be covered unless provided within 120 days of the termination of the person’s coverage. Orthodontia is never covered, even if necessary as a result of an Accidental Dental Injury. No services will be covered if provided more

than 120 days after the termination of the person’s coverage.

2. Facility charges for Medically Necessary services provided in a Hospital, Ambulatory Surgical Center, Outpatient Health Care Facility, or Skilled Nursing Facility. Physician services (including general and specialty dentists and oral surgeons) and services provided by other treatment providers are not covered.
3. Anesthesia services, including general anesthesia and hospitalization services, required to assure the safe delivery of necessary dental care provided in a Hospital or Ambulatory Surgical Center if:
 - a. the covered dependent is under 8 years of age and it is determined by a dentist and the covered dependent’s Physician that:
 - i. dental treatment is necessary due to a dental Condition that is significantly complex; or
 - ii. the covered dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
 - b. you or your covered dependent have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Diabetes Outpatient Self-Management

Diabetes outpatient self-management training and educational services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes and pre-diabetes, if your treating physician or a physician who specializes in the treatment of diabetes certifies that such services are medically Necessary, are covered. In order to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed dietitian. Covered services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diabetes equipment and supplies will be covered in accordance with the terms and conditions of the prescription drug coverage section of this Plan Booklet and Benefits Document.

Drugs and Pharmaceutical Products

The following may be covered under the medical portion of the Plan:

1. Drugs, medicines, medications, treatments, and/or immunizations that are consumed and/or administered at a covered health care provider's office or other covered inpatient or outpatient health care facility; and,
2. Drugs, medicines, supplies, treatments, and/or medications that must be administered under the direct supervision of a covered health care provider.

The medical portion of the Plan does not cover drugs, medicines, supplies, medications, and treatments that are:

1. typically filled by a prescription order;
2. provided at no cost to the member;
3. over-the-counter drugs, supplies, and treatments;
4. injectable self-administered and do not require medical supervision; and,
5. take home drugs, supplies, treatments furnished by the health care provider that can be dispensed by a retail or mail order pharmacy.

Durable Medical Equipment (DME)

Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, Hospital beds, TENS units, CPAP devices and oxygen equipment. Repair or replacement of DME due to growth of a child or due to a change in your Condition may be covered. Supplies and service to repair DME may be covered only if you own or are purchasing the equipment.

1. Coverage is limited to the standard model unless an upgraded model is determined to be Medically Necessary.
2. Coverage for the purchase of equipment is limited to the Network Allowed Amount or Non-Network Allowance minus any amount already paid by the Plan for rental.
3. Coverage for the rental of DME will not exceed the Network Allowed Amount or Non-Network Allowance for the purchase of such equipment; if you continue to rent such equipment, no additional payments will be made by this Plan.
4. Coverage for DME purchased after being rented will be limited to the Network Allowed Amount or Non-Network Allowance less any amount already paid by the Plan for rental.

5. Coverage for one breast pump per birth; 100 percent of network allowed amount or 100 percent of non-network allowance.

Enteral Formulas

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

Coverage to treat inherited diseases of amino acid and organic acids, up to age 25, shall include coverage for food products modified to be low protein.

Eye Glasses or Contacts

Coverage is limited to standard frames and lenses for the first pair of eyeglasses or contacts following an accident to the eye or cataract surgery.

Fertility Testing and Treatment

Tests to determine the cause of infertility and the treatment of medical conditions resulting in infertility are covered services. Fertility tests and treatments considered experimental or Investigational are not covered. Please refer to the exclusions section for further information.

Hearing Tests

Hearing tests are covered after related covered ear surgery or when Medically Necessary for diagnosis of a covered condition other than hearing loss. Hearing tests for supplying or fitting of a hearing aid are not covered. Hearing tests may be covered under preventive care.

Newborn screening for the detection of hearing loss

All newborns in the State of Florida will be screened, or referred for screening in the case of home births or births at a Birthing Center, for the early detection of possible hearing loss. Hearing screening tests, when ordered by your treating physician, will include auditory brainstem responses, evoked otoacoustic emissions, or other appropriate technology as approved by the United States Food and Drug Administration. This Plan covers these services and any Medically Necessary follow-up re-evaluations

leading to a diagnosis. Hospitals are required to screen newborns for the detection of hearing loss prior to discharge, but no later than 30 days after discharge. If your child is born at a Birthing Center, the Birthing Center is required to refer your newborn within 30 days after discharge for these hearing screenings. If your child is born at home, the attending health care provider will refer your newborn within three months after your child's birth for these hearing screenings. A licensed audiologist, Physician, Hospital or other newborn hearing-screening provider can provide hearing screenings. You, as the parent or legal guardian, may object in writing, to the health care provider attending your child and prevent your child from receiving these hearing screenings.

Home Health Care

Services include, but are not limited to: nursing services, treatment, physical therapy, respiratory therapy, occupational therapy, equipment, medication and supplies.

Services must meet all the following criteria:

- You must be confined at home, restricted in ambulation, convalescing, or significantly limited in physical activity due to a Condition.
- Services must be provided directly by (or indirectly through) a Home Health Agency.
- Service must be prescribed by a Physician and include a formal written treatment plan that is reviewed and updated every 30 days by the prescribing Physician. A copy of the written treatment plan may be required.
- You must meet or achieve the treatment goals set forth in the treatment plan and documented in the clinical progress notes.

Hospice Care

Treatment for, and counseling of, terminally ill patients whose doctor has certified that they have less than six months to live are covered. In order to be covered, hospice services must be provided by an approved hospice program. Unless prior approval has been received from Florida Blue, services of a person who normally resides in the home of the terminally ill patient or member of the patient's family or spouse's family are not covered.

Coverage includes the following services:

In-Home Care

1. Physician services;
2. physical, respiratory and occupational therapy;

3. drugs, medicines and Medical Supplies;
4. private duty nursing services in a series of shifts (e.g., three eight-hour shifts);
5. Home Health Aide services;
6. rental of Durable Medical Equipment; and
7. oxygen.

Hospice Outpatient Care

1. Physician services;
2. laboratory, x-ray and diagnostic testing; and
3. same covered services as in-home Hospice care.

Hospice Inpatient Care

1. room and board and general nursing services, including the cost of overnight visitations by covered family members;
2. inpatient care services same as inpatient Hospital care; and
3. same covered services as in-home and outpatient Hospice care.

While in the hospice program, regular Plan benefits are not payable for expenses related to the terminal illness.

Prospective reimbursement for hospice treatment can be requested. To do this, the hospice program submits a 90-day treatment plan for hospice care. If approved by Florida Blue, payments are made every 30 days as treatment is completed. A second 90-day treatment plan may be submitted if the patient continues in hospice care. One additional treatment plan for 30 days may be submitted after two 90-day plans are completed. No further benefits are payable after 210 days.

Occupational therapy is covered as a component of hospice care.

Mammograms

Screening mammograms are covered in accordance with current A and B recommendations of the U.S. Preventive Services Task Force and state law.

Medically Necessary (diagnostic) mammograms are covered at any age. Screening mammograms are included in adult preventive services benefit.

Manipulative Services

Payment for Manipulative Services is limited to 26 treatments per calendar year.

Mastectomy and Reconstructive Services

Coverage includes:

1. removal of all or part of the breast for medical necessity;
2. reconstruction of the breast on which the mastectomy was performed;
3. surgery and reconstruction of the other breast for a symmetrical appearance;
4. treatment of physical complications of all stages of mastectomy including lymphedemas; and
5. prostheses and mastectomy bras.

Maternity Care

Maternity coverage includes covered hospital stays for the mother. Covered services related to an eligible newborn will be covered only if the newborn is added to the member's coverage within the enrollment guidelines specified in Section 10. If the newborn is not added to the coverage within the specified guidelines, the PPO Plan will only cover the initial newborn assessment as set forth in s. 627.6574, Florida Statutes.

About maternity care: coverage for mothers and newborns

Under federal law, group health plans offering group health insurance generally may not:

1. restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Cesarean section. However, the Plan may pay for a shorter stay if the attending provider (for example, the Physician, nurse Midwife or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier;
2. set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay; or
3. require that a Physician or other health care provider obtain authorization for prescribing a length of stay up to 48 or 96 hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. See section 7 or contact Florida Blue for information about pre-certification.

Coverage for the care of a mother and her newborn infant includes coverage for post-partum and newborn assessments, respectively. In order for such services to be covered under the Plan, the care must be provided at a hospital, an attending physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in care for a newborn and mother. Coverage for these services includes coverage for a physical assessment of the newborn and mother, and the performance of any medically Necessary clinical tests and immunizations in accordance with prevailing medical standards.

Breastfeeding support and/or lactation services are covered services when rendered:

1. in a physician office setting by a physician, advanced registered nurse practitioner under the supervision of a physician, certified lactation specialist, or other health care provider operating within the scope of their license; or
2. in an inpatient Hospital or outpatient Hospital setting.

NOTE: Covered services related to an eligible newborn will be covered only if the newborn is added to the member's coverage within the enrollment guidelines specified in Section 10. If the newborn is not added to the coverage within the specified guidelines, the PPO Plan will only cover the initial newborn assessment as set forth in s. 627.6574, Florida Statutes.

Mental Health and Substance Dependency Services

Physician office visits, Intensive Outpatient Treatment, Inpatient and Partial Hospitalization and Residential Treatment Services are covered based on medical necessity.

Nursing Services

Nursing care, including inpatient private duty nursing, by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) is covered.

Occupational Therapy

Occupational therapy services are covered for conditions resulting from a physical or mental illness, injury, or impairment. Coverage and payment for occupational therapy shall not exceed 21 treatment days during any six-month period, counting backwards from the date of each treatment. This maximum applies to all out-patient occupational

therapy treatments regardless of location of service. Occupational therapy services must be provided by a healthcare professional licensed to provide such services. Occupational therapy is also covered for the treatment of Autism Spectrum Disorder and Down Syndrome and under both home health care and hospice services.

Physical Therapy and Massage Therapy

Physical therapy services must be for the purpose of aiding in the Rehabilitation of normal physical function lost due to a covered accident, injury or surgical procedure. Physical therapy is also covered for the treatment of Autism Spectrum Disorder and Down syndrome.

Payment for physical and massage Therapy is limited to a combined maximum of 4 treatments per day, not to exceed 21 treatment days during any six-month period, counting backwards from the date of each treatment. This maximum applies to all outpatient physical and massage therapy treatments, regardless of location of service.

Massage Therapy requires a physician's, Advanced Registered Nurse Practitioner's, or Physical Therapist's prescription noting medical necessity and specifying the number of treatments required, however, not to exceed the physical and massage Therapy maximum noted above. Massage Therapy may be provided by a physician, a chiropractor, a licensed physical Therapist or licensed massage Therapist. Physical therapy may be provided by a physician, chiropractor, or a licensed physical Therapist.

Physician Services

Physician office visits for services, related to disease, illness, injury, accident and preventive care may be covered.

1. There are some special limits on how Doctor visits will be covered by this Plan.
 - a. Whenever you are receiving medical care related to surgery, additional inpatient visits from your Doctor are covered only if:
 - i. you need medical care that is not related to your surgery and is not part of your pre-operative or post-operative care; and
 - ii. you are hospitalized for medical care and the need for surgery develops after you are first admitted to the Hospital. In this case, payment for Doctor visits for other medical care will generally end on the date of surgery.

- b. Non-surgical inpatient Doctor visits are limited to one visit by one Doctor each day. Visits from other Doctors may be covered, however, if needed because of the severity or complexity of your Condition.

- c. Inpatient or outpatient visits to one Doctor for a non-surgical Condition, or related Conditions, are limited to one visit per day.

- d. Outpatient Doctor visits on the same day you have inpatient surgery will not be covered unless the outpatient visit is unrelated to your surgery or is with a Doctor who is not performing your surgery.

2. Outpatient office visits on the same day you have outpatient surgery will not be covered if the charge for the office visit is determined by Florida Blue to be included in the surgery charge. An office visit to a Doctor who is not performing your surgery will be covered, provided the services rendered are covered services as described in this section.

Preventive Care Services

To be eligible for coverage, all services must be for routine preventive care, not for medical diagnosis. Immunizations are covered only within the provisions noted below or when medically Necessary as the result of an accident or injury.

If you use a network Provider, the Plan will pay 100 percent of the allowed amount and you will have no out-of-pocket expenses for eligible services and immunizations. If you use a Non-Network Provider, the Plan will pay 100 percent of the non-network allowance and you will be responsible for the total amount above the Non-Network Allowance. You will be responsible for any costs for services and immunizations in excess of those covered under this provision.

Preventive Care - Adult and Child

Preventive health care (including screening mammograms) and immunization benefits for all covered members shall be age and gender based in accordance with the current grade A and B recommendations of the U.S. Preventive Services Task Force as provided by the Patient Protection and Affordable Care Act and medical policy guidelines established by Florida Blue for preventive services. The assessment of the risk of falls for older adults is included in a preventive care wellness examination or E&M (evaluation and management) visit. Information on covered immunizations and preventive health care services can be found at

www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations, www.cdc.gov/vaccines/acip, and www.healthcare.gov/coverage/preventive-care-benefits.

Covered preventive care services are not subject to a Per Visit Fee (PVF) or calendar year deductible (CYD). Medical/diagnostic mammograms are not included in the preventive care benefit.

Additional Women's Preventive Services: to the extent required by federal law the following services are covered for all female members: human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus (HIV); screening and counseling for interpersonal and domestic violence; screening for gestational diabetes; breastfeeding support, supplies (limited to one breast pump per birth), and counseling; annual well woman visits expanded to include prenatal care, contraceptive counseling and at least one form of contraception in each of the eighteen methods identified in the FDA's most current Birth Control Guide and limited to generic products when available. Other contraceptives may be covered based on medical necessity. For all expanded women's preventive services the Plan will pay 100 percent of the network allowed amount or 100 percent of the non-network allowance. You will be responsible for the total amount above the non-network allowance.

Tobacco screening, cessation counseling and tobacco cessation medications, including prescription and over-the-counter medications, when prescribed by a health care provider and that have a current rating of A or B by the United States Preventive Task Force are covered.

Prostheses

Artificial limbs or eyes may be covered, limited to the first such permanent prosthesis. Coverage is limited to the standard model unless an upgraded model is determined to be medically Necessary. Coverage may be provided for Medically Necessary replacement of a prosthetic device which is owned by you when the replacement is due to irreparable damage, wear, or a change in your condition, or when necessitated due to growth of a child.

Skilled Nursing Facility

Skilled Nursing Facility services are limited to 60 days per calendar year. The patient must meet the following criteria:

1. transferred directly from a Hospital admission of at least three days; and
2. must require skilled care for a Condition that was treated in the Hospital, as certified by a Doctor.

Surgical Procedures

1. Surgery for Female Breast Reduction
Payment for a reduction mammoplasty, which is surgery to reduce the size of the breast and the skin envelope, is not covered unless the patient is experiencing all of the following physical problems:

- a. back or neck pain requiring repeated treatment;
- b. deep grooves in the shoulder from bra straps; and
- c. dermatitis requiring long-term treatment with prescription medications.

In addition to the physical symptoms listed above, the amount of tissue removed from each breast, according to the pathology report, must be at least:

- a. 400 grams for patients 5'2" tall and 110 pounds or less; or
- b. 500 grams for patients over 5'2" tall and 111 pounds or more.

If fewer grams of tissue are to be removed from each breast, benefits may still be paid if:

- a. your Doctor sends a written request for approval to Florida Blue before the surgery is performed, documenting the physical problems and estimating the amount of tissue to be removed;
- b. your Doctor documents the medical reason why the actual amount of tissue was less than the guidelines;
- c. Florida Blue recommends approval; and
- d. DSGI approves the lesser amount.

2. Surgical sterilization

Tubal ligations and vasectomies are covered, whether elective or Medically Necessary.

3. Reimbursement guidelines for multiple surgical procedures:

If more than one surgical procedure is performed at the same time, the primary procedure will be covered at the usual benefit level for the type of provider, meaning the percentage payable for Network or Non-Network Providers.

For the secondary procedure, however, this Plan will pay the lesser of:

- a. 50 percent of the Network Allowed Amount for network care, or 50 percent of the Non-Network Allowance for non-network care; or
- b. 100 percent of the Doctor's fee.

This Plan will not pay any benefits for an incidental procedure performed through the same incision as the primary surgical procedure.

Transplants

In order to be covered, all organ transplants require prior approval by Florida Blue except kidney or cornea. The following transplants may be covered, if prior approval is obtained (except kidney or cornea):

1. bone marrow; donor costs are covered in the same way, including limitations and non-covered services, as costs for the covered person. Donor search costs are limited to immediate family and the National Bone Marrow Donor Program;
2. heart;
3. heart/lung;
4. lung;
5. liver;
6. kidney;
7. kidney/pancreas; and
8. cornea.

Weight Loss Services

In the event that your surgeon requires you to lose weight before a Medically Necessary covered surgical procedure can safely be performed, office visits and non-surgical weight loss services may be covered.

1. Medically Necessary intestinal surgery, stomach bypass surgery or gastroplasty surgery, or
2. Medically related services, excluding prescription drugs, provided as part of a weight loss program when weight loss is required by the covered person's surgeon before performing a Medically Necessary covered surgical procedure. Coverage for these non-surgical weight loss services is limited to a maximum payment of \$150 per person in any 12-month period.

Wigs

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

Section 4: Pre-existing Condition Limitations

This Plan does not have a pre-existing condition limitation provision.

Section 5: Exclusions

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

Abortions which are elective, performed at any time during a pregnancy.

Arch Supports, shoe inserts designed to effect conformational changes in the foot or foot alignment; orthopedic shoes; over-the-counter, custom-made or built-up shoes; cast shoes; sneakers; shoe brace or shoe support, unless the shoe is attached to a brace; for any diagnosis except as required for the treatment of severe diabetic foot disease in accordance with s. 627.6408, Florida Statutes.

Autopsy or post mortem services.

Bulk Powders, Bulk Chemicals, and Proprietary Bases used in compounded medications and over-the-counter products used in compounded medications.

Cardiac Rehabilitation

Clinical Trials

1. Costs that are generally covered by the clinical trial itself, including, but not limited to:
 - a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
 - b. The investigational item, device or Service itself.
 - c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
2. Services related to an Approved Clinical Trial received outside of the United States.
3. Experimental and/or investigational treatment, services, and supplies.

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

and mental healing; mind expansion or elective psychotherapy such as, but not limited to, Gestalt Therapy, Transactional Analysis, Transcendental Meditation, Z-therapy and Erhard Seminar Training; aromatherapy; manual healing methods such as the Alexander technique, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications Resulting from Non-Covered Services, including any service(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications.)

Cosmetic Enhancements to Artificial Limbs

Cosmetic Services, including any service to improve the appearance or self-perception of an individual, are covered only in the limited circumstances identified in Section 3: Covered Services. All other cosmetic services are excluded under this Plan, including without limitation: cosmetic surgery and procedures, prescription drugs or supplies to correct hair loss/baldness or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

Costs Related to Telephone Consultations, failure to keep a scheduled appointment, failure to cancel an appointment timely, and completion of any form(s) and/or medical information.

Custodial Care including, but not limited to, assistance with the activities of daily living. See section 15 for a definition of Custodial Care.

Dental Services and Supplies except those identified as covered in "Section 3: Covered Services.

Drugs and Pharmaceutical Products

The medical portion of the Plan does not cover drugs, medicines, supplies, medications, and treatments that are:

1. typically filled by a prescription order;
2. provided at no cost to the member;
3. over-the-counter drugs, supplies, and treatments;
4. injectable self-administered and do not require medical supervision; or
5. take home drugs, supplies, treatments furnished by the health care provider that can be dispensed by a retail or mail order pharmacy.

E-Medicine, including but not limited to, online medical evaluations, online visits, e-visits, e-consultations, and other services provided remotely to members via the Internet.

Education or Training, except for diabetes outpatient self-management training and educational services pursuant to s.627.6408, Florida Statutes.

Educational Therapy

Electrolysis

Exercise Programs, including cardiac rehabilitation exercise programs, or visits for the purpose of exercise by bicycle ergometer, treadmill or other equipment. These programs or visits are excluded even if the purpose is to determine the feasibility of an exercise program.

Experimental or Investigational Services, prescription drugs and procedures as determined by Florida Blue, CVS Caremark and DSGI, or services, prescription drugs and procedures not in accordance with generally accepted professional medical standards, including complications resulting from these non-covered services including any related services such as anesthesiology, laboratory, pathology, and radiology.

Food, Medical Food Products or Substitutes, regardless of whether these products provide the sole source of nutrition, food substitutes or vitamins, except certain enteral formula food products pursuant to s.627.42395, Florida Statutes, Dietary, nutritional or herbal supplements; non-federal legend drugs or over-the-counter drugs.

Fertility Testing and Treatment for the specific purpose to assist in achieving pregnancy, including in-vitro fertilization, artificial insemination, follicle puncture for retrieval of oocyte, abdominal or

endoscopic aspiration of eggs from ovaries, all other procedures related to the retrieval and/ or placement and/ or storage of oocyte, eggs, embryos, ovum or embryo placement or transfer, gamete intrafallopian transfer, cryogenic and/ or other preservation techniques used in such and/ or similar procedures.

Genetic Tests to determine the father of or the sex of a child.

Hearing Aids or the examination, including hearing tests, for the prescription or fitting of hearing aids. Hearing tests associated with a covered ear surgery, in accordance with child and adult preventive health care benefits, or for the diagnosis of a covered Condition are covered.

Home Health Care

1. homemaker or domestic maid services;
2. sitter or companion services;
3. services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center; or a nursing home facility;
4. speech therapy provided for a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals;
7. services rendered in a Hospital, nursing home, or intermediate care facility; and
8. Home Health Aid, Nurse's Aide or Nursing Assistant.

Human Growth Hormones for the diagnosis and/ or treatment of idiopathic short stature syndrome.

Immunizations and Physical Examinations, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except (1) when the immunizations and/ or physical examinations are within the scope of, and coincide with, the child and/ or adult preventive care benefits or (2) when immunizations are necessary as the result of an Accident.

Marriage Counseling

Mental Health and Substance Dependency Services

1. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for intellectual disabilities;

2. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or for intellectual disabilities;
3. Services for pre-marital counseling;
4. Services for court-ordered care or testing, or required as a condition of parole or probation;
5. Services to test aptitude, ability, intelligence or interest;
6. Services required to maintain employment;
7. Services for cognitive remediation; and
8. Inpatient stays that are primarily intended as a change of environment.

Mental Retardation including all services related to the treatment of mental retardation.

Nursing Home services and supplies provided by an institution that is used mainly as a nursing home or rest facility for the care and treatment of the aged.

Orthodontia even if Medically Necessary as a result of an Accidental Dental Injury.

Orthoptics and/or Vision Therapy

Orthotic Devices, over-the-counter or custom fabricated orthotics, appliances or devices which straighten or reshape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets) except when such appliance is utilized post-operatively to stabilize an infant's skull following craniosynostosis surgery.

Oversight of a Medical Laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion shall include, but not be limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. the calibration of laboratory machines or testing of laboratory equipment;
3. the preparation, review, or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and,
4. laboratory equipment or laboratory personnel for any reason.

Penile Prosthesis including insertion except when necessary in the treatment of organic impotence resulting from:

1. diabetes mellitus;

2. peripheral neuropathy;
3. medical endocrine causes of impotence;
4. arteriosclerosis/postoperative bilateral sympathectomy;
5. spinal cord injury;
6. pelvic-perineal injury;
7. post prostatectomy;
8. post priapism; or
9. epispadias and exstrophy.

Personal Comfort, Hygiene or Convenience Items including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance services);
8. motel/hotel or other housing accommodations or lodging even if recommended or prescribed or approved by and/or deemed medically necessary by a physician or other service provider but does not have as its primary purpose the provision of medical services or treatment, although it may facilitate the receipt of medical treatment, including housing obtained or provided by or with assistance of a medical facility;
9. equipment which is primarily for your convenience and/or comfort, or the convenience of your family or caretakers; modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; electric scooters; water therapy devices such as Jacuzzis, hot tubs, swimming/lap pools or whirlpools; membership to health clubs, exercise, physical fitness and/or massage equipment; hearing aids; air conditioners and purifiers, furnaces, air filters, humidifiers; water softeners and/or purifiers; pillows, mattresses or waterbeds; escalators, elevators, stair glides; emergency alert equipment; blood pressure kits, handrails and grab bars; heat appliances and dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. heating pads, hot water bottles, or ice packs; and
11. massages except as described in section 3.

12. In addition to the above, also excluded are other services not directly used to provide treatment.

Preventive Care except those services covered as part of the child or adult preventive health care benefits described in section 3.

Recreational Therapy including but not limited to treatment services and recreational activities that use a variety of techniques such as arts and crafts, animals, equine, sports, games, dance and movement, drama, music, and community outings.

Refractive Services and Supplies including services for treating or diagnosing refractive disorders such as eye glasses, contact lenses, or the examination for the prescribing or fitting of eye glasses or contact lenses (except one annual eye examination, as covered under child or adult preventive services), unless required because of an Accident or cataract surgery. This Plan will cover only the first pair of standard frames and lenses for eyeglasses or contact lenses following an Accident to the eye or cataract surgery.

Reversal of Voluntary Surgical Sterilization Procedures including the reversal of tubal ligations and vasectomies.

Sexual Reassignment, or Modification Services or Supplies, including, but not limited to, any health care service related to such treatment, such as services necessary to treat sexual deviations and disorders, psychosexual dysfunction or services or supplies provided in connection with intersex surgery.

Skilled Nursing Facility services and supplies provided by a Skilled Nursing Facility for:

1. Custodial Care, including but not limited to, assistance with the activities of daily living;
2. alcoholism, drug addiction or Mental and Nervous Disorders; or
3. the convenience of the covered person or covered person's family.

Sleep Therapy

Speech Therapy and/or Speech Evaluations except for the treatment of cleft lip or cleft palate for children under 18 years old and for the treatment of Autism Spectrum Disorder and Down syndrome.

Telephone Consultations

Testicular Prosthesis services or supplies.

Tobacco Cessation Programs including any service or supply to eliminate or reduce a dependency on, or addiction to, tobacco, except those identified as covered in Section 3: Covered Services.

Travel, Vacation, or Repatriation Expenses even if prescribed or ordered by a physician.

Vocal Therapy

Weight Reduction Services including all services, supplies, and prescription drugs related to obesity except those identified as covered in Section 3: Covered Services.

Wigs and Expenses for Wigs, unless hair loss is caused by chemotherapy, radiation therapy or cranial surgery. Coverage for wigs in those cases is limited to a maximum payment of \$40 for one wig and fitting in the 12 months following treatment or surgery.

Additional Exclusions include, but are not limited to:

1. Services and supplies to diagnose or treat a Condition which, directly or indirectly resulted from or is in connection with:
 - a. war or act of war while in any active military, naval or air service, whether declared or not; or
 - b. the covered person's participation in a crime punishable as a felony or illegal occupation.
2. Services, supplies or treatment provided without charge.
3. Services or supplies, and any related services that are not Medically Necessary, as determined by Florida Blue and/or CVS Caremark clinical staff and DSGI.
4. Services, supplies, care or treatment provided by:
 - a. a person who usually lives in the covered person's home; or
 - b. a person or facility that is not included as covered in this Plan Booklet and Benefits Document.
5. Services for any occupational Condition, ailment or injury arising out of or in the course of employment by any employer. The covered person will not be eligible for benefits from this Plan, even if the covered person waives rights to the benefits or services mentioned above.
6. Services provided to a covered person under the laws of the United States or any state or political

subdivision. The covered person will not be eligible for benefits from this Plan, even if the covered person waives rights to the benefits or services mentioned above.

7. Services of a Covered Provider that are not patient specific. Such non-patient-specific services include, but are not limited to, the oversight of a medical laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, testing equipment, or laboratory technicians.
8. Any health care service received prior to your and/or your dependent's effective date or after the date your and/or your dependent's coverage terminates.
9. Claims for services that have been submitted for payment to Florida Blue or CVS Caremark more than 16 months after the date the services, prescription drugs or supplies were received.
10. Agreements you or your covered dependent sign with a Network provider for special pricing or for expedited services may negate the Network provider's agreement with Florida Blue to accept a Network Allowed Amount as well as your cost share as payment in full resulting in additional out-of-pocket expenses for you.
11. Services rendered by any provider that are outside the scope of such provider's license or certification.

Section 6: About the Provider Network

Preferred Patient CareSM (PPCSM) Network

The Blue Cross and Blue Shield of Florida Preferred Patient CareSM (PPCSM) Network is this Plan's preferred provider organization (PPO) network. The PPCSM Network includes a broad range of Hospitals, independent doctors, and other health care provider specialties, including but not limited to family practice, internal medicine, obstetrics and gynecology, and pediatrics.

Florida Blue, as the PPCSM Network manager, evaluates the credentials of providers for membership in the PPCSM Network. The responsibility of selecting the providers and facilities that make up the network and for addressing Network-Provider related issues and concerns rests with Florida Blue as the PPCSM Network manager. Contractually, DSGI does not have authority over the development and make-up of the PPCSM Network.

Florida Blue negotiates contract agreements with the providers in the PPCSM Network to provide health care services to Plan participants at reduced amounts. PPCSM Network Providers have agreed to accept these negotiated rates as payment for covered services.

You are responsible for any applicable Copayment and/or a percentage of the Network Allowed Amount as your Coinsurance. The Network Provider cannot bill you for the difference between the provider's actual charges and the Network Allowed Amount for the service (called balance-billing).

How to Use the PPCSM Network

As a member of this Plan you can find providers participating in the PPCSM Network by:

- Calling Florida Blue Customer Service toll-free at (800) 825-2583;
- Logging into the Florida Blue websites, www.floridablue.com/state-employees or www.floridablue.com; or
- Asking the health care professionals of your choice if they participate in the PPCSM Network.

Because the PPCSM Network is extensive, you may find that the health care professionals you already use are part of the network. However, it's always a good idea to confirm that the provider is still in the network. A provider's network status can change at any time without notice.

When you go for treatment, take your Florida Blue identification card with you. Your card will help the provider confirm your eligibility and coverage and will also ensure that your claim's paperwork is handled properly.

Non-Network Providers in the Traditional Network

If you are going to receive services from a Non-Network Provider, you should try to choose a Non-Network Provider that is participating in Florida Blue's Traditional Network.

Florida Blue has agreements with providers throughout the state, including Doctors, Hospitals, and other health care Specialists, who are not in the PPCSM Network but have agreed to charge within a negotiated limit that is not higher than the Non-Network Allowance. These providers are sometimes called Traditional Program Providers and include Payment for Professional Services (PPS) and Payment for Hospital Services (PHS) providers. These providers can be identified by asking the provider or by calling Florida Blue Customer Service toll-free at (800) 825-2583.

Since Traditional Network providers are Non-Network or Non-Participating, when you go to Traditional Network providers this Plan pays at the lower Non-Network level of benefits. You have a higher Non-Network member cost share, but you are protected from being balance-billed for charges above the Non-Network Allowance.

Important Information About Using Non-Network Providers (Non-Participating Providers)

In the case of a Non-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Non-Network Provider for the specific Covered Services provided to you, the Non-Network Allowance will be the lesser of that Non-Network Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to:

- payment for such Covered Services under the Medicare and/or Medicaid programs;
- payment often accepted for such Covered Services by that Non-Network Provider and/or by other providers, either in Florida or in other comparable market(s), that Florida Blue

determines are comparable to the Non-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Non-Network Provider and/or by other providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations);

- payment amounts which are consistent, as determined by Florida Blue, with our provider network strategies (e.g., does not result in payment that encourages providers participating in a Florida Blue network to become non-participating); and/or,
- the cost of providing the specific Covered Services.

In the case of a Non-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard® Program, the Non-Network Allowance for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the services were provided at the amount such organization would pay Non-Network Providers in its geographic area for such services.

In no event will the Non-Network Allowance be greater than the amount the Non-Network Provider actually charges.

If a particular Covered Service is not available from any provider that is in PPCSM, as determined by Florida Blue, the Non-Network Allowance, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar providers in a geographical area established by Florida Blue.

You may get an estimate of the Non-Network Allowance or the Network Allowed Amount for particular services by calling Florida Blue Customer Service toll-free at 1-800-825-2583. The fact that Florida Blue or DSGI may provide you with such information does not mean that the particular service is a Covered Service. All terms and conditions included in this Plan Booklet and Benefits Document apply. Please refer to Section 1 (Standard PPO Option Summary of Benefits), Section 2 (PPO High Deductible Health Plan Option Summary of Benefits), Section 3 (Covered Services), and Section 5 (Exclusions) for more detailed information on the Plan and member cost share amounts, covered services, and exclusions.

Non-Network Providers may bill you their regular charges. You will be responsible for larger Coinsurance and Deductible amounts and for paying the difference between the provider's charges and the amount established as the Non-Network Allowance. This is called balance billing.

There are two exceptions to the practice of balance billing.

Effective July 1, 2016 and in accordance with s. 627.662(15), Florida Statutes, Non-Network Providers may not balance bill Plan members for:

1. Covered emergency services, as defined in s. 641.47(8), Florida Statutes; or
2. Covered nonemergency services provided at an In-Network Facility when you do not have the ability and opportunity to choose a Participating Provider.

A Non-Participating Provider of Covered emergency services and Covered nonemergency services, as described in numbers one and two in this box, may not collect or attempt to collect from you any amounts greater than the appropriate Non-Network Copayments, Coinsurance, and Deductibles.

To receive the highest level of benefits from this Plan, it is important to understand your out-of-pocket expenses when you use Non-Network Providers. The Summary of Benefits in Sections One and Two clearly display the cost share that will be paid by you and this Plan when you use Network and Non-Network Providers.

You may request that Network Providers be used whenever possible. However, in some situations you will have no choice but to use Non-Network Providers. In those cases, the Non-Network Provider's services will be paid at the Non-Network benefit level. Out-of-pocket expenses for Non-Network services may be significantly greater than for Network services

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED.

You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. **YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.**

Continuity of Care

To provide continuity of care, DSGI and Florida Blue have developed a “transition of care” policy for certain situations when your provider terminates his or her PPO network participation during a course of treatment. When it would not be consistent with quality medical care to require that you transfer your care to another In-Network Provider, this Plan may continue to provide in-network benefits for services rendered by your current provider during the course of treatment or for a set period of time. Examples of Conditions and services, which may qualify for the transition of care policy, include but are not limited to:

Pregnancy – when in the second trimester as of the date the provider’s participation status changed.

Pre-Scheduled Surgery – when approved and scheduled prior to the provider’s participation status change and performed within 30 days of the change in the provider’s participation status.

End Stage Renal Disease (ESRD) – when approved within 30 days of the provider’s change in participation status.

Outpatient Rehabilitation Services – initiated prior to the date of the provider’s change in participation status, when approved through 30 days as of the date the provider’s participation status changed.

Chemotherapy/Radiation Therapy – when approved through the conclusion of the concurrent treatment plan in process, through 90 days, as of the date the provider’s participation status changed.

Section 7: Additional Required Provisions

IMPORTANT NOTE: Hospital admission certification and hospital stay certification only certifies the inpatient setting. Certification of an inpatient setting does NOT guarantee that any services or procedures rendered during the inpatient stay will be covered.

Hospital Admission and Hospital Stay Certification

Non-Network Hospital: Non-emergency Admission

Every non-emergency admission to a non-network Hospital must be pre-certified. This means that before services are provided Florida Blue must certify the Hospital admission and provide the number of days for which certification is given. Precertification of non-network Hospital stays is your responsibility, even if the Doctor admitting you or your dependent to the Hospital is a Network Provider. Failure to obtain pre-certification will result in penalties (higher out-of-pocket costs). For more information on penalties, see “If You Do Not Pre-Certify Your Stay” within this section below.

To pre-certify your stay in a non-network Hospital, ask your Doctor to call Florida Blue at (800) 955-5692 before your Hospital admission and provide the reason for hospitalization, the proposed treatment or surgery, testing, and the number of Hospital days anticipated.

Florida Blue will review your Doctor’s request for admission certification and immediately notify your Doctor or the Hospital if your admission has been certified and the number of days for which certification has been given. If the admission is not certified, your Doctor may submit additional information for a second review.

If your Hospital stay is certified and you need to stay longer than the number of days for which certification was given, your Doctor must call Florida Blue to request certification for the additional days. Your Doctor should make this call as soon as possible.

Non-Network Hospital: Emergency Admission

If you are admitted to a non-network Hospital in a medical emergency, including maternity admissions, you must notify Florida Blue within one working day of your admission, or as soon as reasonably possible. You are responsible for this notification. Florida Blue will review the admission information and certify the Hospital stay as appropriate.

If You Do Not Pre-certify Your Stay: Non-Network Hospital

1. Benefits for covered services **will be reduced** by 25 percent of the covered charges, not to exceed a maximum benefit reduction of \$500 IF you are admitted to a participating Hospital (Payment for Hospital Services or PHS provider) that is not part of the Preferred Patient CareSM (PPCSM) Network and admission certification has not been requested on your behalf or the request is denied.
2. This Plan **will not pay** room and board benefits for your first two days of hospitalization IF your non-network Hospital admission is denied, but you are admitted to a non-network Hospital anyway.
3. This Plan **will not pay** room and board benefits for your entire Hospital stay IF you are admitted to a non-network Hospital without having your Doctor call prior to the admission.
4. This Plan **will not pay** room and board benefits for the additional days that were not certified IF your non-network Hospital admission is certified but your stay is longer than the number of days for which the admission was certified.

Network Hospital

You are not required to obtain pre-admission certification to a network Hospital. The network Hospital handles precertification for you. Because precertification is the Hospital’s responsibility when you use network Hospitals, you will not be penalized if the network Hospital fails to pre-certify your admission.

Florida Blue will review requests for Hospital admissions and for extended Hospital days in accordance with national Hospital admission criteria standards. Only a medical Doctor can deny a Hospital admission or request for additional Hospital days.

Pre-Determinations and Prior Authorizations – Medical Services

Diagnostic Imaging Program

The Diagnostic Imaging Program is designed to ensure you receive clinically appropriate care when your medical provider considers certain advanced imaging services, including CT scans, PET scans, MRIs, MRAs, and nuclear cardiology. Because of the specialized nature of advanced imaging services and the need to determine if the service is covered under this Plan, Florida Blue utilizes the expertise of National Imaging Associates, Inc. (NIA), a nationally recognized radiology management firm. Managing advanced imaging services promotes member safety in addition to addressing quality outcomes.

The Diagnostic Imaging Program offers a voluntary pre-service coverage review to determine if your advanced imaging service or procedure is covered under this Plan. The pre-service reviews are conducted to determine if, at the time of the review, the service or procedure would be covered. To take advantage of the Diagnostic Imaging Program, ask your Doctor to request a pre-service coverage review for any advanced imaging procedures by contacting NIA at (866) 326-6302. Medical professionals will review your case with your provider and make a medical necessity determination before certain advanced imaging services are rendered.

A pre-service review does not guarantee that a service will or will not be covered. The final determination of coverage will be made when your claim is actually received and processed by Florida Blue. However, a pre-service review may indicate that there is a possibility that a service or procedure will not be covered under this Plan. It is strongly recommended that you have a pre-service review for all advanced imaging procedures to avoid the surprise and financial liability if the claim for the advanced imaging procedure is denied.

Provider Administered Drug Program

The Provider Administered Drug Program (PADP) is a utilization management pre-service review program for specific oncology and related drugs. This program, administered on behalf of Florida Blue by Magellan Rx, promotes quality of care and affordability for you as a member. Not all Network Providers participate in this utilization management pre-service review program for certain immune globulin (IG) therapy drugs, oncology and related drugs administered in the Physician office. It is

strongly recommended that you have your provider request a pre-service review.

If your Network Provider participates in the PADP, it is the Network Provider's sole responsibility to comply with the pre-service review process before the drug is purchased or administered. If a pre-service review is not obtained by the PADP participating Network Provider you will not be responsible for any related benefit reductions or costs. However, if authorization for a drug is denied in pre-service review and you elect to receive the drug anyway, you will be responsible for the total cost of the drug and its administration.

PADP participating providers should contact Magellan RX Management at <http://ih.magellanrx.com> or (800) 424-4947 to obtain a mandatory utilization management pre-service review.

A provider not participating in the PADP (network or non-network) may request a pre-service review. However, such voluntary pre-service coverage review is not required. If a pre-service review is not requested by a provider who does not participate in the PADP (network or non-network), you will be responsible for the entire cost of the drug and its administration if the drug is ultimately determined to be not Medically Necessary. A voluntary pre-service coverage review does not guarantee that a service or drug will be covered.

A provider not participating in the PADP (network or non-network) should contact Florida Blue at (800) 955-5692 to obtain a voluntary pre-service review.

Clinical/Utilization Review – Prescription Drugs

Specialty Drugs are high-cost injectable, infused, oral, or inhaled drugs that are used to treat certain chronic or complex disease states. Specialty Drugs may include genetically engineered drugs (sometimes called Biotech drugs) that are used to treat rare or chronic Conditions, including but not limited to, rheumatoid arthritis, hepatitis C, multiple sclerosis, growth hormone deficiency and cancer. These therapies often require customized management and frequent monitoring as well as having unique handling, distribution, and administration requirements.

The majority of all specialty medications are delivered through CVS Specialty pharmacy. Your prescribing Physician must contact CVS Caremark in advance at www.cvsspecialty.com or <https://info.caremark.com/epa> or (800) 237-2767 to verify coverage and to

receive authorization for the specialty medication. You may choose how to get your medication: have it delivered to an address of your choice, such as your home or your physician's office; or you may pick it up at your local CVS retail pharmacy, including those located inside Target stores.

Specialty Drugs are subject to clinical/utilization review under the Specialty Guideline Management Program that provides specific treatment guidelines for specialty medications covered under this Plan. Through this Program, CVS Caremark will work with your Physician to ensure that the most appropriate drug treatment is being prescribed and utilized including but not limited to diagnosis review in accordance with the most recent evidence-based medical guidelines, U. S. Food and Drug Administration labeling, lab results, safety requirements, and day supply quantity limits.

If approval for a Specialty Drug is denied, in accordance with the treatment guidelines of the Specialty Guideline Management Program, and you elect to receive the Specialty Drug anyway, you will be responsible for the total cost of the Specialty Drug.

If clinical/utilization review is not requested and approval received you may be responsible for the total cost of the Specialty Drug if the drug is ultimately considered not Medically Necessary or is not in compliance with treatment guidelines under the Specialty Guideline Management Program.

IMPORTANT NOTE

Some specialty medications may qualify for third-party copayment assistance programs, including manufacturer copay coupons, that when used will lower your out-of-pocket costs for the specialty medication. If you use any such third-party copayment assistance for your specialty medication, you will not receive credit toward your annual deductible, annual coinsurance maximum out-of-pocket, or annual global in-network maximum out-of-pocket for any copayment or coinsurance amount(s) that are applied to a manufacturer coupon or rebate.

Section 8: Special Plan Features

Member-Focused Programs

Member-focused programs are designed to address such things as health promotion, prevention and early detection of disease, chronic illness management programs, case management programs and other member-focused programs. This subsection provides an overview of some of the programs available to you.

Healthy Addition® Prenatal Education Program

Healthy Addition® is Florida Blue's prenatal education and early intervention program. It is designed to educate pregnant employees or eligible spouses about appropriate prenatal education and care, including monitoring of high-risk pregnancies. Under this voluntary program, trained nurses will screen pregnant employees or eligible spouses for potential risk factors and assist in the development of a personalized educational and monitoring program.

To participate in the Healthy Addition® program, call Florida Blue at (800) 955-7635, option 6. A member of the prenatal nursing team will contact you or your spouse to begin helping you with your new family addition.

Health Dialog®

The Health Dialog® Program, a product of Health Dialog Corporation, is a health information program offered at no cost to you through Florida Blue. When it comes to making important decisions about your health, a little extra information and support may be helpful. The Health Dialog Program offers:

- Health Coaches: Day or night, 365 days a year, you can talk about immediate or everyday health concerns;
- Educational materials by mail: Members receive at no charge;
- Online Dialog CenterSM: Health Dialog's educational website;
- Audiotapes by phone: Audiotapes on more than 300 health care topics.

On the phone and online, access to Health Dialog® is easy. Call toll-free (877) 789-2583 (for hearing and speech impaired assistance, dial (877) 900-4304) or get additional information online at www.floridablue.com or www.floridablue.com/state-employees.

Please remember that all decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely your responsibility and the responsibility of your Physicians and other health care providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how care should be provided. In making Health Dialog® available to you, neither the State of Florida, Florida Blue nor Health Dialog Services Corporation shall be deemed to be providing medical care or advice to you. Health Dialog® and Dialog CenterSM are trademarks of Health Dialog Services Corporation. Used with permission.

Medical Case Management Program

The Medical Case Management Program provides a valuable service if you have a complex Condition that requires many types of treatment over a lengthy period of time. The program allows your health care providers to consider all the alternatives available, not just the traditional services typically covered by health insurance plans.

Through this program, Florida Blue helps coordinate alternative treatments when a covered person is faced with a serious or complicated medical Condition. These alternative treatments may include services that are not usually covered by this Plan.

The medical case management program is voluntary. Health care professionals will review the case with the patient, the patient's family and Doctor and, if appropriate, suggest an alternative treatment plan. The patient and the patient's Doctor must agree to the suggested treatment plan.

If the patient's alternative treatment plan is approved by Florida Blue, recommended services will be paid at 100 percent of the charge negotiated by Florida Blue.

The case management alternative treatment plan will end if:

1. the patient's Condition changes and the level of care provided under case management is no longer necessary;
2. the traditional Plan benefits; or
3. the patient is no longer eligible to take part in this Plan.

To obtain information on the Case Management Program call Florida Blue Customer Service at (800) 825-2583 or to participate in the Case Management Program call the Florida Blue Case Management Voice Mailbox at (800) 955-5692, Option 3.

Florida Blue Website

The Florida Blue website, floridablue.com, is a website that provides helpful information you need to know about the Plan, plus free tools and resources to help manage your health care needs—any time, day or night. You can log in to:

- Review your plan benefits.
- See where you stand with your deductible.
- View your claim activity, status and history.
- Find a Doctor or Hospital in the Preferred Patient CareSM (PPCSM) Network.
- View and print your Member Health Statement.
- Communicate with a Health Dialog[®] Health Coach including nurses, Dieticians and respiratory therapists.
- Join Better You Strides, an online program that gives you a step-by-step guide to better health:
 - Take a personal health assessment to get a picture of your health.
 - Receive your Personal Health Itinerary[®] to help you get and stay healthy. Based on your interests, needs and goals, this custom-made plan contains programs about healthy eating, tips to move more and ways to manage stress.
 - Track your progress from your smart phone using the CaféWell mobile app.
 - Participate in wellness challenges that make getting healthy fun.
- Save money on health-related discounts that are not part of this Plan, including gym memberships, weight loss programs, vision and hearing care.

To register, go to www.floridablue.com or www.floridablue.com/state-employees.

HopeBlue Palliative Care Program

The HopeBlue Palliative Care Program is for patients suffering from symptoms due to a serious illness. The program allows your health care providers to focus on curative treatment, while palliative care experts help to coordinate care for to help manage treatment of symptoms such as severe pain, anxiety and depression.

To participate in the HopeBlue Palliative Care Program, call Florida Blue at (800) 955-5692, option 3.

Care Profile Program – A Payer-Based Health Record Program

Under the Florida Blue Care Profile Program, a care profile is available to treating Physicians for each person covered under the Plan. This care profile allows a secure, electronic view of specific claims information for services rendered by Physicians, Hospitals, labs, pharmacies, and other health care providers. Unless you have chosen to opt out, here are a few of the benefits of participation in the Care Profile Program:

1. All authorized treating Physicians will have a consolidated view – or history – of your health care services, assisting them in improved decision-making in the delivery of health care.
2. In times of catastrophic events or emergency care, the care profile will be accessible from any location by authorized Physicians so appropriate treatment and service can still be delivered.
3. Safe and secure transmission of claim information. Only authorized health care providers or authorized members of the provider's staff will have access to your information.
4. Coordination of care among your authorized treating health care providers.
5. More efficient health care delivery for State Employees' PPO Plan participants.

Keeping your health information private is extremely important, so your care profile will not include certain health information that pertains to "sensitive" medical Conditions for which the law provides special protection. Health care providers access the care profile using the same secure, electronic channel they use to file claims. In addition, only authorized members of the provider's staff will have access to the information. Remember, this will help your Physician in obtaining important information concerning your health history.

However, if for some reason you, or any of your family members, choose not to provide your treating Physician access to your claim history, the use of this information may be restricted. Should you choose not to participate, call (800) 825-2583 and inform a service representative of your decision.

PATCH (Physician Assessment, Treatment and Consultations at Home) Program

PATCH is a program for patients who are homebound due to a medical Condition which limits the patient's ability to access care. The program promotes access to Physicians who can provide medical care in the home setting for patients unable to access such care from his or her own treating Physician.

To participate in PATCH, call Florida Blue at (800) 955-5692, option 4.

Patient-Auditor Program

Sometimes providers make a mistake and Overcharge a patient. This may result in an overpayment of the claim by this Plan. If you discover an overpayment for:

1. a charge for a covered service or supply that the covered person did not receive;
2. a charge higher than the amount previously agreed to in writing by the provider in a pre-treatment estimate, other than charges for complications or procedures that were not anticipated; or
3. a charge that is part of an arithmetic billing error, you may receive 50 percent of any amount the Plan recovers, up to a maximum of \$1,000 per inpatient stay or outpatient claim. Contact DSGI at (850) 921-4600 to request a form to file a Patient Auditor claim. Report any suspected Overcharges to DSGI.

BlueCard® Program – Services Outside Florida Blue's Service Area

Overview

Florida Blue, a Blue Cross and Blue Shield Licensee, has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you or your covered family member access Covered Services and Supplies outside Florida Blue's service area, the claim for those Covered Services and Supplies may be processed through one of these Inter-Plan Arrangements.

When you or your covered family members receive care outside of the BlueCard® Service Area, which includes the United States, the Commonwealth of

Puerto Rico, and the U.S. Virgin Islands, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). However, some Providers ("Nonparticipating Providers") don't contract with a Host Blue.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types that are eligible to be processed through Florida Blue when those claim services are rendered inside the state of Florida are eligible to be processed by these Inter-Plan Arrangements.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Florida Blue will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you and your covered family members receive Covered Services outside of Florida and the claim is processed through the BlueCard® Program, the amount you and your covered family members pay for Covered Services is calculated based on the lower of:

- The billed covered charges for such Covered Services; or
- The negotiated price that the Host Blue makes available to Florida Blue.

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

The use of estimated or average pricing may result in a difference (positive or negative) between the price paid on a specific claim and the actual amount the Host Plan pays your provider. However, the BlueCard® Program requires that the amount paid to your provider is a final price; no further price

adjustment will result in increases or decreases to the pricing of past claims.

Return of Overpayments

Recoveries from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied in general, on either a claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such third party may be charged under the BlueCard® Program as a percentage of the recovery.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require that a surcharge, tax or other fee be applied to claims paid by self-funded health insurance plans. When applicable, Florida Blue will include any such surcharge, tax or other fee as part of the claim.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, this Plan's payment will be based on the Non-network allowance, as defined in Section 15 of this Benefits Document. You and your covered family members may be responsible for the difference between the amount that the non-participating provider bills and amount paid by this Plan.

Blue Cross Blue Shield Global® Core Program

If you and your covered family members are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands ("BlueCard® Service Area"), you and your covered family members may be able to take advantage of the Blue Cross Blue Shield Global® Core Program when accessing Covered Services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard® Program in certain ways. For instance, although the Blue Cross Blue Shield Global® Core Program will assist you with locating Network Providers, the Network is not served by a Host Blue. As such, when you receive care from such Providers outside the BlueCard® Service Area, you will typically have to pay the Providers and then submit the claims yourself to get reimbursement for any Covered Services.

If you and your covered family members need medical assistance services (including locating a

doctor or hospital) outside the BlueCard® Service Area, you and your covered family members should call the Blue Cross Blue Shield Global® Core Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global® Core Service Center for assistance, Network hospitals will not require you to pay for inpatient Covered Services other than your normal cost share amounts. In such cases, the Network hospital will submit your claims for Covered Services to the Blue Cross Blue Shield Global® Core Service Center to begin claims processing. If you use a Non-Network hospital or for any other reason pay in full at the time of service, you must submit a claim to receive reimbursement for any Covered Services. When you use a Non-Network provider this Plan will pay at the lower Non-Network level of benefits but you are protected from being balance billed and will not be responsible for the charges above the Non-Network Allowance.

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard® Service Area will typically be Non-Network Providers and will generally require you to pay in full at the time of service. You must submit a paper claim to receive reimbursement for any Covered Services. When you use a Non-Network provider this Plan will pay at the lower Non-Network level of benefits.

Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered Services outside the BlueCard® Service Area (the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands), you must submit a claim to receive reimbursement for Covered Services. The claim form is available from the BlueCard Global Core Service Center or online at www.bcbsglobalcore.com Please remember to attach the Provider's itemized bill(s) and mail to the address on the claim form. If you need assistance with submitting your claim, you may call the BlueCard Global Core Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Blue Cross Blue Shield Global® Core Website

The Blue Cross Blue Shield Global® Core website includes many valuable resources in addition to helping you find hospitals and doctors outside the BlueCard® Service Area. After accepting the Terms of Use and End User License Agreement and entering the first three letters of your member ID number (XJJ), you will have the availability to search for doctors and hospitals in dozens of countries throughout the world; you can even search for specific doctor specialties. The provider profile lists the address (including a map), phone number, languages, education/certification, and more. You can also download a claim and submit it online. Additional information on the website includes country telephone codes, embassy locations and phone numbers, unit of currency and converter, general country information, vaccination requirements and health risks, Travel Resources including Department of State Travel Warnings, City Health Profile, translations for drug names, medical terms and medical phrases, and so much more. Before you travel outside the United States take advantage of the valuable information and resources on this website.

Section 9: Prescription Drug Program

How the Program Works

You automatically participate in the State Employees' Prescription Drug Plan if you are enrolled in the State Employees' PPO Plan. The Plan features a network of participating retail pharmacies and a mail order program. Below is an overview suggesting when to use each.

Participating Retail Pharmacies: 30-Day Supply

Use for short-term medications, or medications that you need immediately, like antibiotics for a sick child, up to a 30-day supply at one time. Maintenance medications must be filled through the mail order program or by a participating 90-Day Maintenance at Retail pharmacy after three (3) fills at a 30-day retail pharmacy.

Mail Order Program and Participating Retail Pharmacies: 90-Day Supply

Use for maintenance or long-term medications you take regularly, like high blood pressure medication, up to a 90-day supply at one time, as long as the prescription is written to allow dispensing of a 90-day supply. Maintenance medications must be filled through the mail order program or by a participating 90-Day Maintenance at Retail pharmacy after three (3) fills at a 30-day retail pharmacy.

Purchasing Prescriptions at 30-day Retail Pharmacies

When your Doctor prescribes a medication, you may have your prescription filled at any pharmacy, but using pharmacies that participate in the pharmacy network has advantages, such as:

- You pay a set Copayment for prescriptions (Standard PPO Option only)
- You do not have to file a claim form

Participating 30-day retail pharmacies include most major drug chains, with over 59,000 pharmacies nationwide. To find out if a pharmacy participates in the 30-day retail network, call (888) 766-5490 or visit www.Caremark.com.

Using a Participating 30-Day Retail Pharmacy

When you take your prescription to a participating pharmacy, simply present your prescription drug program card to the pharmacist. You will pay a Copayment or Coinsurance for up to a 30-day supply of each covered prescription:

Standard PPO Option

- \$7 for a generic drug
- \$30 for a preferred brand name drug
- \$50 for a non-preferred brand name drug
- For oral cancer treatment medications your cost will be the lesser of the appropriate copay or \$50
- The brand Copayment *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

PPO High Deductible Health Plan Option

- 30% for a generic drug subject to calendar year deductible (CYD)
- 30% for a preferred brand drug (subject to CYD)
- 50% for a non-preferred brand drug (subject to CYD)
- For oral cancer treatment medications your cost will be the lesser of the appropriate coinsurance or \$50 (subject to CYD)
- The CYD and/or brand Coinsurance *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

There is no paperwork when you use your prescription drug program card at a participating 30-day retail pharmacy. The claim will be submitted electronically.

Medication Synchronization at Retail Pharmacies

Medication Synchronization (Med Sync) allows you to save time and reduce the number of trips to your network retail pharmacy by requesting that your retail pharmacist "synchronize" all your medication refills so you can pick them all up on the same day. Med Sync is optional and only allowed once per calendar year at a network pharmacy and some medications are not eligible for synchronization. Ineligible medications are: all controlled substances, any drug dispensed in unbreakable packaging from the manufacturer, and a multi-dose unit of medication. When synchronizing or aligning your refills some prescriptions will be for a shorter day supply. When this happens your copay or coinsurance will be prorated to the shortened-day supply that is actually dispensed. For example: assume by synchronizing your prescription you will

only be picking up an eight-day supply of what would normally be a 30-day supply. If your cost is \$7.00 for this 30-day supply the cost per day is \$0.23 ($\$7 \div 30 = .23$), but since you are only getting an eight-day supply you will pay \$1.87 ($\0.23×8). Important Note: Any short or sync prescription fill that would have normally been filled for a 30-day supply will count as one of the three fills of maintenance medications allowed at a retail pharmacy before being required to use mail order or a 90-day participating retail pharmacy

What if You Request a Brand Name at a Participating 30-day Retail Pharmacy?

If your prescription is filled with a generic, you pay only the applicable Copayment or Coinsurance. If a generic equivalent isn't available for a brand name drug, or if your Doctor writes on the prescription "dispense as written" or "brand name Medically Necessary," you pay the applicable Copayment or Coinsurance for the brand name. However, if you request a brand name instead of an available generic equivalent, you will pay the lesser of

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

An Example – Using a Participating 30-Day Retail Pharmacy on the Standard PPO Option:

At network pharmacies, the Plan's contracted rate for a drug is less than the full retail price. Assume you request a preferred brand name drug that costs the Plan \$50 instead of the available generic substitute that costs the Plan \$25. In this case, you would pay:

The difference in the Plan's cost between preferred brand name and generic		Brand	\$50
	–	Generic	\$25
		Total	\$25
Preferred Brand name Copayment	+		\$30
Your cost			\$55

Using a Non-Participating Pharmacy

To receive prescription drug benefits when you use a non-participating pharmacy, you must pay the full retail price for your prescription and file a claim for reimbursement. You will not be reimbursed in full for prescriptions filled at a non-participating pharmacy.

If you fill your prescriptions at a non-participating pharmacy, you will be reimbursed based upon

the network pharmacy contracted rate minus your Copayment or Coinsurance amount. Additionally, you pay any amount above the network pharmacy contracted rate.

An Example – Using a Non-Participating Pharmacy on the Standard PPO Option:

Suppose you fill a prescription for a brand name drug with a network pharmacy rate of \$50 and a retail price of \$85. You will pay \$85 for the prescription and submit a claim for reimbursement. You will be reimbursed:

\$85 minus \$50		\$35.00
<i>minus</i> your Copayment	–	\$30.00
Total reimbursement		\$5.00

In this example, the cost to you for using a non-participating pharmacy is \$80.00 (\$85.00 retail price minus reimbursement of \$5.00). If you had filled this prescription at a participating 30-day pharmacy and your Physician requested the brand name drug, you would have paid only the \$30 Copayment on the Standard PPO Option.

What are Generics?

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

- Generic equivalent drugs have the same active ingredients as the brand name, but they are less expensive because the brand name manufacturer makes the initial investment for product research and development.
- The Food and Drug Administration (FDA) reviews generic products regularly to make sure they are safe and effective.
- Ask your Doctor if a generic can be substituted for its brand name equivalent.

Using a Mail Order Pharmacy or a Participating 90-Day Retail Pharmacy

If you are taking a maintenance medication, this Plan requires that you use either the prescription drug mail order pharmacy or a participating 90-day retail pharmacy after three (3) 30-day fills at a retail pharmacy.

To order up to a 90-day supply by mail order, you:

- Complete a mail order form available from CVS Caremark at (888) 766-5490 or www.Caremark.com.
- Be sure to have at least a 14-day supply on hand when ordering.
- Your medication will arrive usually within ten days after your order is received by CVS Caremark.

- The Copayment or Coinsurance will be based on the date the prescription is filled, not on the date the prescription is received by CVS Caremark.
- Order online at www.Caremark.com or call CVS Caremark at (888) 766-5490 and CVS Caremark will contact your physician to get a mail order prescription for you.
- Ask your doctor to call CVS Caremark at (888) 766-5490 to call in your prescription or to obtain instructions on how to fax your prescription directly to CVS Caremark.
- CVS Caremark will process your prescription upon receipt from either you or your physician.

To fill at a participating 90-day retail pharmacy:

- Call CVS Caremark at (888) 766-5490 or visit www.Caremark.com/sofrxplan or log in at www.Caremark.com to find a participating 90-day retail pharmacy.
- Take your prescription written for up to a 90-day supply to a participating 90-day maintenance at retail pharmacy.

Automatic Refill and Renewal Options at Mail Order

If you are taking long-term or maintenance medications, automatic refills offer easy and convenient refill and/or renew options through mail order for many, but not all, medications.

If you sign up for this program (and have refills remaining) CVS Caremark will automatically fill and mail your medications at the appropriate refill time saving you time from ordering online or by phone. Also, CVS Caremark will contact your Physician and request a new prescription automatically after your last available refill, CVS Caremark will alert you in advance.

For additional information on this program or to sign up please go to www.Caremark.com or call (888) 766-5490.

Standard PPO Option

The Copayments for mail order and a participating 90-day retail pharmacy are up to a 90-day supply for a single Copayment, as long as the prescription is written to allow a 90-day supply to be dispensed.

The Copayments are:

- \$14 for a generic drug
- \$60 for a preferred brand name drug
- \$100 for a non-preferred brand name drug
- The brand Copayment plus the difference in the Plan's cost between the brand name and the

generic if a generic is available and you, rather than your Doctor, request the brand name drug.

PPO High Deductible Health Plan Option

Using mail order or a participating 90-day retail pharmacy allows you to obtain up to a 90-day supply, as long as the prescription is written to allow a 90-day supply to be dispensed. The Coinsurance amounts are:

- 30% for a generic drug after CYD
- 30% for a preferred brand drug after CYD
- 50% for a non-preferred brand drug after CYD
- The brand Coinsurance plus the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your Doctor, request the brand name drug.

How You Will Save at Mail Order or at a Participating 90-Day Retail Pharmacy

If you use a drug regularly, you will save on Copayments or Coinsurance at mail order and at participating 90-day retail pharmacies. For instance, if the drug you use is a preferred brand name, here is the resulting impact to you on the Standard PPO Option:

Mail Order/90-Day Retail	Participating 30-Day Retail Pharmacy
up to a 90-day maximum supply	up to a 30-day maximum supply
\$60 Copayment	\$30 Copayment
You pay \$60 for 90 days and order once	You pay \$90 for 90 days and make three trips to the pharmacy

If you mail a prescription for a 30-day supply to the mail order pharmacy, your prescription will be filled for a 30-day supply and you will be responsible for the appropriate mail order Copayment for either a generic, preferred brand or non-preferred brand medication. Ask your Physician for a prescription for a 90-day supply to send to the mail order pharmacy.

Covered by the Prescription Drug Program

Covered drugs include:

1. Federal legend drugs;
2. State restricted drugs;
3. Compounded medications when all of the following criteria are satisfied:

- a. All active ingredients are federal legend drugs;
- b. The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation unless medically necessary;
- c. The compounded medication is specifically produced for use by a covered person to treat a covered condition;
- d. The compounded medication including all sterile compounded products is made in compliance with Chapter 465, Florida Statutes.

Additionally:

- a. Over-the-counter (OTC) products and bulk powders, bulk chemicals, and proprietary bases used in compounded medications are not covered; and,
 - b. Reconstitution of oral powders is not considered compounding. The compounding pharmacist must bill the NDC of the product used in the quantity of final reconstituted volume.
4. Tobacco cessation medications, including prescription and over-the-counter medications, when prescribed by a health care provider and that have a current rating of A or B by the United States Preventive Services Task Force, are covered;
 5. Insulin and other covered injectable medications;
 6. Needles and syringes for insulin and other covered injectables;
 7. FDA-approved glucose strips, tablets and lancets; and
 8. Zoster vaccine (administration of this vaccine is not covered under the Prescription Drug Program.)

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

coverage review, clinical/utilization review, and are limited to eight doses per month.

Most clinical/utilization reviews are valid for a one-year period and must be renewed after expiration; however, clinical/utilization reviews may be as brief as one month.

Not Covered by the Prescription Drug Program

The prescription drug program does not cover:

1. Oral, topical, and injectable products for cosmetic purposes including but not limited to Retin-A, scar treatment products, depigmentation products, and hair growth and/or removal products.
2. Anti-obesity drugs and amphetamines and/or anorexiant for weight loss;
3. Infertility/fertility drugs;
4. Devices or appliances;
5. Non-federal legend drugs, over-the-counter (OTC) products, and bulk powders, bulk chemicals, and proprietary bases used compounded medications;
6. Drugs labeled "Caution: Limited by Federal Law to Investigational Use," or Experimental drugs;
7. Non-prescription drugs, aids and supplies to deter tobacco use unless prescribed by a health care provider and have a current rating of A or B by the United States Preventive Services Task Force;
8. Immunization agents such as flu shots (except Zoster vaccine used for shingles);
9. Medication that is covered by Workers' Compensation or Occupational Disease Laws or by any state or governmental agency;
10. Medication furnished by any drug or medical service for which no charge is made;
11. Maintenance medications exceeding three (3) 30-day fills at a retail pharmacy;
12. Viagra and other drugs prescribed solely for psychosexual disorders; Viagra and similar drugs prescribed for males under the age of 18 years; Viagra and similar drugs prescribed for females;
13. Enteral formulas that are food products used to treat inherited diseases of amino acid and organic acids shall only be covered up to age 25;
14. Growth hormones for the diagnosis of idiopathic short stature syndrome;
15. Overlapping therapies, even if used for different conditions, within the same drug classification, e.g. an erectile dysfunction drug for the treatment of benign prostatic hyperplasia (BPH) and an

erectile dysfunction drug for the treatment of erectile dysfunction, as both are in the same drug classification of erectile dysfunction drugs; or

16. Products packaged or bundled for convenience that contain OTC products and that are otherwise available as single entity products (e.g. Noxipak, Dermacinrx, etc.)

The Plan's general limitations and exclusions apply to the prescription drug program. See section 5 for a complete listing of Plan exclusions.

Important Information about the Prescription Drug Program

1. The Preferred Drug List (PDL) is updated and subject to change on a quarterly basis. Contractually, CVS Caremark has full authority over the development of the PDL; therefore, DSGI cannot require that specific drugs be included.
2. Generic Substitution: Prescriptions written for brand name drugs that have a generic equivalent will be automatically substituted unless the prescribing Physician writes "dispense as written" or "DAW," on the prescription. Generally, even if the prescription includes "DAW" CVS Caremark will still contact the Physician to ask if the generic equivalent may be substituted.
3. Only the prescribing Physician or an authorized agent of the Physician can authorize changes or provide clarifications to a prescription. Authorizations may be obtained verbally or in writing. If CVS Caremark is unable to contact the Physician or an authorized agent of the Physician, the prescription may be returned, unfilled, to the member.
4. CVS Caremark mail order facilities will only substitute with generic drugs that have received an "A" or "AB" rating by the Federal Drug Administration (FDA). Retail pharmacies may choose to dispense drugs with a different FDA rating.
5. Certain medications, including most biotech and/or Specialty Drugs, are only available through CVS Specialty pharmacy. Generally, these drugs are for chronic or genetic disorders including, but not limited to, multiple sclerosis, growth hormone deficiency and rheumatoid arthritis and may require special delivery options, such as temperature control. Your prescribing physician may contact CVS Specialty pharmacy at (800) 237-2767. You can choose how to get your medication: have it delivered to an address of your choice such as your home or your physician's office; or you may pick it up at your local CVS retail pharmacy, including those located inside Target stores.
6. CVS Caremark may contact the prescribing Physician when a prescription for a non-preferred brand name drug is submitted and a therapeutically equivalent preferred drug is available. If the Physician or an authorized agent of the Physician authorizes a change to the preferred drug, CVS Caremark will dispense the alternative drug and provide written notification of the change to the member.
7. CVS Caremark will contact the prescribing Physician if the prescribed dosage differs from the dosage recommended by the FDA or the manufacturer's guidelines. Dosage is the number of units, the strength of such units, and the length of time to take the medicine. If the Physician or an authorized agent of the Physician authorizes a change to the dosage, CVS Caremark will change the dosage amount, dispense the new dosage, and provide written notification of the change to the member.
8. During the prescription review process, your mail order and retail pharmacy prescription history, age, self-reported allergies, and self-reported disease states are reviewed along with the FDA drug indications and manufacturer's guidelines to determine if there are any interactions, side effects, and/or contraindications. CVS Caremark will contact the prescribing Physician if any questions, conflicts or issues are identified. CVS Caremark may contact the prescribing Physician if any indication of fraud or excessive usage is identified. If the Physician or an authorized agent of the Physician authorizes any changes, CVS Caremark will change the prescription accordingly, dispense the drug accordingly, and provide written notification of the change to the member.
9. For mail order, CVS Caremark will contact the prescribing Physician to verify the prescription if the prescription is illegible, written in different pen and/or penmanship, or altered in any way. If CVS Caremark cannot reach the Physician or an authorized agent of the Physician, the prescription will be returned to the member unfilled.
10. Prescriptions for treatment of Conditions for unapproved indications or "off-label" use will not be filled if not proven safe and effective for the treatment of the Condition based on the most recently published medical literature of the United States, Canada or Great Britain, using

generally accepted scientific, medical or public health methodologies or statistical practices.

11. Seventy-five percent of the previous prescription or fill must be utilized, if used as prescribed, before a request for a refill will be processed.
12. Requests for mail order refills that are received within 90 days of the "too soon to fill" date (based on the previous paragraph) will be held and filled when eligible to be filled. You may check your medication label for the next available refill date, or if the prescription was filled through mail order, you may log on to www.Caremark.com for the next available mail order refill date.
13. CVS Specialty pharmacy administers the Specialty Management Program for this Plan. This Program is intended to optimize outcomes and promote the safe, clinically appropriate and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for this Program during the coverage review will result in denial of medication coverage for the Plan participant and discontinuation of medication coverage for the Plan participant.

The Specialty Management Program is a process by which authorization for a specialty medication is obtained based on the application of currently acceptable medical guidelines and consensus statements for the appropriate use of the medication in a specific disease state. Therapies reviewed under this Program include, but are not limited to, the following: multiple sclerosis, oncology, allergic asthma, human growth hormone deficiency, hepatitis C, psoriasis, rheumatoid arthritis, and respiratory syncytial virus. Additional therapies may be added from time to time. For additional information on specialty medications or to see if your medication is in this category call CVS Caremark Customer Care toll-free at (888) 766-5490. and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for this Program during the coverage review will result in denial of medication coverage for the Plan participant and discontinuation of medication coverage for the Plan participant.

IMPORTANT NOTE

Some specialty medications may qualify for third-party copayment assistance programs, including manufacturer copay coupons, that when used will lower your out-of-pocket costs for the specialty medication. If you use any such third-party copayment assistance for your specialty medication, you will not receive credit toward your annual deductible, annual coinsurance maximum out-of-pocket, or annual global in-network maximum out-of-pocket for any copayment or coinsurance amount(s) that are applied to a manufacturer coupon or rebate.

Section 10: Eligibility and Enrollment Information

Who is Eligible to Participate in the Plan?

You and your eligible dependents may only be covered under one State of Florida health plan.

Active Employees

To be eligible to participate in the Plan, you must be a full-time or a part-time employee as defined in s. 110.123(2)(c) and (f), Florida Statutes.

Plan eligibility is determined by whether an employee's position is salaried career service, selected exempt service (SES), or senior management service (SMS); and, in the case of an other personal services (OPS) position, the expected hours of service of the employee.

Full-time state employees are eligible to participate in the Plan. These employees are salaried career service, SES, and SMS employees; and OPS employees expected to work an average of 30 or more hours per week.

Part-time state employees are eligible to participate in the Plan. These employees are salaried career service, SES, and SMS employees who work less than 30 hours per week. Employees in these positions are eligible to participate in the Plan but pay a pro-rated share of the employer premium.

OPS employees expected to work less than 30 hours per week on average are not eligible to participate in the Plan.

Seasonal workers in OPS positions are not eligible to participate in the Plan. These employees hold positions for which the customary annual employment is six months or less and begins each year at approximately the same part of the year, such as summer or winter.

Plan eligibility is initially determined at the point of hire. For OPS employees who are not reasonably expected to work 30 or more hours per week, eligibility for subsequent plan years is determined using a look-back measurement method.

The 12-month look-back measurement method involves three different periods:

1. Measurement period – counts hours of service to determine Plan eligibility.
 - a. Initial Measurement Period – If you are an OPS employee who is not reasonably expected to work at least 30 hours per week

at the point of hire, your hours of service from the first day of the month following your date of hire to the last day of the 12th month of employment will be measured.

An example: Assume you are hired October 5, 2017. Your initial measurement period will run from November 1, 2017 through October 31, 2018. If your hours worked during the initial measurement period average 30 hours or more per week, you are eligible to enroll in the Plan with an effective date of December 1, 2018.

If you are an OPS employee and become reasonably expected to work 30 hours or more per week during the initial measurement period, you become eligible to participate in the Plan at that time.

- b. Open enrollment measurement period – If you have been employed long enough to work through a full measurement period, you are considered an ongoing employee. Your hours of service are measured during the open enrollment measurement period. This period runs from October 3 through the following October 2 of each year and will determine Plan eligibility for the plan year that follows the measurement period.

If you are an employee who is reasonably expected to work an average of 30 hours or more per week upon hire you are eligible to enroll in the Plan. Plan eligibility will continue until your hours are measured during the next or second (depending on date of hire) open enrollment measurement period to determine Plan eligibility for the next plan year. If you were a non-full-time OPS employee at the time of your initial hire but become reasonably expected to work 30 hours or more per week during the open enrollment measurement period, you become eligible to participate in the Plan at that time.

An example: Assume you are hired January 5, 2017, in an OPS position and are expected to work an average of at least 30 hours per week. You are eligible to enroll in the Plan at your point of hire and will continue Plan eligibility through December 31, 2018. You will then be measured on October 3, 2018, by looking back at the previous 12-month period to determine if you worked at least 30 hours per week. Your eligibility for the 2019

plan year will depend on whether you worked an average of 30 hours or more per week during the 12-month measurement period or whether your employer reasonably expects you to work 30 or more hours per week.

2. **Stability Period** – follows a measurement period. If you are an OPS employee, the hours of service during the measurement period determines whether you are a full-time employee who is eligible for coverage during the stability period. If you are a full-time employee in the stability period, your eligibility is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the State of Florida. However, if you were a non-full-time OPS employee but become reasonably expected to work 30 hours or more per week during the stability period, you become eligible to participate in the Plan at that time. For ongoing employees, the stability period lasts 12 consecutive months.
3. **Administrative Period** – the time between the measurement period and the stability period when administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment, are performed. If you are determined to be eligible, a benefits package showing your available options, costs, and effective dates will be mailed to your mailing address in People First, the system of record.

The rules for the look-back measurement method are complex, and this is a general overview of how the rules work. More complex rules may apply to your situation. The State of Florida intends to follow applicable IRS final regulations (including any future guidance issued by the IRS) when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, call the People First Service Center at (866) 663-4735 weekdays from 8 a.m. to 6 p.m. Eastern time.

Retirees

You are eligible for the Plan if you were a state officer or state employee and you:

1. retire under a State of Florida retirement system or a state optional annuity or state retirement program or go on disability retirement under the State of Florida retirement system, as long as you were covered by the Plan at the time of your retirement and you begin receiving retirement benefits immediately after you retire; or

2. retire under the Florida Retirement System Investment Plan, and you: (i.) meet the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29), Florida Statutes, or have attained the age specified by s. 72(t)(2)(A)(i), Internal Revenue Code and you have six (6) years of creditable service; and, (ii.) take an immediate distribution; and, (iii) maintained continuous coverage under the Plan from termination until receiving your distribution; or,
3. retired before January 1, 1976, under any state retirement system and you are not eligible to receive any Social Security benefits.

If you do not continue health insurance coverage at retirement, you will not be allowed to elect state health insurance at a later date as a retiree.

If you are a retiree that returns to active employment as a full-time equivalent (FTE) or other personnel services (OPS) employee and you are enrolled in the Plan at the time of retirement, you will automatically be enrolled in active employee health insurance coverage. When you later terminate employment or return to retirement you will be allowed to continue retiree coverage, provided you have had continuous coverage.

Dependents Eligible for Coverage

If you are eligible for the Plan, you may also cover your eligible dependents by selecting family coverage. Eligible dependents include:

1. your legal spouse
2. your natural children, legally adopted children and children placed in the home for the purpose of adoption in accordance with Chapter 63, Florida Statutes
3. your stepchildren if you are still married to the stepchildren’s parent
4. your foster children
5. your children for whom you have established legal guardianship, Chapter 744, Florida Statutes, or unmarried children where you have been granted court-ordered temporary or other custody
6. your children with a qualified medical support order requiring you to provide coverage
7. a newborn dependent of a covered dependent – a newborn child born to a dependent while the dependent is covered under the Plan. The newborn must be added within 60 days of the birth. Coverage may remain in effect for up to

18 months or until the covered dependent is no longer covered

8. Eligible children of your surviving spouse
9. Children of law enforcement, probation, or correctional officers who were killed in the line of duty and who are attending a college or university beyond their 18th birthday.

You may be asked to provide documentation to verify your dependent(s) eligibility. If you do not provide sufficient documentation to verify dependent eligibility as requested your dependent's coverage will be terminated. You or your dependent may also be responsible for any cost for premiums for a higher level of coverage (family instead of individual) and reimbursement of all medical or prescription services covered under the Plan while your dependent was listed as eligible but was ultimately determined to be ineligible.

Eligibility Requirements for Dependents

In accordance with 60P, Florida Administrative Code, children must meet the following eligibility requirements to be covered under the Plan:

1. Children from birth through the end of the calendar year in which they turn 26.
2. Your unmarried children ages 26 to 30 who don't meet the criteria above are eligible to continue or enroll in coverage as over-age dependents if:
 - a. they have no dependents of their own; and
 - b. they are a resident of Florida or are a full-time or part-time student; and
 - c. they have no other health insurance.

This is individual health coverage for your over-age dependent; however, both you and your eligible over-age dependent must be enrolled under this Plan. The amount of financial support you provide determines whether the premiums can be pretax or must be post-tax. In other words, your financial support determines if the monthly premium for coverage will come out of your paycheck pretax or if you must mail in payment post-tax. You may call the People First Service Center for more information.

3. Your unmarried children with intellectual or physical disabilities are eligible to continue coverage after they reach age 26 if:
 - a. they are enrolled in the Plan before they turn age 26; and
 - b. they are incapable of self-sustaining

employment because of intellectual or physical disability;

- c. the required documentation supporting the intellectual or physical disability has been reviewed and confirmed by Florida Blue prior to their 26 birthday; and
- d. they are chiefly dependent on you for care and financial support.

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

The treating Physician must provide documentation supporting the child's intellectual or physical disability. You must submit the documentation to Florida Blue P.O. Box 2896, Jacksonville, FL 32232-0079 for review and confirmation. Disability status will be verified every five years. Failure to respond or to meet disability requirements will result in disenrollment of the dependent and may result in nonrefundable family premiums if the disenrolled dependent was the only dependent on your coverage.

When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they become ineligible, unless otherwise noted above. If your dependents become ineligible for coverage, go to the People First website to remove them from this Plan or call the People First Service Center at (866) 663-4735. Service Center hours are from 8:00 a.m. to 6:00 p.m. Eastern Time.

In the event of divorce, you have 60 days, including the date of divorce, to provide the final judgment of divorce to People First. If you fail to timely notify People First of a divorce, you will be responsible for reimbursing the Plan for any claims incurred by ineligible dependents (e.g., ex-spouse, any ex-stepchildren) or for paying COBRA continuation coverage premiums for any months ineligible dependents were covered.

When Coverage Suspends

If you are an employee your coverage under the Plan will suspend on the last day of the month in which you do not make the required contribution for coverage. Your coverage will only be reinstated when People First receives the total amount due, applies the remittance (payment of contribution) to your account, and notifies Florida Blue and CVS Caremark of the reinstatement.

When Coverage Ends

Your coverage under the Plan ends:

1. when your employment is terminated; for active employees premiums are paid one month in advance, so coverage ends on the last day of the month following the month you were terminated;
2. on the last day of the month in which you do not make the required contributions for coverage, including the months when you are in layoff status;
3. when your hours of service are measured and you no longer meet eligibility requirements as describe in this section; or
4. on the last day of the month in which you remarry, if you have coverage as a surviving spouse of an employee or retiree.

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

1. your coverage is terminated;
2. your spouse remarries after your death (see "Surviving Spouse Coverage" in this section for details); or
3. you and your spouse divorce.

Your dependent children's coverage ends:

1. on the last day of the month in which your coverage is terminated; or
2. the end of the calendar year they reach age 26 (age 30 for over-age dependents); or
3. on the last day of the month in which your child no longer meets the definition of an eligible dependent.

Enrollment Opportunities

Before Plan coverage can begin, you must enroll. You may make benefit elections:

1. within 60 days when you are hired as a new employee;
2. within 60 days of a qualifying status change (QSC) event, unless otherwise noted;
3. during the annual Open Enrollment period;
4. if you are a surviving spouse; or
5. if you and your spouse both work for the State of Florida.

Option 1 – Hired as a New Employee

If you are a newly-hired, full-time or part-time employee, you have 60 days from the date you were

hired to enroll in the Plan. You may enroll online at <https://peoplefirst.myflorida.com>. If you do not enroll within 60 days of your hire date, you can only enroll during the next Open Enrollment period or if you experience a QSC event. Choose your options carefully. Once you make this election, you cannot make changes until the next Open Enrollment period unless you have an appropriate QSC event.

Your coverage begins on the first day of the month after the month in which a full month's coverage cost, or premium, has been payroll deducted or received by People First. Coverage will always begin on the first day of a month and will continue for the rest of the calendar year, as long as premiums are paid on time, and you remain eligible.

An example: Assume you are hired July 20. If People First receives your enrollment information before August 1, your coverage begins September 1, after one full month's premium is deducted from your paycheck; however, you can elect an earlier effective date of August 1, provided you submit the full month's premium by check.

Option 2 – Qualifying Status Change (QSC) Event

If you have a QSC event, you have 60 days (unless otherwise noted) from the date of the event to make changes to your benefits, such as enrolling, increasing coverage from individual to family or adding dependents. You must submit all required documentation to People First. QSC events include but are not limited to:

1. marriage or divorce
2. death of a dependent
3. birth or adoption
4. legal guardianship
5. change in a dependent's eligibility
6. change in employment status for you or your dependents resulting in a gain or loss of eligibility for group coverage

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

1. you must make the change online at the People First website within 60 days of the event. If your specific QSC event is not listed, you should call the People First Service Center or complete all forms authorizing the change. The People First Service Center must receive the required enrollment forms within 60 days of the QSC event. If the forms arrive after 60 days, your requested benefit change(s) will be denied and

you will not be able to make changes until the next Open Enrollment period.

2. you may be asked to provide the supporting documentation to People First (e.g. marriage license, birth certificate, divorce decree, etc.) before a change will be processed.

Note: To make an enrollment change based on a QSC event, federal law requires the event to result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if you have family health insurance coverage and you get a divorce and no longer have dependents, you may change from family to individual coverage. However, you cannot cancel enrollment in health insurance because the QSC event only changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

If you enroll yourself or eligible dependents during the year because of a QSC event, coverage will begin on the first day of the month following the month in which a full month's coverage cost, or premium, has been payroll deducted or received by People First. Coverage will always begin on the first day of a month and will continue for the rest of the calendar year, as long as premiums are paid on time, and you remain eligible.

Important Reasons to Call People First

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

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

Option 3 - Open Enrollment

Held in the fall, the annual Open Enrollment period gives you an opportunity to review benefit plan options and make changes for the next plan year, which is January 1 through December 31. Changes you can make include but are not limited to: changing health plans (this Plan to an HMO if

available in your area), adding or removing eligible dependents, or canceling coverage. All benefits chosen during this time take effect on January 1 of the next calendar year. Any changes you make will remain in effect for the entire calendar year if your premiums are paid on time and you remain eligible, unless you make changes because of a qualifying status change event.

Option 4 - Spouse Program

When both you and your spouse are active, state employees, you are eligible for health insurance coverage at a reduced monthly premium. You must take the following steps to enroll in the Spouse Program:

1. you and your spouse must complete and sign the Spouse Program Election Form located at www.myBenefits.myFlorida.com and list all eligible dependents.
2. attach a copy of your marriage license to the Spouse Program Election Form when you submit it to the People First Service Center. Please remember to include your People First ID number on each page.
3. you and your spouse must enroll in the same health plan.
4. you and your spouse must agree to notify the People First Service Center immediately when becoming ineligible for the Spouse Program. Employees become ineligible for the Spouse Program if:
 - a. one or both end employment with the state;
 - b. a divorce occurs; or
 - c. one or both retire.

It is your responsibility to notify the People First Service Center if you become ineligible for the Spouse Program. If you fail to notify the People First Service Center of your ineligibility for the program within 60 days, you will be financially liable for incurred medical or prescription drug claims and any premiums the state paid during the time you were not eligible. Additionally, you may have to pay for a higher level of coverage than you need; for example, you may be required to pay for family coverage instead of individual coverage. The People First Service Center will add covered dependents to the primary spouse's plan, unless you direct the People First Service Center otherwise.

Option 5 – Surviving Spouse

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

1. a deceased state officer, state employee or retiree if the spouse was covered as a dependent at the time of death;
2. an employee or retiree who died before July 1, 1979; or
3. a retiree who retired before January 1, 1976 under any state retirement system and who is not eligible for any Social Security benefits.

The surviving spouse and dependents, if any, must have been covered by the participant at the time of death. To enroll, the surviving spouse has 60 days to notify the People First Service Center of the death and 31 days to enroll after receipt of the enrollment package. Coverage is effective retroactively once the enrollment form and current premiums have been received. Coverage must begin the first of the month following the last month of coverage for the deceased; in other words, there can be no break in coverage.

Coverage for surviving spouses and covered dependents ends on the first of the month following remarriage; however, they are eligible to continue coverage under COBRA for a limited time.

Coverage Continuation

Family and Medical Leave and Job-Protected Leave

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

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

In addition, the FMLA provides special unpaid, job-protected leave for up to 12 weeks if you have a

family member called to active military duty and for up to 26 weeks when such family member is injured while on military duty.

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

Furthermore, under the laws of the State of Florida, certain employees may be eligible to have their unpaid job-protected parental or family medical leave extended up to six months. You may call your personnel office if you need more details. If you are on authorized parental or family medical leave, your employer will continue to pay its share of the premium (if any) for up to six months of unpaid leave. Your coverage will be maintained until you return to work as long as premiums are paid.

If you cancel this Plan while on any of these leave types and subsequently return to work before or at the end of the leave, you and your eligible dependents may enroll under the Plan without regard to pre-existing Conditions that arise while on job-protected leave, provided you cancelled your coverage within 60 days of going out on leave.

If you do not cancel coverage within 60 days of going out on leave and your coverage is subsequently canceled for non-payment, you will only be able to enroll during the next Open Enrollment period.

Coverage Continuation When You are Off Payroll

You may continue your coverage in the Plan if you go off the payroll for one of these reasons:

1. authorized leave without pay;
2. suspension;
3. layoff;
4. Workers’ Compensation disability leave;
5. less than year-round employment; or
6. military leave.

To continue coverage while you are off the payroll, you must pay your share of the premium by personal

check or money order. You may be required to pay the full premium cost, your share and the state's share, depending on the reason you are off the payroll. Contact People First for more information. Rules for this coverage continuation are provided by state regulation in the Florida Administrative Code.

COBRA

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

If you or your dependent is disabled under the Social Security Act at any time during the first 60 days of COBRA continuation coverage you have because of termination of employment or change in employment status, an additional 11 months of coverage may be available. To be eligible for this disability extension, the disabled person must receive a Social Security disability determination and notify People First within 60 days of the determination. Both the Social Security disability determination and the notice to People First must happen before the end of the initial 18 months of COBRA coverage. Non-disabled family members who receive COBRA coverage because of the same termination of employment or change in employment status as the disabled person are also eligible for the disability extension. The monthly premium for the additional 11 months of coverage is 150 percent of the cost of coverage.

Under COBRA, spouses of employees and/or their dependent children may choose continuation coverage and keep it for up to 36 months, as long as they pay the required costs, if their healthcare coverage ends because of:

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

If you have a newborn child or adopt a child during the time you are covered by COBRA continuation

coverage, that child can be enrolled under the continuation coverage. Like your other dependents, that child can keep continuation coverage for up to 36 months from the date your COBRA coverage began if the coverage would otherwise end because of one of the three events described above.

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

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

Under COBRA, the employee or spouse is responsible for notifying People First of a divorce, legal separation, death or a child's losing dependent status under the Plan. Notice must be given within 31 days of the event (60 days in the case of death). Involved individuals must also provide People First with a current and complete mailing address. If notice is not received within 31 days of the event, the dependent will not be entitled to choose continuation coverage.

Upon notification, People First will send an enrollment form for COBRA continuation coverage to the eligible individual, along with notification of the premium. The eligible individual must complete the enrollment form and return it to People First within 60 days of:

1. the date coverage is lost because of one of the events described above; or
2. the date the form is received from People First, whichever is later.

If an individual does not complete the COBRA election form and return it to People First within the 60-day period, coverage will end:

1. on the last day of the month in which the event, such as divorce, that caused ineligibility for coverage took place; or
2. on the last day of the month following the month you were terminated.

If an eligible individual chooses COBRA continuation coverage, the state must provide coverage identical to that provided to comparably situated employees.

An eligible individual's COBRA continuation coverage will end when:

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

Converting Health Insurance Plan Coverage to a Private Policy

If coverage under the Plan ends for you or your eligible dependents for reasons other than your choice to cancel coverage or your failure to pay your share of the premium cost, you may convert to a private policy. You must apply in writing to Florida Blue and pay the first month's premium within 63 days of the date your group coverage ended. When you convert, you will have the standard Florida Blue conversion policy. The benefits provided by the conversion policy may be different from the benefits provided under the State Employees' PPO Plan.

If you choose COBRA continuation coverage when your Plan coverage ends, you can convert to a private policy when COBRA coverage ends. In this case, you must still apply in writing and pay the first month's premium within 63 days of the date your COBRA coverage ends. Contact Florida Blue at (800) 876-2227 for information.

Continuation of Benefits if You are Disabled

If you or your covered dependent is totally disabled at the time your Plan coverage ends, the Plan will continue to pay benefits for covered services that are directly related to the disability if:

1. the disability is a result of a covered Illness or Accident; and
2. the Plan's claims administrator, Florida Blue, determines that you or your eligible dependent is totally disabled at the time coverage ends.

For this continuation of benefits, total disability means:

1. for an employee: you are unable to perform any work or occupation for which you are reasonably qualified and trained; or
2. for a dependent, retiree or surviving spouse: the person is unable to engage in most normal activities of someone the same age and sex who is in good health.

This extension of benefits is provided at no cost to you and can continue:

1. as long as total disability lasts, up to a maximum of 12 months; or
2. until you become covered by another plan providing similar benefits, whichever occurs first.

COBRA coverage will not be available if this coverage is selected.

Extension of Benefits if the Plan is Terminated

If the Plan is ever terminated, benefits will be extended for the following reasons only:

1. If you are in the Hospital when the Plan is terminated, your covered services will be eligible for payment for 90 days following Plan termination.
2. If you are pregnant when the Plan is terminated, covered maternity benefits will continue to be paid for the rest of your pregnancy.
3. If you are receiving covered dental care when the Plan is terminated, benefits will continue to be paid for 90 days following Plan termination or until you become covered under another policy providing coverage for similar dental procedures, as long as the dental care is recommended in writing by your Doctor or dentist and is for the treatment of a covered Illness or Accidental Dental Injury. Both the Illness or Accidental Dental Injury and the treatment recommendation must occur prior to termination of the Plan. These extended dental benefits do not include coverage for routine examinations, prophylaxis, x-rays, sealants, orthodontic services, or dental care that is not covered.

Section 11: How to File a Claim

Medical Claims

Network Providers

When you go to a Network Provider or Non-Network Provider participating in the Traditional Program, you do not need to file a claim. This includes providers in the PPCSM Network, the BlueCard[®] Program, and Non-Network Providers who are Florida Blue Traditional Program Providers, including PPS or PHS providers. The provider will file the claim for you and you will be responsible for paying any Coinsurance, deductibles, Copayments and non-covered services. Claims for services or supplies received from a Network Provider must be filed within 16 months of the date you receive the services or supplies. The third party administrator, Florida Blue, will process the claim in accordance with Plan benefits, usually within 30 days of receipt. Florida Blue will send you a monthly Health Statement that will give you important information about medical claims processed for you and your covered dependents over the previous 21-day period.

Non-Network Providers

If you go to a Non-Network Provider, you will be responsible for filing your own claim. Your Non-Network Provider may choose to file on your behalf. The claim must be filed within 16 months of the day you received services or supplies. Benefits will be paid directly to you or to the provider to whom you specifically assign benefits in accordance with s. 627.638, Florida Statutes.

A written attestation of the assignment of benefits may be required. You can get medical claim forms from Florida Blue by calling (800) 825-2583 or at www.floridablue.com or www.floridablue.com/state-employees.

To submit the claim:

1. Complete all information on the claim form, as indicated.
2. Attach original bills to the claim form; make sure the bills include the patient's name, date, place and nature of treatment, procedure and diagnosis codes, and the Physician's name and federal tax ID number.
3. Send the claim to:
Florida Blue
P.O. Box 2896
Jacksonville, FL 32232-0079

If you have filed a duplicate claim with another health insurance plan or with Medicare, include a copy of the other plan's Explanation of Benefits (EOB) statement with your claim form.

Keep in mind that when you use Non-Network Providers, you may be responsible for any charges above the Non-Network Allowance as well as any Coinsurance, deductibles, Copayments and non-covered services.

There may be times when Florida Blue will request additional information from you to process your claim. You are responsible for providing the additional information within 30 days of receiving the request.

Health Statement

You will receive a consolidated health statement called a "Health Statement" or "Member Health Statement" from Florida Blue monthly. The monthly Health Statement replaces the per claim "Explanation of Benefits Statement" and will include specific claim information for all claims processed within the statement period (21-day period) for each family member. The monthly Health Statement will include:

1. the amount paid by this Plan;
2. any deductibles or Copayments applied to the claim;
3. the amount the patient must pay;
4. the reason(s) the claim was denied, if denied;
5. a description of additional information necessary to complete the claim and why the information is necessary;
6. an explanation of steps to take if you want Florida Blue to review a claim denial;
7. a summary of deductible and out-of-pocket amounts for the current calendar year; and
8. tips on healthy living and ways to save money.

No Intended Third Party Beneficiary

The State Employees' PPO Plan has been established by the State and is administered by DSGI solely for the benefit of enrolled Plan participants. No third party shall have any right or interest in the coverage or benefits provided under the Plan or described in this Plan Booklet and Benefits Document, nor shall any third party have a right to enforce against the State, the Department

of Management Services, DSGI, Florida Blue or CVS Caremark any right under the Plan as a third party beneficiary of the Plan or this Plan Booklet and Benefits Document, including any right to payment for the benefits hereunder.

Prescription Drug Claims

Participating Pharmacies

When you use a participating pharmacy, you do not need to file a claim. The claim will be submitted electronically. You will be responsible for your Copayment or Coinsurance, subject to the calendar year deductible, if applicable to your chosen Plan.

If you do use your prescription ID card at a participating pharmacy and pay out-of-pocket for the full cost of the prescription, you may file a claim for reimbursement. Benefits under this Plan will be reimbursed at the participating pharmacy's negotiated reimbursement rate which generally will be less than the cash price of the prescription. For example: You pay \$100 out-of-pocket at a participating retail pharmacy for a 30-day supply of a preferred brand drug, the negotiated reimbursement rate is \$55, and the Plan copay for a 30-day supply of the preferred brand drug is \$30, you will be reimbursed \$25 ($\$55 - \$30 = \25).

Non-Participating Pharmacies

If you use a non-participating pharmacy, you will be responsible for filing your own claim. You must file the claim within 16 months of the day you fill your prescription. Benefits will be paid directly to you. You can get prescription claim forms from CVS Caremark by calling (888) 766-5490 or at www.Caremark.com.

To submit the claim:

1. Complete all information on the claim form, as indicated.
2. Attach original bills to the claim form and make sure the bills include the patient's name, date, pharmacy name, prescription name, quantity dispensed, dosage dispensed, and billed price of medication.
3. Send the claim to:

CVS Caremark
P. O. Box 52010 MC00
Phoenix, AZ 85072-2010

Section 12: Appealing a Denied Claim

If your benefit claim is totally or partially denied, Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus will send you a written notice indicating the specific reason(s) for the denial within 30 days of receiving your claim. The notice will include a list of any additional information needed to appeal the denial to Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus.

If you want your authorized representative to appeal a totally or partially denied claim, please call the toll-free Customer Service telephone number on your Florida Blue or CVS Caremark ID card, or contact Healthcare Bluebook at (800) 513-6118 or SurgeryPlus at (844) 752-6170 and ask if any specific documentation must be completed such as the Florida Blue Appointment of Representative form.

NOTICE OF WAIVER: You or your authorized representative may appeal any totally or partially denied medical or prescription drug claim. You will WAIVE ALL RIGHTS OF APPEAL if you fail to file your appeal within the time frame indicated on the notice that is mailed to you. Please refer to the applicable information on the appeal process, including mandatory appeal filing deadlines, in this Section.

Appealing to Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus – A Level I Appeal

You, or your authorized representative on your behalf, have the right to appeal a full or partial denial of benefits or payment of a claim for medical services, supplies and/or prescription drugs you have received (post-service) or are planning to receive (pre-service). Your appeal must be received by Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus (as appropriate), within 180 days of the adverse benefit determination notice (the ending statement period date on the Member Health Statement (MHS), the Explanation of Benefits (EOB) Statement or other notice of denial).

There are three types of appeals: urgent pre-service, pre-service, and post-service. You may request an urgent pre-service appeal from Florida Blue or CVS Caremark if the timeframe to complete a Level I Pre-Service Appeal would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent appeal.

If your appeal is for the denial of an urgent pre-service claim or a concurrent care decision, you may verbally request an urgent Level I Appeal by calling the Customer Service toll-free telephone number on your member ID card (Florida Blue or CVS Caremark, as appropriate) and stating that you are requesting an urgent Level I Appeal. Urgent appeals for services offered by Healthcare Bluebook or SurgeryPlus are not available.

If your appeal is for a pre-service (non-urgent) or post-service claim, you must submit your Level I Appeal in writing to Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus, and explain your reason for the appeal. Your appeal should include all relevant medical records, as well as, any additional documentation, information, evidence, or testimony that you would like reviewed and considered during the appeal process.

For medical claims, mail your written Level I Appeal to:

**Florida Blue
P.O. Box 2896
Jacksonville, FL 32232-0079**

You may also fax your Level I Appeal to Florida Blue at (904) 301-1875.

For prescription drug claims, mail your Level I Appeal to CVS Caremark:

**CVS Caremark
Appeals Department MC 109
P.O. Box 52071
Phoenix, AZ 85072-2071**

You may also fax your non-specialty drug Level I Appeal to CVS Caremark toll-free at (866) 443-1172. You may fax your specialty drug Level I Appeal toll-free at (855) 230-5548.

For Healthcare Bluebook claims, mail or email your written Level I Appeal to:

Rewards@healthcarebluebook.com

Or

**Healthcare Bluebook
ATTN: Rewards Team
330 Franklin Rd., Ste. 135A-428
Brentwood, TN 37027**

For SurgeryPlus claims, mail your written Level I Appeal to:

**MCMC LLC
300 Crown Colony Drive, Suite 203
Quincy, MA 02169**

Prior to the notification of the Level I Appeal decision, you will be provided, free of charge, copies of any new or additional evidence or rationale considered in connection with your claim and you will be provided an opportunity to respond to such new evidence or rationale.

Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus, as appropriate, will review your Level I Appeal and provide a written notice of the review decision. If the appeal is for a pre-service denial, Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus will respond within 15 days from receipt of your appeal; if the appeal is for a post-service denial, Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus will respond within 30 days from receipt of your appeal; and, if your appeal is urgent, Florida Blue or CVS Caremark will respond within 72 hours from receipt of your appeal.

If Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus's review is unfavorable (Level I Appeal is denied), the notice of denial will include information about appealing the decision to DSGI.

Appealing to Division of State Group Insurance (DSGI) – A Level II Appeal

If you are not satisfied with the Level I Appeal decision, you may file a Level II Appeal to DSGI. You may request a Level II urgent appeal if the timeframe to complete the pre-service Level II Appeal would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent appeal.

If your Level II Appeal is for the denial of a pre-service or concurrent care decision, you may verbally request an urgent Level II Appeal by calling DSGI at (850) 921-4600 and stating that you are requesting an urgent Level II Appeal.

If your appeal is for a pre-service (non-urgent) or post-service claim, you must submit your Level II Appeal in writing and explain your reason for the appeal. Your appeal should include all relevant medical records, as well as, any additional documentation, information, evidence, or testimony that you would like reviewed and considered during the appeal process.

Your Level II Appeal must be in writing or filed verbally (for urgent appeals) and must be postmarked within 60 days of the written notice of Florida Blue's, CVS Caremark's, Healthcare

Bluebook's, or SurgeryPlus's denial of your Level I Appeal. Your Level II Appeal must include:

1. A copy of the denial notice (EOB, MHS, or other notice of denial);
2. A copy of your letter to Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus requesting a Level I Appeal;
3. A copy of Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus's Level I Appeal denial;
4. A Level II Appeal letter to DSGI appealing the Level I Appeal decision; and
5. All relevant medical records, as well as, any other information or documentation that could assist in the review of your appeal.

Mail your written Level II Appeal to DSGI at:

**Division of State Group Insurance
Attention: Appeals Coordinator
P.O. Box 5450
Tallahassee, FL 32314-5450**

Any Level II Appeal received without, at a minimum, the above information, will be returned to you or the representative who submitted your Level II Appeal. Prior to the notification of the Level II Appeal decision, you will be provided, free of charge, copies of any new or additional evidence or rationale considered in connection with your claim and you will be provided an opportunity to respond to such new evidence or rationale.

DSGI will review the Level II Appeal and provide a written notice of the review decision. If the Level II Appeal is for a pre-service (non-urgent) denial, DSGI will respond within 15 days from receipt of your appeal; if the Level II Appeal is for a post-service denial, DSGI will respond within 30 days from receipt of your appeal; and, if your appeal is urgent, DSGI will respond within 72 hours from receipt of your appeal. If DSGI's review is unfavorable (Level II Appeal is denied), the notice from DSGI will include information of any additional appeal or review rights available to you.

For requests that received (1) a Level I denial from Florida Blue, CVS Caremark, or SurgeryPlus, and (2) a Level II denial from DSGI, two review options are available to contest the Level II Appeal denial; an Administrative Hearing and an external review from an Independent Review Organization. You may request a review through either or both of these options. However, please note that each option has a specific timeframe for requesting a review as described below.

For requests that received (1) a Level I denial from Healthcare Bluebook, and (2) a Level II denial from DSGI, you may request an Administrative Hearing to contest the Level II Appeal denial. Please note the specific timeframe for requesting review, as described below.

Requesting an Administrative Hearing

If you want to contest the Level II Appeal decision of DSGI through the Administrative Hearing process, you must submit a petition for an administrative proceeding that complies with Rule 28-106.201 or 28-106.301, Florida Administrative Code. Your petition must be received within 21 days after you received the written adverse decision on your Level II Appeal.

Requesting an External Review from an Independent Review Organization

For requests that received (1) a Level I denial from Florida Blue, CVS Caremark, or SurgeryPlus, and (2) a Level II denial from DSGI, you have the right to request an external review from an Independent Review Organization (IRO) **after the finalization of both the Level I and Level II Appeal processes.**

You may call the Customer Service toll-free telephone number on your member ID card (Florida Blue, CVS Caremark, or SurgeryPlus, as appropriate) for additional information about requesting or to request an external review. External review is not available for claim denials based on an individual's eligibility under a plan. You may request an external review in writing within four months after receipt of the Level II Appeal decision.

Standard External Review

For requests that received (1) a Level I denial from Florida Blue, CVS Caremark, or SurgeryPlus, and (2) a Level II denial from DSGI, you may request a standard external review of your Level II Appeal denial if:

1. the decision involved a:
 - a. denial of your request for payment of a claim and the decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is experimental or investigational; or
 - b. rescission (cancellation) of coverage; and

2. An external review is requested by you within four months of the Level II Appeal denial date.

The IRO will review your request for a standard external review and provide a written notice of the review decision within 45 days from the date of receipt of the request by the IRO.

Expedited or Urgent External Review

For requests that received (1) a Level I denial from Florida Blue or CVS Caremark, and (2) a Level II denial from DSGI, you may request an expedited or urgent external review if the timeframe to complete a standard external review would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent external review and if:

1. the decision involved a:
 - a. denial of your request for payment of a claim and the decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is experimental or investigational; or
 - b. rescission (cancellation) of coverage; and
2. An external review is requested by you within four months of the Level II Appeal denial date.

The IRO will review your request for an urgent external review and provide a response within 72 hours from the date of receipt by the IRO.

IMPORTANT NOTES:

1. Throughout the appeal and review process, you have the right to present evidence and testimony as well as request and receive, free of charge, copies of all documents and other information relevant to your claim and/or appeal, including, but not limited to, the following information about the processing of your claim:
 - the specific rule, guideline, protocol or other similar criterion used, if any, in making the benefit or payment decision, and/or
 - an explanation of the scientific or clinical factors relied upon if the claim was denied in whole or in part based on the lack of medical

necessity or the experimental or investigational nature of a service or medication.

2. A favorable decision by the IRO is binding on the Plan and is cause to interrupt and stop any administrative hearing proceedings. An unfavorable decision by the IRO is binding on the Plan if you did not previously timely pursue action through the administrative hearing process.
3. If, after commencement of any administrative proceeding, you decide to request an external review by the IRO, the administrative proceeding will be held in abeyance pending the IRO decision.

Section 13: Coordinating Benefits with Other Coverage

Coordination with Other Group Insurance Plans

If you, your spouse or your dependents are covered by this Plan and any other group medical insurance plan, no-fault automobile insurance, health maintenance organization, Medicare, medical payment benefits under any premises liability or other types of liability coverage, or any other insurance providing medical insurance coverage, benefits from this Plan will coordinate with any other benefits you receive. When benefits are coordinated, the total benefits payable from both plans will not be more than 100 percent of the total reasonable expenses. Note: Drugs and supplies covered under the Prescription Drug Program will only be coordinated if you have Medicare as your primary insurance plan. The Prescription Drug Program does not coordinate benefits with any other insurance plans.

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 legally issued in the State of Florida or any other jurisdiction for the purpose of insuring a group of individuals.

In accordance with s. 627.4235(5), Florida Statutes, this Plan will not coordinate benefits with an indemnity-type policy, an excess insurance policy as defined by Florida law, that covers only specific Illnesses or Accidents, or a Medicare supplement policy.

In order to ensure claims processing accuracy and appropriate coordination of benefits, DSGI requires that Florida Blue verify if you, your spouse, or your other dependents have other insurance coverage or other carrier liability (OCL). Each year, approximately 365 days from the previous verification, you will be notified by Florida Blue, in writing, that you should contact its office by mail, telephone (800) 477-3736, ext. 34743, or Florida Blue’s website at www.floridablue.com or www.floridablue.com/state-employees to verify OCL information. Florida Blue will automatically process or reprocess any claims that may have been denied or held once you have provided the requested OCL information.

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 this Plan is primary, it will pay benefits first. Benefits will be paid as they normally would under this Plan, regardless of your other insurance coverage.
- If this Plan is secondary, it will pay benefits second. In this case, benefits from this Plan and from the primary plan will not be more than 100 percent of total reasonable expenses. Also, when this 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

1. The plan covering a person as an employee or member, rather than as a dependent, pays first.
2. 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. In a case where 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

1. 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.
2. In the case of divorce or separation, the plan of the parent with custody pays first, except where a court decrees otherwise.
3. If the parent with legal custody has remarried:
 - a. the plan of the parent with legal custody pays first;
 - b. the plan of the spouse of the parent with custody pays second; and
 - c. the plan of the parent without custody pays last;...unless a court decrees otherwise.

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 you or your dependents to enroll for Medicare coverage when you first become eligible. It is also important that you notify Florida Blue of your Medicare effective date as soon as possible to avoid claims processing disruptions. You must also notify People First and provide a copy of your Medicare ID card to avoid coverage disruption and to reduce premium costs, if appropriate.

Active Employees

If you are an active employee, the spouse of an active employee or dependent of an active employee, this Plan will pay benefits first; Medicare will pay second. However, if this Plan's payment is above what Medicare would normally allow for the service if Medicare were paying first, Medicare will not pay benefits.

If you are an active employee or the spouse of an active employee and become eligible for Medicare because of age or disability, you may choose to defer Medicare Part B benefits until you are no longer on the policy of an active state employee, such as when you or your spouse retires. The Social Security Administration provides a Special Enrollment Period to allow you to enroll in Medicare Part B without incurring an additional Medicare premium in this situation. However, the Medicare Special Enrollment Period rules have no bearing on the provisions of this Plan. If you are Medicare eligible and Medicare Part A and Part B are not in effect at the time of your retirement, benefits for this Plan will be paid as if Medicare Part A and Part B had paid first as the primary plan.

For active employees with a dependent who is disabled for reasons other than end-stage renal disease, this 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 your spouse, your spouse's coverage under this Plan

will continue to be primary, paying benefits first, as long as you are an active employee.

Active Employees and Early Retirees - End Stage Renal Disease

If you or your covered dependent requires treatment for end-stage renal disease, this 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 this Plan will pay benefits second. You must be enrolled in Medicare Parts A & B at the point in which the 30-month period ends because benefits from this Plan will pay second as if you are enrolled regardless of your age. If you become eligible for Medicare because of age or disability, before becoming eligible due to end-stage renal disease, however, Medicare would continue to pay first as your primary carrier and this Plan would pay second.

Retirees, Spouse or Surviving Spouse of a Retiree or Dependent of a Retiree

If you are enrolled in Medicare, Medicare will pay benefits for you first. This Plan will pay benefits second. If you are eligible for Medicare Parts A and B but you have not enrolled, or if your provider has opted out of Medicare, benefits from this Plan will still be paid as if Medicare had paid first as the primary plan, regardless of your age.

Benefits from this Plan and from Medicare will never be more than 100 percent of total reasonable expenses. Also, when this Plan is secondary, it will not pay benefits above what it normally would pay if it were the primary plan.

If you are covered under this Plan through COBRA and become eligible for Medicare, coverage under this Plan will end. Your dependents may generally continue their COBRA coverage.

If you are retired and eligible for Medicare, the PPO Plan will pay secondary even if you do not enroll in Medicare. To avoid high claim costs please enroll in Medicare Part B as soon as you are eligible to ensure your Medicare Part B coverage is active when you retire.

When Medicare is primary, this Plan will pay benefits up to:

1. the covered expenses Medicare does not pay, up to the Medicare allowance; or
2. the amount this Plan would have paid if you had no other coverage;...whichever is less.

Here are some examples showing how coordination of benefits with Medicare works.

Example 1 – Network Office Visit – Standard PPO Option

Assume you go to the Doctor for an office visit that includes an x-ray. First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Doctor's Normal Charge	Network Allowed Amount	Minus per visit network Copayment	Total this plan would pay (100%)
Office visit	\$60	\$50	– \$15	\$35
Radiology	\$30	\$25	– \$0	\$25
Totals	\$90	\$75	– \$15	\$60

An office visit includes all services provided on the same day as the office visit, by the same health care provider. Next, Medicare benefits are calculated.

Type of Service	Medicare Allowance	Medicare Deductible	Medicare Subtotal	Medicare Payment (80%)	What Medicare doesn't pay
Office visit	\$40	–\$0	=\$40	\$32.00	\$8.00
Radiology	\$20	–\$0	=\$20	\$16.00	\$4.00
Totals	\$60	–\$0	=\$60	\$48.00	\$12.00

In this example, the amount Medicare does not pay, \$12, is less than the amount this Plan would pay if you had no other coverage, \$60. This Plan will pay \$12 to the provider. You will not pay anything for these services because this Plan's payment and Medicare's payment together equal the Medicare allowance.

Example 2 – Non-network Office Visit – Standard PPO or PPO High Deductible Health Plan Option

For this example, assume you have not met your deductible and you go to the Doctor for minor surgery and lab work. First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Doctor's Normal Charge	Non-Network Allowance	Expenses applied to non-network deductible	What this Plan would pay
Minor Surgery	\$200	\$100	\$100	\$0
Lab work	\$15	\$15	\$15	\$0
Lab work	\$10	\$10	\$10	\$0
Totals	\$225	\$125	\$125	\$0

Next, Medicare benefits are calculated.

Type of Service	Medicare Allowance	Medicare Deductible	Medicare Subtotal	Medicare Payment (80%)	What Medicare doesn't pay
Minor surgery	\$150	–\$75	=\$75	\$60	\$90
Lab work	\$10	–\$0	=\$10	\$10	\$0
Lab work	\$10	–\$0	=\$10	\$10	\$0
Totals	\$170	–\$75	=\$95	\$80	\$90

In this example, \$125 would be applied to this Plan's non-network deductible. This Plan would not pay anything even if you had no other coverage. You owe the amount that Medicare does not pay: \$90.

Example 3 – Medicare eligible retiree but not enrolled in Medicare A & B

Assume you go to the Doctor for an office visit that includes laboratory services. This Plan’s benefits are calculated as if you have no other coverage.

Type of Service	Doctor’s Normal Charge	Network Allowed Amount	Total this Plan would pay (20%)	Member Responsibility (80%)
Lab work	\$105.75	\$40.86	\$8.17	\$32.69
Lab work	\$115.00	\$34.91	\$6.98	\$27.93
Totals	\$220.75	\$75.77	\$15.15	\$60.62

In this example you will be responsible for \$60.62 or 80 percent of this Plan’s allowed amount; if the provider was non-network you would be responsible for \$205.60, the difference between the provider’s charge and this Plan’s payment (\$220.75 - \$15.15 = \$205.60).

Example 4 – Non-Network Provider – Non-covered item

Assume you are retired and eligible for Medicare; your Doctor refers you to a Non-Network Provider for a hearing aid.

This Plan’s benefits are calculated as if you have no other coverage.

Type of Service	Provider’s Normal Charge	Non-Network Allowance	Total this Plan would pay	Member Responsibility
Hearing Aid	\$923.00	\$ 0 (non-covered)	\$ 0	\$923.00
Totals	\$923.00	\$ 0 (non-covered)	\$ 0	\$923.00

Next, Medicare benefits are calculated.

Type of Service	Medicare Allowance	Medicare Deductible	Medicare Subtotal	Medicare Payment (80%)	What Medicare doesn’t pay
Hearing Aid	\$923.00	-\$ 0	= \$923.00	\$738.40	\$184.60
Totals	\$923.00	-\$ 0	= \$923.00	\$738.40	\$184.60

In the above example, the primary calculation is the lesser amount because this Plan does not cover hearing aids. Therefore, this Plan will not make a payment. You owe the amount Medicare does not pay: \$184.60.

Example 5 – Provider has opted out of Medicare (Network Provider)

Assume your Doctor refers you for an x-ray.

You are eligible for Medicare but receive services from a provider who has chosen to opt out of Medicare. This Plan will pay 20 percent of the Florida Blue allowed amount without application of the deductible or copay.

This Plan’s benefits are calculated.

Type of Service	Doctor’s Normal Charge	Network Allowed Amount	Total this Plan would pay (20%)	Member Responsibility (80%)
X-rays	\$115.00	\$41.52	\$8.30	\$33.22
X-rays	\$125.00	\$55.65	\$11.13	\$44.52
Totals	\$240.00	\$97.17	\$19.43	\$77.74

In this example, you will be responsible for \$77.74 or 80 percent of the Plan’s allowed amount. If this provider were non-network, you would be responsible for \$220.57, the difference between the provider’s charge and this Plan’s payment (\$240.00 - \$19.43 = \$220.57).

Example 6 – Network Services – Standard PPO Option

Assume you have an office visit, electrolysis, and a minor surgical service provided by a network Specialist. First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Normal Charge	Network Allowed Amount	Minus per visit network Copayment	Total this plan would pay
Office Visit	\$150	\$73	-\$25	\$48
Electrolysis	\$125	\$0 (non-covered service)	\$0	\$0
Surgical procedure	\$90	\$38	=\$0	\$38
Totals	\$365	\$111	-\$25	\$86

An office visit includes all services provided on the same day as the office visit, by the same health care provider. This Plan does not cover electrolysis.

Next, Medicare benefits are calculated.

Type of Service	Medicare Allowance	Medicare Deductible	Medicare subtotal	Medicare Payment (80%)	What Medicare doesn't pay
Office Visit	\$71	-\$0	=\$71	\$56.80	\$14.20*
Electrolysis	\$68	-\$0	=\$68	\$54.40	\$13.60
Surgical procedure	\$33	-\$0	=\$33	\$26.40	\$6.60*
Totals	\$172	-\$0	\$172	\$137.60	\$34.40

In this example, the amount Medicare does not pay on lines one* and three*, \$20.80 is less than the amount this Plan would pay if you had no other coverage, \$86. This Plan will pay \$20.80 to the provider. You owe the remaining amount not paid by Medicare and this Plan, \$13.60. This Plan does not include non-covered services (electrolysis) that may be covered by Medicare in calculating the amount this Plan will pay.

Example 7 – Network Service – Standard PPO Option

For this example, assume you have met your deductible and received minor cosmetic surgery from a Network Physician.

First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Normal Charge	Network Allowed Amount	Total this plan would pay
Minor surgery	\$75	\$0 (non-covered service)	\$0
X-ray	\$50	\$35	\$28
Totals	\$125	\$35	\$28

This Plan does not cover cosmetic surgery.

Next, Medicare's benefits are calculated.

Type of Service	Medicare Allowance	Medicare Deductible	Medicare subtotal	Medicare Payment (80%)	What Medicare doesn't pay
Minor surgery	\$0 (non-covered service)	\$0	=\$0	\$0	\$75
X-ray	\$27	\$0	=\$27	\$21.60	\$5.40*
Totals	\$27	\$0	=\$27	\$21.60	\$80.40

In this example, Medicare does not cover the service (cosmetic surgery) and neither does this Plan for line one, \$75. You owe the amount Medicare does not pay, \$75, for this service.

For line two*, the amount Medicare does not pay, \$5.40, is less than the amount this Plan pays if you had no other coverage, \$28. This Plan will pay \$5.40 to the provider. You will not owe anything for this service because this Plan's payment and Medicare's payment together equal the Medicare allowance.

Example 8 – Network Provider (does not participate in Medicare)

Assume that you have met your Plan deductible and you receive massage and physical therapy services from a Network Physician who does not participate in Medicare.

First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Provider's Normal Charge	Network Allowed Amount	Deductible (member responsibility)	Total this plan would pay if primary (80% of allowed amount)	Member Responsibility (20% of allowed amount)
Massage Therapy	\$32	\$25	-\$0	\$20	\$5
Physical Therapy	\$17	\$12	-\$0	\$9.60	\$2.40
Totals	\$49	\$37	-\$0	\$29.60	\$7.40

Next, Medicare's benefits are calculated (non-participating Medicare Provider):

Type of Service	Provider's Normal Charge	Medicare Allowance	Medicare Deductible	Medicare Subtotal	Medicare Payment (80%) to Member	What Medicare doesn't pay
Massage Therapy	\$32	\$30	-\$0	\$30	\$24	\$6*
Physical Therapy	\$17	\$15	-\$0	\$15	\$12	\$3*
Totals	\$49	\$45	-\$0	\$45	\$36	\$9

In this example, this Plan would pay to you \$9, the amount Medicare does not pay to you for lines 1* and 2* (\$6 + \$3 = \$9.) You are responsible for \$4, the difference between the provider's normal charge and what Medicare paid to you and what this Plan paid to you (\$49 - \$36 - \$9 = \$4.) Note: Because this Provider is not participating with Medicare, payments by Medicare and this Plan will be paid to you; you will be responsible for making payment to the Provider.

Example 9 – Non-Network Provider – Standard PPO and PPO High Deductible Health Plan

Assume you have \$170 remaining to meet your non-network deductible and go to a Non-Network Provider for minor surgery.

First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Provider's Normal Charge	Non-Network Allowance	Expenses Applied to Non-Network Deductible	Total this Plan would pay if primary (60% of allowance)	Member Responsibility (40% of allowance)
Minor Surgery	\$200	\$155	\$155**	\$0	\$200
X-rays	\$15	\$15	\$15**	\$0	\$15
Injection	\$10	\$10	\$0	\$6	\$4
Totals	\$225	\$180	\$170	\$6	\$219

Next, Medicare's benefits are calculated.

Type of Service	Provider's Normal Charge	Medicare Allowance	Medicare Deductible	Medicare Payment (80%)	What Medicare doesn't pay
Minor Surgery	\$200	\$150	\$75	\$60	\$15***
X-rays	\$15	\$10	\$0	\$8	\$2***

Type of Service	Provider's Normal Charge	Medicare Allowance	Medicare Deductible	Medicare Payment (80%)	What Medicare doesn't pay
Injection	\$10	\$10	\$0	\$8	\$2*
Totals	\$225	\$170	\$75	\$76	\$19

In this example, this Plan would pay \$2 for the Injection on line 3* and \$170 would be applied to the non-network deductible for lines 1** and 2**. You are responsible for \$92 (\$75 + \$15 + \$2 = \$92) which is the amount applied to the Medicare deductible and the amount Medicare did not pay for lines 1*** and 2***.

Example 10 – Network Specialist Office Visit – Standard PPO Option

Assume you go to a Network Specialist for an office visit that includes an electrocardiogram.

First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Provider's Normal Charge	Network Allowed Amount	Deductible (member responsibility)	Copay	Total This Plan Would Pay, if primary	Member Responsibility
Electrocardiogram	\$45	\$17.15	-\$0	\$17.15	\$0***	\$17.15
Office Visit	\$220	\$120.54	-\$0	\$7.85	\$112.69	\$7.85
Totals	\$265	\$137.69	-\$0	\$25	\$112.69	\$25

Next, Medicare benefits are calculated.

Type of Service	Provider's Normal Charge	Medicare Allowance	Medicare Deductible	Medicare Subtotal	Medicare Payment (80%)	What Medicare doesn't pay
Electrocardiogram	\$45	\$18.08	-\$0	\$18.08	\$14.46	\$3.62**
Office Visit	\$220	\$105.33	-\$0	\$105.33	\$84.26	\$21.07*
Totals	\$265	\$123.41	-\$0	\$123.41	\$98.72	\$24.69

In this example, this Plan would pay the \$21.07* amount Medicare did not pay for line 2* and would pay \$0 for line 1*** (applied to copay for Specialist office visit.) You are responsible for \$3.62** from line 1.

Example 11 – Network Provider – Standard PPO Option

Assume your Plan deductible and annual coinsurance maximum is met and you receive radiology services by a Network Provider.

First, this Plan's benefits are calculated as if you have no other coverage.

Type of Service	Provider's Normal Charge	Network Allowed Amount	Total This Plan Would Pay, if primary (80% of allowed amount)	Member Responsibility
Radiology	\$30.13	\$30.13	\$30.13	\$0
CT Scan	\$1,590	\$509.64	\$509.64	\$0
Radiology	\$123.29	Incidental**	\$0**	\$0
Injection	\$35	\$18	\$18	\$0
Totals	\$1,778.42	\$557.77	\$557.77	\$0

Next, Medicare benefits are calculated.

Type of Service	Provider's Normal Charge	Medicare Allowance	Medicare Deductible	Medicare Subtotal	Medicare Payment (80%)	What Medicare doesn't pay
Radiology	\$30.13	\$25.13	\$0	\$25.13	\$20.10	\$5.03*
CT Scan	\$1,590	\$424.70	\$0	\$424.70	\$339.76	\$84.94*
Radiology	\$123.29	\$93.29	\$0	\$93.29	\$74.63	\$18.66**
Injection	\$35	\$17	\$0	\$17	\$13.60	\$3.40*
Totals	\$1,778.42	\$560.12	\$0	\$560.12	\$448.09	\$112.03

In this example, this Plan would pay \$93.37, the amount not paid by Medicare for lines 1*, 2*, and 4* (\$5.03 + \$84.94 + \$3.40 = \$93.37) and this Plan would deny line 3** as incidental (minor and included in cost of the primary service) to the service on line 2; however, since Medicare allowed for the charge of line 3** you are responsible for \$18.66**.

An Important Note for Retirees

Once you or your spouse become eligible for Medicare, any claims filed with Medicare for you or your spouse may automatically be filed with Florida Blue after Medicare pays what is covered. Call Florida Blue Customer Service at (800) 825-2583 and request to be set up for automatic crossover from Medicare. No separate filing to Florida Blue will be required.

Coordination of Prescription Drug Benefits with Medicare Part B:

CVS Caremark is responsible for ensuring that prescribed drugs eligible for coverage under Medicare Part B are identified at the retail, mail order pharmacy, and specialty pharmacy. Medicare Part B drugs will be rejected at the point of purchase at a retail or mail order pharmacy. If you have Medicare Parts A and B as your primary insurance coverage and if the prescribed drug is eligible for coverage under Medicare Part B, then this Plan will pay as a secondary coverage. If the prescribed drug is not covered under Medicare Part B, this Plan will pay as your primary carrier for such prescribed drugs and there will be no coordination of benefits.

Medicare Part B requires that the pharmacy (retail, mail order, and specialty) obtain a signed Assignment of Benefits/Assignment of Billing/Medical Release Authorization form. This form is required in order to bill Medicare on your behalf. Since some drugs are only eligible under Medicare Part B for specific diagnoses, Medicare Part B requires that each prescription include a written diagnosis. There may be other situations when Medicare Part B requires additional specific documentation before accepting a prescription drug claim for payment. In most cases, Medicare Part B

will only accept claims for a prescription fill up to a 30-day dosage. Generally, Medicare eligible items covered under Medicare Part B are subject to the Medicare calendar year deductible.

Using the Mail Order or Specialty Pharmacy for Medicare Part B Drugs:

1. All appropriate documentation must be on file or presented with the prescription.
2. You must mail the prescription with the appropriate diagnosis to CVS Caremark Mail Service Pharmacy or CVS Specialty pharmacy, as appropriate.

Important Note: The CVS Caremark Mail Service Pharmacy is not a Medicare approved diabetic supplies mail order pharmacy. Prescriptions for diabetic supplies should be filled by an in-network 30-day retail pharmacy or a participating 90-day retail pharmacy that is also an approved or participating Medicare retail pharmacy. Diabetic supplies are considered maintenance and are subject to the maintenance prescription drug provisions. If the prescription drug is determined to be eligible under Medicare Part B, CVS Caremark will forward your prescription request to the CVS Caremark Mail Service Pharmacy for Medicare Part B covered drugs or to the CVS Specialty pharmacy for Medicare Part B covered specialty drugs.
3. CVS Caremark may reach out to you for any information necessary to fill the prescription, within all appropriate prescription guidelines, and file a claim to Medicare Part B on your behalf.
4. You will receive an Explanation of Medicare Benefits (EOMB) after Medicare Part B processes the claim indicating Medicare's payment, amount applied to the deductible, and your responsibility.
5. After the prescription claim is paid by Medicare, CVS Mail Service Pharmacy or CVS Specialty

pharmacy, as appropriate, will submit a claim to CVS Caremark for your secondary benefits under this Plan. CVS Mail Service pharmacy or CVS Specialty pharmacy may bill you for any remaining balance up to the Medicare allowed amount. In most cases, after this Plan has paid secondary carrier benefits and Medicare Part B has paid primary benefits, you will have zero out-of-pocket expenses.

Using an In-Network Retail Pharmacy that Participates with Medicare Part B

1. All appropriate documentation must be on file or presented with the prescription.
2. You must present the prescription with the appropriate diagnosis to the in-network and Medicare Part B participating retail pharmacy.
3. The in-network and Medicare Part B participating Retail Pharmacy will fill the prescription, within all appropriate prescription guidelines and file a claim to Medicare on your behalf.
4. You will receive an Explanation of Medicare Benefits (EOMB) after Medicare Part B processes the claim indicating Medicare Part B's payment, amount applied to the deductible, and your responsibility.
5. The in-network and Medicare Part B participating retail pharmacy will submit a claim to CVS Caremark for secondary benefits under this Plan. In most cases, after this Plan has paid secondary carrier benefits and Medicare Part B has paid primary benefits, you will have zero out-of-pocket expenses.

Using an In-Network Retail Pharmacy that Does Not Participate with Medicare Part B

If you submit a prescription to a retail pharmacy that does not participate with Medicare Part B

you will be responsible, to the retail pharmacy for 100 percent of the cost of the medication. To receive primary benefits under Medicare Part B, you or the non-participating Medicare Part B retail pharmacy must submit a claim directly to Medicare Part B. If the claim is not submitted to Medicare Part B and you do not receive an EOMB, you will not be allowed to submit a claim to CVS Caremark for secondary benefits.

Coordination of Prescription Drug Benefits with Medicare Part D

If you enroll in or are automatically enrolled in a Medicare Part D Prescription Drug Plan, then

this Plan will pay as your secondary prescription coverage. The Medicare Part D Plan will pay as your primary prescription coverage.

If you enroll in or are automatically enrolled in a Medicare Part D Prescription Drug Plan, you will usually pay a monthly premium. You may not pay a Medicare Part D premium if you are receiving assistance through Supplemental Security Income (SSI), Medicare Low Income Subsidy Benefit, State Medicaid, or living in certain facilities, such as a nursing home.

If you are receiving state or federal assistance, you might be automatically enrolled in a Medicare Part D Plan without your knowledge. If you were enrolled in a Medicare Advantage Plan through previous insurance coverage, you were automatically enrolled in a Medicare Part D Plan. If you elected or were automatically enrolled in a Medicare Part D Plan, it is your responsibility to opt out or disenroll from such Medicare Part D coverage. If you elect to disenroll, you must contact the Medicare Part D Plan that you are enrolled in or contact Medicare at (800) 663-4227.

IMPORTANT NOTE: Medicare automatically notifies the State of Florida of any of its Plan members that are enrolled in a Medicare Part D Prescription Drug Plan. Upon such notification from Medicare, this Plan will automatically become the secondary coverage. This Plan will not be changed to the primary coverage until you provide CVS Caremark a letter of creditable coverage or disenrollment from the Medicare Part D Plan. Such letter of creditable coverage must include your name and the effective and termination dates of your Medicare Part D coverage. Due to the confidential nature of your prescription drug information, Medicare will not discuss your Medicare Part D coverage with the State of Florida.

Section 14: Plan's Right to Recover, Recoup, and Sue for Losses

State's Right of Subrogation and Reimbursement

The State has subrogation and reimbursement rights, which help the State continue providing cost-effective health care benefits.

If you or your dependents receive 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, the State will be "subrogated" and succeed to the right of recovery you or your dependents have against any other person or entity to the extent of the benefits paid under the Plan. This means that the State has the right to take legal action against any person to recover benefits paid under the Plan for expenses arising from the Condition caused, directly or indirectly, by the intentional act or negligence or fault of any third person or entity.

In addition to its right of subrogation, the State has the right to be reimbursed in full, and in first priority, by you or your dependents (out of any judgment or settlement proceeds that may be obtained) for any benefits paid under the Plan 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.

These rights of subrogation and reimbursement apply to any judgment or settlement of a claim, regardless of whether there is a lawsuit, and will not be offset by any premiums that have been paid under the Plan. For instance, personal injury protection insurance is designated as the primary payer under Section 627.736, Florida Statutes, and the State has the right to recover payments for benefits that are also covered under a personal injury protection policy. The State's right to subrogation also extends to benefits which may be payable through any other type of insurance coverage, including, but not limited to, uninsured/underinsured motorist's coverage.

The State is entitled to subrogate or obtain reimbursement even if the total amount of any judgment or settlement is insufficient to fully compensate you for your losses. The State is also entitled to subrogate or obtain reimbursement regardless of whether any settlement identifies the particular benefits paid under the Plan and regardless of how any settlement is characterized by you, your lawyers, or any other persons.

The amount recoverable by the State in subrogation or reimbursement is subject to reduction only by the Plan's pro-rata share for any costs and attorney's fees incurred by you in pursuing and recovering any third party payment.

You will not be asked to reimburse the State for an amount higher than the actual payments it made on your behalf. You, your dependent or your legal representative will be required to:

- provide information pertaining to your settlement, settlement negotiations or litigation;
- provide the assistance necessary to enforce the State's right to subrogation or reimbursement;
- notify Florida Blue of any settlement negotiations before entering into any settlement agreement;
- notify Florida Blue of any amount recovered from the third person or entity; and
- obtain the prior written consent of Florida Blue or DSGI before entering into any settlement agreement.

No waiver, release of liability or other documents you execute without notice to Florida Blue shall be binding upon the State, the Department of Management Services, or DSGI.

Right to Recovery and Recoupment

The State, Florida Blue, and CVS Caremark have recoupment rights whenever it is discovered that payments for health services, supplies, and prescription drugs have been made in excess of the maximum provided for under this Benefit Document. The State, Florida Blue, and CVS Caremark will pursue any action available up to and including use of a collection agency to recover excess payments from you, your dependents, or any other person, entity, or organization.

Section 15: Definitions

Here are definitions of selected terms used by this Plan. Note: in this Benefits Document these terms may be capitalized and/or lower case.

Accident...an accidental bodily injury that is not related to any Illness.

Accidental Dental Injury...an injury to sound, natural teeth resulting from a sudden, unintentional, and unexpected event or force that is not related to chewing, any other natural bodily function, or illness.

Acupuncture...for purposes of this Plan Booklet and Benefits Document, means:

1. the technique of passing long, thin needles through the skin to specific points on the body for treatment of certain Conditions; and
2. Massage when performed by a licensed Acupuncturist, including stroking, compression and percussion.

Acupuncturist...a person who is legally qualified and licensed under Florida law or similar law of another state to perform Acupuncture.

Ambulance...any land, air or water vehicle designed, constructed, or equipped for and used for transporting persons in need of medical or surgical attention, that is licensed under Florida law or similar law of another state.

Ambulatory Surgical Center...a facility:

1. licensed under Florida law or similar law of another state to provide elective surgical care;
2. to which the patient is admitted and discharged within the same working day; and
3. that is not 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.

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

Approved Clinical Trial...a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and meets one of the following criteria:

1. The study or investigation is approved or funded by one or more of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare and Medicaid Services.
 - e. A cooperative group or center of any of the entities described in (a.) through (d.) above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following if the conditions described in paragraph (2) are met:
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For a study or investigation conducted by a Department the study or investigation must be reviewed and approved through a system of peer review that the Secretary determines: (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For purposes of this definition, the term "Life-Threatening Disease or Condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Autism Spectrum Disorder...any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;
2. Asperger's syndrome;
3. Pervasive developmental disorder not otherwise specified.

Behavior Analyst...an individual certified pursuant to s. 393.17, Florida Statutes, or licensed under chapters 490 or 491, Florida Statutes or similar law of another state, to provide Applied Behavior Analysis.

Benefits or Plan Document...this document. Your insurance coverage is limited to the express written terms of this Benefits Document. Your coverage cannot be changed based upon statements or representations made to you by anyone, including employees of DSGI, Florida Blue, CVS Caremark, People First or your employer.

Birth center...any facility, institution or place where births are planned to occur following a normal, uncomplicated, low risk pregnancy. The facility must be licensed under Florida law or similar law of another state. A facility is not considered a birth center if it is an Ambulatory Surgical Center, a Hospital or part of a Hospital.

Child Preventive Care Services...Doctor-delivered or Doctor-supervised services that include a history, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests based on prevailing medical standards under the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Coinsurance...a percentage share of the costs for covered services that you pay after you meet your deductible.

Condition...any disease, illness, injury, Accident, bodily dysfunction, pregnancy, drug addiction, alcoholism or Mental or Nervous Disorder.

Congenital Anomaly...physical abnormalities that occur before a baby is born and that are obvious at birth or by one year of age.

Convenient Care Center...an ambulatory center that is licensed under Florida law or similar law of another state:

1. is usually housed in a retail business;
2. shares clinical information about the treatment with the patient's primary care physician;
3. treats a limited number of common, low-intensity illnesses when ready access to the patient's primary care physician is not possible; and
4. is staffed by at least one Advanced Registered Nurse Practitioner (ARNP) who operates under a set of clinical protocols that strictly define and restrict the conditions the ARNP can treat.

Although no physician is present at the Convenient Care Center, medical oversight is based on a written collaborative agreement between a supervising physician and the ARNP.

Copay or Copayment...a set dollar amount you must pay the provider for certain covered services and prescription drugs.

Covered Provider...a person, institution or facility defined in this booklet that furnishes a covered service or supply. When this Plan requires licensing or certification by the State of Florida, the license of the state in which the service or supply is provided may substitute for the Florida license or certificate.

Covered Services and Supplies...health care services and supplies, including pharmaceuticals as described in Section 9, for which reimbursement is covered under this Plan. The Division of State Group Insurance (DSGI) has final authority to determine if a service or supply is covered, limited or excluded by the Plan.

Custodial Care or Services...care or services that are maintenance in nature that serve to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered or administered by a trained home care giver. Custodial Care essentially is care that does not require the continuing attention of trained medical or paramedical personnel and that can be provided by or taught to home caregivers. In determining whether a person is receiving Custodial Care, consideration is given to the level of care and

medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation or rehabilitation potential.

Care or services that meet this definition are not covered by the Plan. See section 5 of this booklet.

Developmental Disability... a disorder or syndrome that: 1. is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome, 2. manifests before the age of 18, and 3. constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

Diabetes Educator...a person who is legally certified or licensed under Florida law or similar law of another state to supervise diabetes outpatient self-management training and educational services. These services are designed to teach pre-diabetics and diabetics self-management skills and lifestyle changes to effectively manage diabetes and to avoid or delay complications from diabetes.

Dialysis Center...an outpatient facility certified by the U.S. Health Care Financing Administration and the Florida Agency for Health Care Administration or otherwise authorized under the laws of another state to provide hemodialysis and peritoneal dialysis services and support.

Dietician...a person who is licensed under Florida law or similar law of another state to provide nutritional counseling for diabetes outpatient self-management services.

Durable Medical Equipment (DME) Provider... a person or entity licensed by the state of Florida or similar law of another state to provide home Medical Equipment, oxygen therapy services or dialysis supplies in the patient's home under a Physician's prescription.

Doctor/Physician...a Doctor of medicine (M.D.), Doctor of osteopathy (D.O.), Doctor of surgical chiropody (D.S.C.) or Doctor of podiatric medicine (D.P.M.), who is licensed by the state of Florida or under similar law of another state, to practice medicine and perform surgery at the time and place the service is rendered. Doctor also means:

1. a licensed dentist who performs surgical or non-dental procedures covered by this Plan, or provides treatment of injuries resulting from Accidents;
2. a licensed optometrist who performs procedures covered by this Plan;

3. a licensed psychologist or licensed mental health professional, as defined by Florida law or similar law of another state, who provides covered services; and
4. a licensed chiropractor who performs procedures covered by this Plan.

To be considered a Doctor/Physician by this Plan, any health care professional must be providing covered services that are within the scope of his or her professional license.

Down Syndrome...a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

Experimental or Investigational Services...any evaluation, treatment, therapy or device that meets any one of the following criteria:

1. cannot be lawfully marketed without approval of the U.S. Food and Drug Administration or the Florida Department of Health, and approval for marketing in the United States has not been given at the time the service is provided to the covered person; or
2. is the subject of ongoing Phase I or II clinical investigation, or the 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; or
3. is generally regarded by experts in the United States as requiring more study to determine maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the Condition; or
4. has not been proven safe and effective for 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; or
5. is not accepted in consensus by practicing Doctors in the United States as safe and effective for the Condition; or
6. is not regularly used by practicing Doctors in the United States to treat patients with the same or a similar Condition.

Florida Blue, CVS Caremark and DSGI determine whether a service or supply is Experimental or Investigational.

Financially Responsible...the degree of financial support sufficient to claim an eligible dependent as an exemption on a subscriber's federal income tax return.

Home Health Aide...a person legally certified under Florida law or similar law of another state as having completed an approved course of study and employed by a state-licensed institution or agency.

Home Health Care Agency...an agency or institution licensed by the appropriate Florida state agency or similar law of another state to provide an approved plan of service for people who are confined and convalescing at home instead of in the Hospital. A Home Health Care Agency may operate independently or as part of a Hospital. Organizations or other persons providing home hemodialysis services are not home health care agencies.

Hospice...an 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. This team of providers includes a Doctor and nurse and may also include a social worker, a clergy member or counselor and volunteers.

Hospital...an institution licensed under Florida law or similar law of another state providing medical care and treatment to a patient as a result of Illness, Accident or Mental or Nervous Disorders on an inpatient/outpatient basis and that meets all the following:

1. It is accredited by the Joint Commission, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities. Licensed institutions in rural, sparsely populated geographic regions, however, may not be required to 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-hour-a-day nursing service by or under the supervision of Registered Nurses.

The term "Hospital" does not include a Specialty Institution or residential facility, or a U.S. Government Hospital or any other Hospital operated by a governmental unit, unless a charge is made by the Hospital that the patient is legally required to pay without regard to insurance coverage.

Hospitalists...Physicians who specialize in the care of members in an acute inpatient setting (acute care Hospitals and Skilled Nursing Facilities). A Hospitalist oversees a member's inpatient admission and coordinates all inpatient care. The Hospitalist is required to communicate with the member's selected Physician by sending records and information, such as the discharge summary, upon the member's discharge from the Hospital or Skilled Nursing Facility.

Illness...physical sickness or disease, pregnancy, bodily injury or Congenital Anomaly. For this Plan, Illness includes any Medically Necessary services related to non-emergency surgical procedures performed by a Doctor for sterilization.

Independent Clinical Laboratory...a facility properly licensed by the state of Florida or under similar law of another state where human materials or specimens are examined for the purpose of diagnosis, prevention or treatment of a Condition.

Intensive Care Unit...a specialized area in a Hospital where an acutely ill patient receives intensive care or treatment. Included in the Hospital's charge for an Intensive Care Unit are the services of specially trained professional staff and nurses, supplies, the use of any and all equipment and the patient's board. A coronary care unit is also considered an Intensive Care Unit.

Intensive Outpatient Treatment...treatment in which an individual receives at least three (3) clinical hours of institutional care per day (24-hour period) for at least three (3) days a week and returns home and/or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Manipulative Services...physical medicine involving the skillful and trained use of the hands to treat diseases or symptoms resulting from misalignment of the spine.

Massage Therapist...a person licensed under Florida law or similar law of another state to practice Massage Therapy.

Massage or Massage Therapy...the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Plan Booklet and Benefits Document, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Medically Necessary...services required to identify or treat the Illness, injury, Condition, or Mental and Nervous Disorder 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. at the most appropriate level of medical supply, service, or care that can be safely provided.

In applying the definition of Medically Necessary to a specific service, prescription drug, or supply we may apply our coverage and payment guidelines then in effect. The fact that a service, prescription drug, or supply is prescribed by a Doctor does not necessarily mean that the service is Medically Necessary. Florida Blue, CVS Caremark, and DSGI determine whether a service, prescription drug, or supply is Medically Necessary. You are free to obtain a service, prescription drug, or supply even if we deny coverage because the service, prescription drug, or supply is not Medically Necessary; however, you will be solely responsible for paying for the service, prescription drug, or supply.

Medical Supplies or Equipment...supplies or equipment that are:

1. ordered by a Physician;
2. of no further use when medical need ends;
3. usable only by the particular patient;
4. not primarily for the patient's comfort or hygiene;
5. not for environmental control;
6. not for exercise; and
7. specifically manufactured for medical use.

Mental and Nervous Disorder...any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD10-CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

Midwife...a person licensed by the state of Florida or under similar law of another state, to assist in childbirth. A nurse Midwife has received special training in obstetrics and is qualified to deliver infants.

Network Allowed Amount (Allowed Amount)...the maximum amount this Plan will approve for Covered Services and Supplies received from a Covered Provider who is a member of Florida Blue's PPCSM preferred provider organization network.

Network Provider (In-Network, Preferred, or Participating)...Covered Providers who are members of Florida Blue's PPCSM Network, or members of another Blue Cross and/or Blue Shield Plan's preferred provider network available to covered individuals under the rules of the BlueCard[®] Program.

Non-Network Allowance (Allowance)...the maximum amount this Plan will approve for Covered Services and Supplies received from a Covered Provider who is not a member of the preferred provider organization network.

Non-Network Provider (Out-Of-Network, Non-Preferred, or Non-Participating)...Covered Providers who are not members of Florida Blue's PPCSM Network or another Blue Cross and/or Blue Shield Plan under the BlueCard[®] Program.

Nurse's Aide...a person who assists professional nurses in a hospital or other setting and performs routine tasks that require little or no formal training, education, certification, or licensing.

Nurse Anesthetist...a Registered Nurse licensed by the state of Florida or under similar law of another state, who administers anesthesia to patients in the

operating and delivery room. Anesthesia causes partial or complete loss of sensation and is usually administered by injection or inhalation.

Outpatient Health Care Facility...a facility, licensed by the state of Florida or under similar law of another state, other than a Doctor's, Physical Therapist's or Midwife's office that provides outpatient services for treatment of an Illness or Accident, other than Mental or Nervous Disorders, drug addiction or alcoholism.

Overcharge...in the opinion of DSGI, any of the following for which a Patient Auditor Program claim is submitted within six (6) months of the date of the health insurance claim payment:

1. any charge paid under this Plan for a covered service and/or supply when such service or supply is not received by the covered participant;
2. any charge by a Covered Provider for a covered service or supply which is paid under this Plan and exceeds the amount previously agreed to by the provider, in writing, to furnish the participant such service or supply; however, in no case shall an Overcharge include any amount above the Plan's allowed amount or allowance for such service or supply nor shall it include any additional charges resulting from complications or other Medically Necessary procedures which were not previously apparent; or
3. any amount paid under this Plan because of a billing error by a Covered Provider.

Partial Hospitalization...treatment in which an individual receives at least six (6) clinical hours of institutional care per day (24-hour period) for at least five (5) days per week and returns home and/or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Payment for Hospital Services (PHS) Providers... providers not in the Preferred Patient CareSM Network but who have a Hospital services agreement with Florida Blue to provide services, as Florida Blue PHS providers, at a negotiated fee. These providers are also called Florida Blue Traditional Program participating providers.

Payment for Professional Services (PPS) Provider... providers not in the Preferred Patient CareSM Network but who have a provider agreement with Florida Blue to provide services, as Florida Blue PPS providers, at a negotiated fee. These providers

are also called Florida Blue Traditional Program Participating Providers.

Palliative Care...reduction or abatement of pain and other troubling symptoms through services provided by members of the Hospice team of health care providers.

Physical Therapist...a person licensed under Florida law or similar law of another state to engage in the practice of physical therapy.

Physician Assistant...a specially trained individual licensed by the state of Florida or under similar law of another state to perform tasks ordinarily done by a Physician. Physician Assistants work under the supervision of a Physician.

Preferred Patient CareSM Network (PPCSM)...a registered trademark name for Florida Blue's preferred provider organization network.

Primary Care Physician...any covered Physician with a primary practice in Family Practice, General Practice, Internal Medicine, or Pediatric Medicine.

Prosthetist/Orthotist...a person or entity licensed by the state of Florida or under similar law of another state to provide services for the design and construction of medical devices such as braces, splints and artificial limbs under a Physician's prescription.

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

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

Registered Dietician...a person who is legally certified by the state of Florida or under similar law of another state to provide nutrition counseling for diabetes outpatient self-management services.

Registered Nurse (RN) or Licensed Practical Nurse (LPN)...a person licensed by the state of Florida or under similar law of another state to practice nursing.

Registered Nurse First Assistant...a Registered Nurse who works with a surgeon and has specific knowledge and training in surgical practices.

Rehabilitative Hospital or Comprehensive

Rehabilitative Hospital...a Hospital licensed by the Florida Agency for Health Care Administration or under similar law of another state as a specialty Hospital; provided that the Hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the Hospital are classified as "comprehensive rehabilitative beds," and are not classified as "general beds."

Residential Treatment Facility...a facility properly licensed under Florida law or a similar applicable law of another state, to provide care and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

- Has Mental Health Professionals on-site 24 hours per day and 7 days per week;
- Provides access to necessary medical services 24 hours per day and 7 days per week;
- Provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk; and,
- Is not a wilderness treatment program or any such related or similar program, school and/or education service.

With regard to Substance Dependency treatment, in addition to the above, must meet the following:

- If Detoxification Services are necessary, provides access to necessary on-site medical services 24 hours per day and 7 days per week, which must be actively supervised by an attending physician;
- Ability to assess and recognize withdrawal complications that threaten life or bodily function and to obtain needed services either on-site or externally; and,
- Is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation.

Residential Treatment Services...treatment in which an individual is admitted by a Physician licensed by the state of Florida or under similar law of another

state overnight to a Hospital, Psychiatric Hospital or Residential Treatment Facility all of which are licensed by the state of Florida or under similar law of another state and receives daily face-to-face treatment by a Mental Health Professional licensed by the state of Florida or under similar law of another state for at least eight (8) hours per day, each day. The Physician must perform the admission evaluation with documentation and treatment orders within 48 hours and provide evaluations with documentation at least weekly. A multidisciplinary treatment plan must be developed within three (3) days of admission and must be updated weekly.

Skilled Nursing Care...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 participant's medical needs, or supervision of a medical treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired medical results.

Skilled Nursing Facility...an institution licensed by the state of Florida or under similar law of another state, 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. rehabilitation services by, or under the supervision of, licensed Physical Therapists; and
3. other Medically Necessary related health services.

Sound Natural Teeth...teeth that are whole or properly restored (restoration with amalgams, resin, or composite only); are without impairment, periodontal, or other conditions; and are not in need of services provided for any reason other than an accidental dental injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics are not Sound Natural Teeth.

Specialty Physician or Specialist...any covered health care provider not considered a Primary Care Physician.

Specialty Drugs...high-cost injectable, infused, oral, or inhaled drugs that are used to treat certain chronic or genetic Conditions or disease states. Specialty Drugs include genetically engineered drugs (sometimes called Biotech drugs) that are

used to treat Conditions that include but are not limited to Rheumatoid Arthritis, Hepatitis C, Multiple Sclerosis, Growth Hormone Deficiency and Oncology. These drugs often require customized management and frequent Physician monitoring and may require unique mailing (i.e. overnight delivery), storage (i.e. refrigeration), and administration (i.e. injection training).

Specialty Facility or Institution...any facility that specializes in the treatment of psychiatric or substance abuse disorders, is licensed by the State of Florida Department of Children and Families as a Specialty Facility or Institution, and is accredited by the Joint Commission.

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

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

Terminally Ill...a person has a life expectancy of six months or less because of a chronic, progressive Illness that is incurable according to the person's Doctor.

Traditional Program Providers...providers that are not in the Preferred Patient CareSM (PPCSM) Network but that have participation agreements with Florida Blue and have been designated by Florida Blue as Traditional Program Providers, including PPS and PHS providers.

State of Florida Employees' Group Health Insurance Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information.

This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by employer health plans — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the State of Florida's privacy practices its flexible spending accounts, health savings accounts, health reimbursement accounts, the State Group Health Insurance Plan(s), health maintenance organization(s) (HMO), State Employees' Prescription Drug Program, and other plans of the State Group Insurance Program (collectively "Plans").

The Plans covered by this notice, because they are all sponsored by the State of Florida, participate in an "organized health care arrangement." The Plans may share health information with each other, their agents, and the State to carry out treatment, payment, or health care operations.

The Plans' duties with respect to health information about you

The Plans are required by law to maintain the privacy of your health information, to provide you with a notice of their legal duties and privacy practices with respect to your health information, and to notify you following a breach of unsecured protected health information.

Members of a State Group Health Insurance Plan, health maintenance organization (HMO), or other plan will receive notices and other correspondence directly from the third-party administrator or insurance carrier that administers the plan (e.g., Florida Blue, Aetna, AvMed, United Healthcare, Capital Health Plan, SurgeryPlus, CVS Caremark, etc.). Members will also receive notices directly from other agents of the State Group Insurance Program.

It's important to note that these rules apply only with respect to the Plans identified above, not to the State as your employer. Different policies may apply to other state programs and to records unrelated to the Plans.

How the Plans may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment, and operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers, doctors, or Plans. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plans may share health information about you with physicians who are treating you.
- Payment includes activities by these Plans or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plans may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.
- Health Care Operations include activities by these Plans (and in limited circumstances other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plans may use information about your claims to review the effectiveness of wellness programs.

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under HIPAA.

How the Plans may share your health information

The Plans will disclose your health information without your written authorization to the State for plan administration purposes. The State agrees not to use or disclose your health information other than as permitted or required by plan documents and by law.

The Plans may also disclose “summary health information” to the State for purposes of obtaining premium bids to provide coverage under the Plans, or for modifying, amending, or terminating the Plans. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information have been removed.

In addition, the Plans may disclose to the State information on whether an individual is participating in the Plans or has enrolled or disenrolled in any available option offered by the Plans.

The State cannot and will not use health information obtained from the Plans for any employment-related actions. However, health information collected by the State from other sources is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

The Plans are also allowed to use or disclose your health information without your written authorization as follows:

- To Business Associates: The Plans may use and disclose PHI to certain other individuals, entities, or agents (Business Associates) we have contracted with to perform or provide certain services on behalf of the Plans. To perform or provide these services, the Business Associate may create, receive, maintain or transmit your PHI. The Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associate. When the arrangement with a Business Associate involves the use or disclosure of PHI, a written contract protecting the privacy of your health information will be implemented. Subcontractors are subject to the same restrictions and conditions that apply to Business Associates.
- To a Family Member, Close Friend, or Other Person Involved in Your Care: In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.
- As Permitted by Law: Your PHI may be used or disclosed to the extent that such use or disclosure is permitted by law.
- For Public Health and Safety: Your PHI may be used or disclosed to the extent necessary to avert a serious and imminent threat to the health or safety of you or others, for public health care oversight activities, and to report suspected abuse, neglect, or domestic violence to government authorities.
- For Worker’s Compensation: Your PHI may be disclosed as permitted by worker’s compensation and similar laws.
- For Judicial and Administrative Proceedings: Your PHI may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For Law Enforcement Purposes: Your PHI may be disclosed for a law enforcement purpose to a law enforcement official. For example, PHI may be disclosed to identify or locate an individual.
- To a Coroner, Funeral Director, or for Organ Donation purposes: Your PHI may be disclosed to a coroner or medical examiner for identification purposes, to determine a cause of death or to allow them to perform their authorized duties. PHI may also be disclosed for cadaveric organ, eye, or tissue donation purposes.
- For Research Purposes: Your PHI may be disclosed to researchers when their research has been approved by an institutional review board or a privacy board and measures have been taken to ensure the privacy of your PHI.
- For Specialized Government Functions: Your PHI may be disclosed for special government

functions such as military, national security, and presidential protective services.

- Inmate: If you are an inmate, your PHI maybe disclosed to the correctional institution or to a law enforcement official for: (i) the provision of health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

The Plans may also use or disclose PHI in providing you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and disclosures of PHI that require authorization

The Plans will obtain your written authorization for:

- Most disclosures of psychotherapy notes.
- Uses and disclosures of your PHI for marketing purposes.
- Disclosures of PHI that constitute a sale.
- Other uses and disclosures not described in this notice.

If you have given the Plans an authorization, you may revoke your authorization at any time. Your request must be submitted in writing to the Plans. However, you can't revoke your authorization for a Plan that has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plans have already made.

Your individual rights

You have the following rights with respect to your health information the Plans maintain. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right for the Plans. Contact the Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL, 32314-5450, to obtain any necessary forms for exercising your rights. The notices you receive from your insurance third-party administrator, CVS Caremark, HMO, or other plan (as applicable) will describe how you exercise these rights for the activities they perform.

Right to request restrictions on certain uses and disclosures of your health information and the Plans' right to refuse

You have the right to ask the Plans to restrict the use and disclosure of your health information for

treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plans to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plans to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request must be in writing.

The Plans are not required to agree to a requested restriction. If the Plans do agree, a restriction may later be terminated by your written request, by agreement between you and the Plans (including an oral agreement), or unilaterally by the Plans for health information created or received after you're notified that the Plans have removed the restrictions. The Plans may also disclose health information about you if you need emergency treatment, even if the Plans had agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plans will accommodate reasonable requests to receive communications of health information from the Plans by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plans must be in writing and you must include a statement that disclosure of all or part of the information could endanger you. This right may be conditioned on you providing an alternative address or other method of contact and, when appropriate, on you providing information on how payment, if any, will be handled.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plans use to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or

administrative proceedings. In addition, the Plans may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plans will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plans expect to address your request.

The Plans may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plans also may charge reasonable fees for copies or postage. If the Plans do not maintain the health information but know where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plans amend your health information in a Designated Record Set. The Plans may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plans (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plans will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period

for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plans have made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law in connection with public health activities unless otherwise indicated below.

You may receive information on disclosures of your health information going back six years from the date of your request. You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request must be in writing. Within 60 days of the request, the Plans will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plans expect to address your request. You may make one request in any 12-month period at no cost to you, but the Plans may charge a fee for subsequent requests. You'll be notified of

the fee in advance and will have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request.

Changes to the information in this notice

The Plans must abide by the terms of the Privacy Notice currently in effect. This notice originally took effect on April 14, 2003, however, it has been subsequently amended. The effective date of this notice is August 27, 2018. The Plans reserve the right to change the terms of their privacy policies as described in this notice at any time and to make new provisions effective for all health information that the Plans maintain. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If a material change is made to a Plans' privacy policies as described in this notice, you will be provided with a revised Privacy Notice through posting on the Division of State Group Insurance (DSGI) web site, <https://www.mybenefits.myflorida.com/health>, and provided the revised notice, or information about the material change and how to obtain the revised notice, in the next annual mailing.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plans and to the U.S. Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. Complaints about activities by your insurer, HMO, or third-party administrator can be filed by following the procedures in the notices they provide. To file complaints with the Plans, contact the DSGI for a complaint form. It should be completed, including a description of the nature of the particular complaint, and mailed to the Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL, 32314-5450.

Contact

For more information on the privacy practices addressed in this Privacy Notice and your rights under HIPAA, contact the Division of State Group Insurance at P.O. Box 5450, Tallahassee, FL, 32314-5450.

Special Notice about the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Removal of all or part of the breast for medical necessity;
2. Reconstruction of the breast on which the mastectomy was performed;
3. Surgery and reconstruction of the other breast for a symmetrical appearance;
4. Treatment of physical complications of all stages of mastectomy including lymphedemas; and
5. Prostheses and mastectomy bras.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan Booklet and Benefits Document. The deductibles and coinsurance for the Standard PPO Option are found in Section 1 of this Plan Booklet and Benefits Document, and the deductibles and coinsurance for the PPO High Deductible Health Plan Option are found in Section 2 of this Plan Booklet and Benefits Document.

For more information, contact the Plan Administrator, the Division of State Group Insurance, at (800) 226-3734.

Special Notice about the Medicare Part D Drug Program

January 1, 2019

Please read this notice carefully. It explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll in Medicare Part D.

Medicare prescription drug coverage (Medicare Part D) became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage.

All approved Medicare prescription drug plans must offer a minimum standard level of coverage set by Medicare. Some plans may offer more coverage than required. As such, premiums for Medicare Part D plans vary, so you should research all plans carefully.

The State of Florida Department of Management Services has determined that the prescription drug coverage offered by the State Employees' Health Insurance Program (State Health Program) is, on average, expected to pay out as much as or more than the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your State Health Program coverage, be aware that you and your dependents will be dropping your hospital, medical and prescription drug coverage. If you choose to drop your State Health Program coverage, you will not be able to re-enroll in the State Health Program.

If you enroll in a Medicare prescription drug plan and do not drop your State Health Program coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Health Program. However, if you are enrolled in a state-sponsored HMO offering a Medicare Advantage Prescription Drug Plan, you may have to change to the State Employees' PPO Plan to get all of your current health and prescription drug benefits.

If you drop or lose your coverage with the State Health Program and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. Additionally, if you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage, and you may have to wait until the following November to enroll.

Additional information about Medicare prescription drug plans is available from:

- www.medicare.gov
- Your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- (800) MEDICARE (800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, payment assistance for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). Contact your local SSA office, call (800) 772-1213, or www.socialsecurity.gov for more information. TTY users call (800) 325-0778.

For more information about this notice or your current prescription drug plan, call the People First Service Center at (866) 663-4735.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium amount (a penalty).

Section 17: Shared Savings Program

The Shared Savings Program is a voluntary program that is available to all Enrollees¹. Under the Shared Savings Program, Members² can earn financial rewards by receiving rewardable healthcare services through Healthcare Bluebook and SurgeryPlus.

Rewards earned by Members will be credited to the Enrollee's State Group Insurance Program health reimbursement account (HRA), post-deductible HRA (for Enrollees in a high deductible health plan), flexible spending account (FSA), limited purpose FSA (for Enrollees in a high deductible health plan), or a health savings account (for Enrollees in a high deductible health plan.) Enrollees may also receive a reimbursement for out-of-pocket healthcare expenses. For any questions about the account(s) that is available to you, please contact Chard Snyder at (855)-824-9284.

A. Healthcare "shopping" through Healthcare Bluebook

Healthcare Bluebook is an online transparency website that allows Members to "shop" for healthcare services and providers. Healthcare Bluebook's website (www.healthcarebluebook.com/cc/SQE) and mobile application display the range of costs of covered in-network healthcare services, as well as, a quality ranking developed by Healthcare Bluebook of inpatient facilities.

Healthcare Bluebook allows Members to review the costs of healthcare services based on a Fair Price™ as determined by Healthcare Bluebook. The Fair Price™ is the amount Members should reasonably expect to pay for a service. Healthcare Bluebook's website and mobile application identify the Fair Price™ of a service and categorize the service as follows:

1. A healthcare service at or below the Fair Price™ is designated with a green ● symbol;
2. A healthcare service slightly above the Fair Price™ is designated with a yellow ▲ symbol; and,

3. A healthcare service with a high price is designated with a red ● symbol.

Some procedures designated with a green ● symbol are available for rewards. Additional information regarding rewards is provided below.

For some facilities, Healthcare Bluebook will conduct its own quality measures and will display a checkmark to indicate the level of quality. A Green Check-Plus ✓+ ranking indicates that a hospital is among the top third of all hospitals in the U.S., a Yellow Check ✓ indicates that the hospital falls in the middle third of all hospitals, and a Red Check-Minus ✓- indicates that the hospital is in the lowest performing third of hospitals in the U.S.

These quality rankings are designed to help Members understand each hospital's level of quality for a particular inpatient clinical area or procedure. Healthcare Bluebook assesses hospital quality for major inpatient clinical categories, such as cardiac surgeries, joint replacement, and neurosurgery. Individual procedures are then mapped to these clinical categories. The clinical groupings allow Healthcare Bluebook to evaluate how well a hospital performs in different areas of care delivery. For example, patients can use the quality rating to understand how well a hospital performs on heart surgeries when compared to joint surgeries. A hospital may have different quality rankings for different clinical areas (e.g., a hospital may have a green ✓+ rating for joint replacement and a red ✓- rating for cardiac surgeries).

Under the "Go Green to Get Green" rewards program, the Healthcare Bluebook website and mobile application will identify the procedures that have rewards and specify the reward amount. Rewards will be credited to Enrollees once all of the following occur:

1. The Enrollee or his/her dependent uses Healthcare Bluebook to "shop" for a rewardable healthcare service;

¹ **Enrollee** means all state officers and employees, Retired State Officers or Employees, Surviving Spouses of deceased state officers and employees, and terminated employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the State Group Insurance Program. "Enrollee" includes all state university officers and employees, retired state university officers and employees, Surviving Spouses of deceased state university officers and employees, and terminated state university employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the State Group Insurance Program.

² **Member** means any person participating in a State Group Health Insurance Plan or a Health Maintenance Organization Plan under the State Group Insurance Program, including Enrollees and covered dependents.

2. The Enrollee or his/her dependent receives the healthcare service from a "green" provider designated by a green ● symbol;
3. Healthcare Bluebook validates the Member's receipt of a rewardable healthcare service and that the Member used Healthcare Bluebook to "shop" for the healthcare service; and,
4. Healthcare Bluebook notifies the Division of State Group Insurance that the Enrollee or his/her dependent earned the reward.

B. Surgical services through SurgeryPlus

SurgeryPlus is a supplemental benefit that allows Members to reduce their cost for many planned, non-emergency surgical procedures. The SurgeryPlus benefit will assist Members with planning and paying for a covered medical procedure, including necessary travel associated with the covered procedure. SurgeryPlus Care Advocates can educate Members on the quality of providers, identify available providers, schedule appointments, and make necessary travel arrangements.

SurgeryPlus's medical procedures are performed by SurgeryPlus's network of healthcare providers. The medical procedures, benefits, and providers offered by SurgeryPlus are separate from the medical benefits offered by the State Employees' PPO Plan (administered by Florida Blue) as generally described in other sections of this Plan Document. However, the copayments, calendar year deductible, calendar year coinsurance maximum, and global network out-of-pocket maximum amounts set forth in Sections 1 and 2 may apply and may be reduced; and, the appeal processes set forth in Section 12 will apply to services offered by SurgeryPlus.

Covered Surgeries and Procedures

SurgeryPlus offers medical and surgical procedures that are "bundled" together into one Episode of Care³. Members will earn one reward for completing an Episode of Care.

SurgeryPlus offers a variety Episodes of Care which may include, but are not limited to, the following:

Spine

- Fusions Disk Repair/Replacement
- Laminectomy
- Laminotomy

Cardiac

- Cardiac Valve Surgery
- Cardiac Defibrillator Implant

General Surgery

- Gallbladder Removal
- Hernia Repair
- Thyroidectomy

Genitourinary

- Hysterectomy
- Bladder Repair

Orthopedic

- Knee Replacement
- Hip Replacement
- Shoulder Replacement
- Ankle/Wrist/Elbow Replacement
- Arthroscopy
- Rotator Cuff Repair
- Tendon Repair
- Carpal Tunnel Bunionectomy

Ear, Nose & Throat

- Septoplasty
- Sinuplasty
- Eustachian Tubes
- Thyroidectomy

³ **Episode of Care** means (i) all services rendered by a SurgeryPlus network provider and provider's professional and medical staff, as applicable and (ii) all hospital- or facility-related expenses under the diagnosis case code. The Episode of Care begins on the day the patient first receives services from the provider related to the diagnosis case code and ends when the patient is discharged from the hospital or facility to return or travel home. Services and expenses under the diagnosis case code commonly included in the Episode of Care are equipment used while in hospital or facility, in-hospital or in-facility medications or biologics and supplies, implants, labs, in-hospital meals, hospital confinement days, pre- and post in-hospital or in-facility nursing care, in-hospital physical therapy and follow-up consultations, and any other medically necessary care related to the diagnosis case code rendered prior to discharge. An Episode of Care shall not include (i) diagnostic testing in advance to determine whether a procedure is necessary; (ii) personal comfort, hygiene, or convenience items; (iii) procedures or care that are not medically necessary; and (iv) Serious Reportable Events (SREs) as defined by the National Quality Forum at <http://www.qualityforum.org/Home.aspx>.

Pain Management

- Cervical Epidural
- Lumbar Epidural Steroid
- Stellate Ganglion Block

For additional information on available medical procedures, or to determine if your planned surgery is included, please contact SurgeryPlus.

Surgery Plus Travel Benefit

The SurgeryPlus benefit includes travel associated with the Episode of Care. Only travel arrangements made through a SurgeryPlus Care Advocate are eligible for coverage under the SurgeryPlus benefit. The travel benefit depends on the procedure, provider, distance between the provider and the Member's residence, and availability. For procedures requiring inpatient admission or overnight recovery, the travel benefit includes the Member and one companion.

Process for Using SurgeryPlus

To receive an Episode of Care through SurgeryPlus, all of the following must occur:

1. The Member must contact a SurgeryPlus Care Advocate before planning the Episode of Care at (844) 752-6170 or online at Florida.SurgeryPlus.com (Portal Access Code: surgeryplus);
2. The Member must agree to supply his or her medical records and any other pertinent information to the SurgeryPlus provider so he/she may assess:
 - a. The medical necessity of the procedure; and,
 - b. The Member's suitability for the prospective treatment or procedure, including any necessary travel. This assessment is referred to as the "initial review/consultation";
3. The Member must be approved for the Episode of Care. The SurgeryPlus provider will determine the medical necessity of the proposed medical procedure based on the initial review/consultation with the Member. If a Member is not satisfied with the SurgeryPlus provider or the initial review/consultation, the Member may contact a Care Advocate and arrange for a second opinion with another SurgeryPlus provider;
4. The Member must accept and agree to the standard terms of treatment of the SurgeryPlus provider. Receiving an initial review/consultation does not commit a Member to proceed with a procedure from SurgeryPlus; and,
5. The Member must verify with SurgeryPlus any out-of-pocket costs associated with the Episode

of Care; additionally, the Member must agree to be financially responsible for all out-of-pocket costs associated with the Episode of Care.

Once the foregoing steps are completed, SurgeryPlus will schedule the Episode of Care.

The SurgeryPlus benefit covers the initial review/consultation, the Episode of Care, and any post-discharge follow-up appointment(s), as prescribed by the SurgeryPlus provider. After completion of the covered care by the SurgeryPlus provider, SurgeryPlus will transfer treatment to the treating provider of the Member's choice. SurgeryPlus will also provide the Member's medical records to the chosen treating provider to ensure continuity of care. Upon request, SurgeryPlus will also provide the Member's medical records to Florida Blue.

Coverage for any medical services outside those provided by SurgeryPlus will be determined according to the provisions of Sections 1-17 of this Plan Document and will be processed by Florida Blue.

Please note that some of SurgeryPlus's providers may also be in-network providers with Florida Blue; however, any services you receive through SurgeryPlus will be billed and treated separately from any benefits offered by the State Employees' PPO Plan (administered by Florida Blue), and the SurgeryPlus benefit will not be processed by Florida Blue.

SurgeryPlus Limitations and Exclusions

Certain examinations, tests, treatments, or other medical services may be required prior to or following the covered services (Episode of Care) with a SurgeryPlus provider. Any medical services performed by anyone other than a SurgeryPlus provider, including pre- and post-care, shall be subject to the covered benefits, exclusions, limitations, and other terms set forth in Sections 1-17 of this Plan Document.

All claims for Members' SurgeryPlus benefits are considered in-network and will be included toward the calendar year deductible, calendar year coinsurance out-of-pocket maximum, and calendar year global network out-of-pocket maximum of the PPO Plan, as appropriate.

Except for any post-operative follow-up appointments prescribed by the SurgeryPlus provider, any care, emergency or otherwise, following the termination of an Episode of Care is subject to the covered benefits, exclusions, limitations, and other terms set forth in Sections 1-17 of this Plan Document. The Episode of Care ends when the Member is discharged from the facility.

The following services are excluded from the SurgeryPlus benefit:

- Diagnostic studies and imaging, except for plain film x-rays and ultrasounds, prior to admission;
- Physical therapy;
- Durable medical equipment;
- Prescription medications outside the Episode of Care;
- Lab work prior to admission;
- Pre-operative labs and testing (Note: Pre-operative labs and testing must be arranged and billed through your on-going provider and all claims for these services must be submitted to Florida Blue, not SurgeryPlus, for claim processing); and,
- Complications that occur after termination of an Episode of Care.

Earning Financial Rewards

Each Episode of Care offered by SurgeryPlus is eligible for a financial reward. The reward will be designated prior to receipt of the service and will be credited to the Enrollee through a reduction in the Enrollee's out-of-pocket costs and/or as a credit to a State Group Insurance savings and spending account.

1. How SurgeryPlus works for Enrollees:

Enrollees are responsible for paying out-of-pocket costs, as described in Sections 1 and 2, as applicable, of this Plan Document. Any applicable out-of-pocket costs may be reduced for Enrollees up to the amount of the financial reward. The remaining portion of the Episode of Care is covered under the SurgeryPlus benefit. To the extent that any portion of the reward remains after the payment of any out-of-pocket costs (or when there are no applicable out-of-pocket costs), the remaining portion of the reward will be credited to the Enrollee's savings and spending account(s).

Enrollees in a high deductible health plan must meet the deductible amount prior to the SurgeryPlus reward becoming available. Once the Enrollee has met the maximum deductible, the Enrollee's out-of-pocket costs may be reduced, up to the specified reward amount. To the extent that any portion of the reward remains after the payment of any out-of-pocket costs (or when there are no applicable out-of-pocket costs), the remaining portion of the reward will be credited to the Enrollee's savings and spending account(s).

2. How SurgeryPlus works for Dependents:

Dependents are responsible for paying out-of-pocket costs, as described in Sections 1 and 2, as applicable, of this Plan Document. The remaining portion of the Episode of Care is covered under the SurgeryPlus benefit. To the extent that any portion of the reward remains after the payment of any out-of-pocket costs (or when there are no applicable out-of-pocket costs), the remaining portion of the reward will be credited to the Enrollee's savings and spending account(s).



An Independent Licensee of the
Blue Cross and Blue Shield Association