The State Employees' PPO Plan

A Self-Funded Health Care Plan for State of Florida Employees, Retirees, COBRA Participants, and their Eligible Dependents

Summary of Plan Description
Material Modification

Summary of Plan Description Material Modification

The Division of State Group Insurance, Department of Management Services, has amended the State Employees' PPO Plan, a self-insured health insurance plan, effective **January 1, 2022**, **unless otherwise noted**. Accordingly, certain provisions in your State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document have been clarified to describe and explain the PPO Plan, as amended. The description below adds to or replaces the information in the Benefit Document as indicated.

Department of MANAGEMENT SERVICES
Division of State Group Insurance

Servicing Agent:
Florida Blue
Your local Blue Cross Blue Shield

The State Employees' PPO Plan

A Self-Funded Health Care Plan for State of Florida Employees,
Retirees, COBRA Participants, and their Eligible Dependents

Summary of Plan Description
Material Modification

The Division of State Group Insurance, Department of Management Services, has amended the State Employees' PPO Plan, a self-insured health insurance plan, effective January 1, 2022, unless otherwise noted. Accordingly, certain provisions in your *State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document* have been clarified to describe and explain the PPO Plan, as amended. The description below adds to or replaces the information in the Benefit Document as indicated.

Page II — Section 16: Notices, on following lines indent and insert the following:

-State of Florida Employees' Group Health Insurance Privacy Notice

-Special Notice about the Women's Health and Cancer Rights Act

-Special Notice about the Medicare Part D Drug Program

-Your Rights and Protections Against Surprise Medical Bills Notice

Page VI — "Who to Call for Information", insert new row before "PPO Plan Pre-Admission Hospital Certification" and insert in first column "Finding Florida Blue Medical Coverage Guidelines" and insert in the second column www.floridablue.com/providers/tools-resources/medical-policies-medical-coverage-guidelines.com.

First column, after "Health Dialog®" insert ", one-on-one nurse support 24/7"

Page 1-1 — "Global Network (OOP) Maximum", second column, delete "$8,550" and insert "$8,700" and delete "$17,100" and insert "$17,400"

Page 1-3 — Last line on the page, after "facility" insert "within the state of Florida"

Page 1-4 — "Weight Loss Services", after "period" insert "; refer to page 3-8"

"Wigs", delete "per person per event" and insert "one wig and fitting in the 12 months following treatment or surgery"

Page 1-8 — First column, fourth paragraph, line four, after "1-800-825-2583." Insert new sentence "The procedure code, diagnosis code, and the provider's charge are required to provide an estimate of the Non-Network Allowance or Network Allowed Amount."

Second column, after box insert the following:

How To Determine Your Cost Share

After claims are processed by Florida Blue for services received by you or your covered dependent, Florida Blue will send you a Monthly Health Statement (MHS); the MHS will detail how the claim(s) processed including any amount you owe for copayments, deductibles, coinsurance, balance billing for non-network provider claims, and costs for noncovered services.

It is important to compare the MHS to the bill you receive from your provider to ensure that you pay the provider the correct amount shown on the MHS.

Summary of Plan Description
Material Modification

If Medicare is the primary coverage for you or your dependent, you will receive a MHS from Florida Blue as well as an Explanation of Medicare Benefits (EOMB). You will need to review both the MHS and the EOMB to determine your correct member cost share, if any, after both this Plan and Medicare have processed the claim(s). You should subtract the amount paid to the provider shown on the MHS from the amount on the EOMB that Medicare shows as your responsibility; any difference is your cost share to pay the provider.

If Medicare is your primary coverage, any provider that accepts Medicare and Medicare Assignment of Benefits is deemed a Network provider; any provider that does not accept Medicare Assignment of Benefits is deemed a Non-Network provider. When using providers outside the state of Florida, you should verify if the provider accepts Medicare Assignment of Benefits. If so, remind the provider to mark on the claim, that the provider submits to Medicare, that Assignment of Benefits is accepted; if accepting Assignment of Benefits is not marked, the claims will be processed as Non-Network which may result in a larger out-of-pocket cost share for you.

Please refer to Section 13: Coordinating Benefits with Other Coverage for examples of how this Plan coordinates benefits.

Page 2-1 "Global Network (OOP) Maximum", second column, delete "$6,900" and insert "$7,050"

Page 2-3 Last line on the page, after "facility" insert "within the state of Florida"

Page 2-4 Massage and/or Physical Therapy, after "excluding" delete "occupational" and insert "physical"

Occupational Therapy, after "excluding" delete "physical" and insert "occupational"

"Weight Loss Services", after "period" insert "; refer to page 3-8"

"Wigs", delete "per person per event" and insert "one wig and fitting in the 12 months following treatment or surgery"

Page 2-7 Second column, fourth paragraph, line four, after "1-800-825-2583." Insert new sentence "The procedure code, diagnosis code, and the provider's charge are required to provide an estimate of the Non-Network Allowance or Network Allowed Amount."

Page 2-8 First column, after box insert the following:

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Summary of Plan Description
Material Modification

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If Medicare is your primary coverage, any provider that accepts Medicare and Medicare Assignment of Benefits is deemed a Network provider; any provider that does not accept Medicare Assignment of Benefits is deemed a Non-Network provider. When using providers outside the state of Florida, you should verify if the provider accepts Medicare Assignment of Benefits. If so, remind the provider to mark on the claim, that the provider submits to Medicare, that Assignment of Benefits is accepted; if accepting Assignment of Benefits is not marked, the claims will be processed as Non-Network which may result in a larger out-of-pocket cost share for you.

Please refer to Section 13: Coordinating Benefits with Other Coverage for examples of how this Plan coordinates benefits.

Page 3-1 "Cleft Lip and Cleft Palate", last line, after "services" insert ", in accordance with s. 627.66991, Florida Statutes"

Page 3-5 Second column, "Nursing Services", line three, after "covered" insert "subject to the determination of medical necessity"

Page 3-7 Second column, "Surgical Procedures", 1., line four, after "envelope, is" delete everything and insert "covered subject to medical necessity and medical coverage guidelines."

Page 3-8 "Telehealth and Virtual Visits", first paragraph, line one, delete "rendering primary care benefits,"

"Telehealth and Virtual Visits", line two, after "communication" delete ","

"Telehealth and Virtual Visits", third paragraph, line one, delete "primary care benefits"

"Telehealth and Virtual Visits", third paragraph, line three, delete "primary care"

Page 6-1 First column, "How to Use the PPCSM Network", third bullet, second line, delete "participate" and insert "are contracted with Florida Blue as a participating provider"

Page 6-2 Second column, sentence before first blue box, at the beginning of the sentence insert "Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260),"

Second column, sentence before first blue box, delete "There" and insert "there"

Page 6-3 "Continuity of Care" delete all and insert the following:

Continuity of Care

Summary of Plan Description
Material Modification

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 within 90 days prior to the provider's change in participation status and performed within 90 days of the change in the provider's participation, or for a set period of time. Florida Blue will provide benefits for continuing care patients as required by the federal No Surprises Act (H.R. 133, P.L. 116-260). Examples of conditions and services, which may qualify for the continuation of care when in active treatment include, but are not limited to:

- Pre-scheduled surgery
- End Stage Renal Disease (ESRD)
- Outpatient Rehab Services
- Chemo/Radiation Therapy
- Pregnancy (regardless of trimester and the continuity of care period is through the postpartum visit)

Page 7-1 Second column, first paragraph, after number 4., insert "5. Numbers one through four above do not apply if you are admitted as inpatient through the emergency room (ER visit).

Page 8-1 First column, first paragraph, line five, after "programs." insert "To receive one-on-one support managing your medical condition you may call the Florida Blue Care Team at (844) 730-2583 (844-730-Blue)."

First column, "Health Dialog®" delete first paragraph and four bullets and insert "The Health Dialog® Program, a product of Health Dialog Corporation, is a 24/7 Nurse Line and 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 registered nurse Health Coaches that are available 24 hours a day, 365 days a year; you can talk about immediate or everyday health concerns."

Page 8-2 First column, first paragraph, last line, delete "(800) 955-5692, Option 3" and insert "(844) 730-2583 ((844) 730-BLUE)"

Page 9-4 Second column, "Not Covered by the Prescription Drug Program", number 4, after "Devices" insert ", including prescription therapeutic devices,"

Page 9-6 Second column, insert:

Summary of Plan Description
Material Modification

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.

Page 13-2 First column, "Coordination with Medicare", line four, after "date" insert "and your Medicare ID number"

Second column, "Retirees, Spouse or Surviving Spouse of a Retiree or Dependent of a Retiree", insert new third paragraph:

When Medicare is your or your dependent's primary coverage, any provider that accepts Medicare and Medicare Assignment of Benefits is deemed a Network provider; any provider that does not accept Medicare Assignment of Benefits is deemed a Non-Network provider. When using providers outside the state of Florida, you should verify if the provider accepts Medicare Assignment of Benefits. If so, remind the provider to mark on the claim, that the provider submits to Medicare, that Assignment of Benefits is accepted; if accepting Assignment of Benefits is not marked, the claims will be processed as Non-Network which may result in a larger out-of-pocket cost share for you.

Page 13-9 Second column, "Important Note" put this paragraph in a bold black box

Pages
16-1 – 16-5 Delete and replace with the following:

State Group Insurance Program Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can access 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 PHI held by employer health plans — whether received in writing, in an electronic medium, or oral communication. This notice describes the State of Florida's privacy practices for its flexible spending accounts, health savings accounts, health reimbursement accounts, the State Group Insurance Program health plan(s), health maintenance organization(s) (HMO), preferred provider organization (PPO), State Employees' Prescription Drug Program, and other plans of the State Group Insurance Program (collectively "Plans").

Because they are all sponsored by the State of Florida, the plans covered by this notice participate in

an "organized healthcare arrangement." The Plans may share PHI with each other, their agents, and the State to carry out healthcare treatment, payment, or healthcare operations.

The Plans' duties with respect to PHI about you

The Plans are required by law to maintain the privacy of your PHI, to provide you with a notice of their legal duties and privacy practices with respect to your PHI, and to notify you following a breach of unsecured PHI.

Members of a State Group Insurance Program health plan, health maintenance organization (HMO), preferred provider organization (PPO), or another 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, Humana, SurgeryPlus, Healthcare Bluebook, 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 records unrelated to the Plans.

How the Plans may use or disclose your PHI

The privacy rules generally allow the use and disclosure of your PHI without your permission (known as an authorization) for purposes of healthcare treatment, payment, and operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing healthcare by one or more healthcare providers, 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 PHI about you with physicians who are treating you.
- Payment includes activities by these Plans or providers to obtain premiums, make coverage determinations, and provide healthcare reimbursement. 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 to coordinate payment of benefits.
- Healthcare 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. Healthcare 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.

Summary of Plan Description
Material Modification

How the Plans may share your PHI

The Plans will disclose your PHI (without your written authorization) to the State for plan administration purposes. However, the State agrees not to use or disclose your PHI 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 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 PHI obtained from the Plans for any employment-related actions. However, PHI 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 PHI

The Plans are also allowed to use or disclose your PHI, 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 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 PHI 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 PHI may be disclosed without authorization to a family member, close friend, or another 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 a 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 PHI may be disclosed without authorization to your legal representative.
- As Permitted by Law: Your PHI maybe 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 healthcare 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 another lawful process.
- For Law Enforcement Purposes: Your PHI may be disclosed to a law enforcement official for a law enforcement purpose. For example, PHI may be disclosed to identify or locate an individual.
- To a Coroner, Funeral Director, or for Organ Donation purposes: Your PHI maybe 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 maybe disclosed to researchers when an institutional review board has approved their research 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 may be disclosed to the correctional institution or a law enforcement official for: (i) the provision of healthcare 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 already utilized 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 PHI 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 another 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 PHI and the Plans' right to refuse

You have the right to ask the Plans to restrict the use and disclosure of your PHI for treatment, payment, or healthcare 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 PHI 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 the use and disclosure of PHI 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 PHI created or received after you're notified that the Plans have removed the restrictions. The Plans may also disclose PHI about you if you need emergency treatment, even if the Plans had agreed to a restriction.

Right to receive confidential communications of your PHI

If you think that disclosure of your PHI by the usual means could endanger you in some way, the Plans will accommodate reasonable requests to receive communications of PHI from the Plans by alternative means or at alternative locations.

If you want to exercise this right, your request 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 another method of contact and, when appropriate, on you providing information on how payment, if any, will be handled.

Right to inspect and copy your PHI

With certain exceptions, you have the right to inspect or obtain a copy of your PHI in a "Designated Record Set." This may include medical and billing records maintained for a healthcare 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 PHI 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 for reviewing your request will be extended for no more than 30 additional 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 PHI 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 PHI but know where it is maintained, you will be informed of where to direct your request.

Right to amend PHI that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plans amend your PHI in a Designated Record Set. The Plans may deny your request for several reasons. For example, your request may be denied if the PHI is accurate and complete but 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 for reviewing your request will be extended for no more than 30 additional 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 PHI

You have the right to a list of certain disclosures the Plans have made of your PHI. 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 PHI dating back six years from the date of your request. However, 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 PHI;
- 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" (PHI that excludes certain identifying information).

Summary of Plan Description
Material Modification

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 period for providing this list will be extended for no more than 30 additional 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 Jan. 1, 2022. 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 PHI that the Plans maintain. This includes PHI that was previously created or received, not just PHI 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) website, 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.

Page 16-6 Delete the last paragraph and insert the following box:

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Summary of Plan Description
Material Modification

ANNUAL NOTICE:
Special Notice about the Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the State Employees' PPO Plan, Group Health Insurance Plan Booklet and Benefits Document, provides benefits for mastectomy-related services, including all stages of reconstruction, surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact the Plan Administrator, the Division of State Group Insurance, at (800) 226-3734 for more information.

Page 16-7 Delete and replace with the following:

Special Notice ABOUT THE MEDICARE PART D Drug Program, Effective January 1, 2022

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. However, 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 Group Insurance 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.

Should you decide to enroll in a Medicare prescription drug plan and drop your State Group Insurance health plan 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 Group Insurance Program health plan coverage, you will not be able to re-enroll in a State Group Insurance Program health plan.

If you enroll in a Medicare prescription drug plan and do not drop your State Group Insurance Program health plan coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Group Insurance Program.

If you drop or lose your coverage with the State Group Insurance 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 increase by no less than one (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 at www.medicare.gov.

Your State Insurance Assistance Program is through the Florida SHINE (Serving Health Insurance Needs of Elders) program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number); and (800) MEDICARE or (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 visit www.socialsecurity.gov for more information. Text Telephone (TTY) users can 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 as proof that you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium amount (a penalty).

Pages 16-8 Insert the following:

Your Rights and Protections Against Surprise Medical Bills Notice

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

Summary of Plan Description
Material Modification

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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, may not collect or attempt to collect from you any amounts greater than the appropriate Non-Network Copayments, Coinsurance, and Deductibles.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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, may not collect or attempt to collect from you any amounts greater than the appropriate Non-Network Copayments, Coinsurance, and Deductibles.

<u>When balance billing isn't allowed, you also have the following protections</u>:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:

Summary of Plan Description
Material Modification

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the federal No Surprises Help Desk (NSHD) at (800) 985-3059.

For more information about your rights under federal law, visit www.cms.gov/nosurprises.

For more information about your rights under state of Florida laws, visit the Agency for Health Care Administration (AHCA) at (www.ahca.myflorida.com) or the Department of Health (DOH) at www.floridahealth.gov/licensing-and-regulation/enforcement/index.html).

APPENDIX 1:

Plan Summary of Material Modifications, effective January 1, 2021

The Division of State Group Insurance, Department of Management Services, has amended the State Employees' PPO Plan, a self-insured health insurance plan, effective January 1, 2021, unless otherwise noted. Accordingly, certain provisions in your State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document have been clarified to describe and explain the PPO Plan, as amended. The description below adds to or replaces the information in the Benefit Document as indicated.

Page V — Insert new section after "Medical Necessity":

"Medical Policies (Medical Coverage Guidelines)

Florida Blue develops medical policies in consultation with expert physicians from various medical specialties, clinical studies published in respected scientific journals, and various medical specialty organizations. These medical policies which consist of medical guidelines are used when making clinical determinations. A link to medical policies (medical coverage guidelines) are available at www.FloridaBlue.com/state-employees."

Page 1-1 — "Global Network (OOP) Maximum," second column, delete "$8,150" and insert "$ 8,550" and delete "$16,300" and insert "$17,100"

Section "Calendar Year Deductible/Copays/Limits", after subsection that includes "Physician Office Per Visit Fee (PVF)", insert new subsection with the following:

Teladoc®	$0.00 PVF	N/A
Virtual Visit Primary Care Physician (PCP)	$15 PVF	Coinsurance Only; No CYD or PVF

Summary of Plan Description
Material Modification

Teladoc®	$0.00 PVF	N/A
Specialist	$25 PVF	Coinsurance Only; No CYD or PVF

Section "Physician Services", after subsection "Office Visits" insert new subsection with the following:

Teladoc®	100% of Allowed Amount	N/A
Virtual Visit	100% of Allowed Amount after applicable PVF	60% of the Allowance No CYD or PVF

Page 2-1 Section "Calendar Year Deductible/Copays/Limits", after subsection that includes "Physician Office Per Visit Fee (PVF)", insert new subsection with the following:

Teladoc®	CYD	N/A
Virtual Visit	Coinsurance and CYD	Coinsurance and CYD

Section "Physician Services", after subsection "Office Visits" insert new subsection with the following:

Teladoc®	100% of Allowed Amount after CYD	N/A
Virtual Visit	80% of Allowed Amount after CYD	60% of Allowed Amount after CYD

Page 3-1 First column, "Ambulance", insert new last paragraph "Coverage for ambulance services listed above applies to transportation both inside the United States and out of the country. If you are traveling, you may want to consider personal travel insurance that will transport you back to the U.S. or your home state for treatment. Ambulance services that are not identified above are excluded under Section 5: Exclusions of this Plan."

Page 3-6 Second column, "Preventive Care Services", second paragraph, line four, after "immunizations." insert "If you use a retail pharmacy for your immunizations, the retail pharmacy must be In-Network with CVS Caremark and participating in CVS Caremark's Broad Vaccination Network."

Second column, last paragraph, line eight, after "Florida Blue" insert "and CVS Caremark"

Summary of Plan Description
Material Modification

Page 3-8 Before "Transplants" insert new section "Telehealth and Virtual Visits"

Telehealth services are Covered Services when rendering primary care benefits, provided remotely through a two-way interactive electronic device that includes both audio and visual communication, and not otherwise excluded as described in Section 5. You and your covered dependents may use Florida Blue's telehealth vendor, Teladoc®, or virtual visits provided by your current Network or Non-Network Provider.

Teladoc® provides service 24 hours a day/seven days a week and employs a national network of U.S. board-certified physicians that can diagnose, treat, and prescribe medications for your non-emergency conditions. To set up your account at Teladoc® go to www.Teladoc.com. For additional information you may call Teladoc® at (800) 835-2362 or Florida Blue Customer Service at (800) 825-2583.

Your current Network or Non-Network Provider may also provide primary care benefit services through an electronic audio-visual method. Ask your Provider if he or she provides virtual services and if your primary care service is suitable for a virtual visit. For more information on telehealth virtual visits you may call Florida Blue Customer Service at (800) 825-2583.

Page 5-1 First column, alphabetically insert "**Ambulance services** are only covered as specifically identified in Section 3: Covered Services. All other ground, water, and air ambulance services are excluded under this Plan, including but not limited to non-emergency transportation, transportation for convenience, and transportation to move closer to home or family. If you are traveling, you may want to consider personal travel insurance that will transport you back to the U.S. or your home state for treatment."

Second column, "Dental Services and Supplies", line two, delete "quotation mark (")"

Page 5-2 First column, "E-Medicine", line four, after "Internet" insert "except as described under Telehealth and Virtual Visits in Section 3: Covered Services."

Page 5-4 First column, "Telephone Consultations", insert "except as described under Telehealth and Virtual Visits in Section 3: Covered Services."

Page 7-3 Box "Important Note", delete

Page 8-2 First column, seventh bullet, third hyphen (-), delete all and insert "Track your progress using more than 100 popular wearable fitness devices and apps."

Page 8-4 First column, "Nonparticipating Providers Outside Florida", line one, after "Services" insert ", including services rendered at an In-Network facility,"

Page 9-3 Second column, above "Covered by the Prescription Drug Program" insert new section:

Immunizations at Participating In-Network Pharmacies

Summary of Plan Description
Material Modification

You and your covered family members can get your no-cost routine vaccinations, including flu shots, at any In-Network pharmacy participating in the CVS Caremark Broad Vaccination Network. Before you go, call the pharmacy just to make sure that the immunization you need is available and if an appointment is required. Retail pharmacies practice within the parameters of state and federal laws and regulations; it is possible that not all vaccinations will be available for everyone, i.e. some pharmacies may not be legally allowed to vaccinate children.

To locate an In-Network retail pharmacy participating in the Broad Vaccination Network go to www.Caremark.com/sofrxplan or log in at www.Caremark.com; click on Find a Pharmacy or Pharmacy Locator; enter the applicable zip code or city and state; click on Advanced Options; and click on Vaccine Network. Pharmacies that participate in the Broad Vaccination Network are identified with a syringe icon.

Page 9-4 First column, number "7.", line two, delete "and"

First column, number "8." delete everything and insert "Blood glucose monitors and supplies, continuous glucose monitors and supplies, and disposable insulin pumps and supplies; and,"

First column, after number "8." Insert new number "9. Preventive Immunizations provided at an In-Network retail pharmacy participating in CVS Caremark's Broad Vaccination Network and that have a current rating of A or B by the United States Preventive Task Force and recommended by the Centers for Disease Control."

Second column, number "8." delete and renumber remaining list.

Page 9-6 Box "Important Note", delete

Page 10-6 First column, "Option 5 – Surviving Spouse", paragraph after number three, line five, delete "31" and insert "60"

Page 11-2 "Non-Participating Pharmacies", after first paragraph, after "the claim" insert "by mail"

"Non-Participating Pharmacies", after number "3." insert the following:

"To submit the claim electronically:

1. Electronic claims must be submitted by the Subscriber and registered on Caremark.com;
2. Log in at Caremark.com on either the Caremark website or the CVS Caremark mobile app;
3. Click on Plan & Benefits, next click on "Submit a Prescription Claim, and follow the prompts;
4. Complete all information as requested;
5. Attach original bills to the claim form and make sure the bills include the patient's name, date dispensed, pharmacy name, quantity dispensed, dosage dispensed, and billed price of the medication; and,

Summary of Plan Description
Material Modification

6. Review under Final Review and click the signature box before submitting. You will receive a confirmation number for your records.

Page 12-1 First column, "Appealing to Florida Blue, CVS Caremark, Healthcare Bluebook, or SurgeryPlus – A Level I Appeal", insert new second paragraph:

"You will find the required or recommended forms for filing a Level I Appeal to Florida Blue at www.FloridaBlue.com/state-employees. The forms are:

1. State Employees' PPO Plan Appeal Form: this form is highly recommended and clearly details all the information needed for reviewing your Level I Appeal; including this form may expedite Florida Blue's review and prevent any otherwise unnecessary outreach to you for additional information; and,
2. Appointment of Representative Form: this form is required if you or your adult dependent is authorizing someone else to file the Level I Appeal on your behalf; you may file an appeal for yourself, your minor dependents, or your adult child with intellectual or physical disabilities as described in Section 10: Enrollment and Eligibility.

Page 12-2 First column, "Appealing to Division of State Group Insurance (DSGI) – A Level II Appeal", second paragraph, line two, after "decision" insert "and meets the criteria in the paragraph immediately above,"

First column, "Appealing to Division of State Group Insurance (DSGI) – A Level II Appeal", second paragraph, line three, after "by" insert "submitting your urgent Level II Appeal request and any necessary documentation to support your urgent Level II Appeal to DSGI electronically at DSGIAppeals@dms.myflorida.com or"

First column, "Appealing to Division of State Group Insurance (DSGI) – A Level II Appeal", fourth paragraph, line two, after "appeals" insert "only"

First column, "Appealing to Division of State Group Insurance (DSGI) – A Level II Appeal", fourth paragraph, line two, after "be" insert "submitted electronically at DSGIAppeals@dms.myflorida.com or"

Second column, fourth paragraph (beginning DSGI will review), line eight, after "appeal." insert "DSGI will notify you within the 72-hour period if your urgent Level II Appeal does not contain sufficient information and/or documentation for a review and decision; the 72-hour period will be suspended when the notice is sent to you. The notice will include a specific due date that DSGI must receive any additional information and/or documentation to review in consideration of your urgent Level II Appeal; the 72-hour period will restart on the noted due date."

Page 12-3 First column, "Requesting an External Review from and Independent Review Organization", line six, after "processes", delete "." and insert "only if:

1. the denial decision involved a:
    a. denial of your request for payment of a claim and the decision involved a medical

judgement 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 date.

First column, "Requesting an External Review from and Independent Review Organization", insert new second paragraph:

"You will find the required or recommended forms for filing an External Review request through Florida Blue to an Independent Review Organization at www.FloridaBlue.com/state-employees. The forms are:

1. External Review Request Form: this form is highly recommended and clearly details all the information needed for reviewing your External Review request; including this form may expedite the Independent Review Organization's review and prevent any otherwise unnecessary outreach to you for additional information;
2. Physician Certification for Experimental Investigational Denials Form: this form is required if the External Review request is for a claim that denied as experimental and/or investigational; and,
3. Certification for Expedited Consideration: this form is required if the treating physician believes that the time frame for completing a standard External Review would seriously jeopardize the life or health of you or your covered dependent.

Page 15-8 After "Substance Dependency" insert new definition "Telehealth and Virtual Visits… means the lawful practice of medicine by a Provider where patient care, treatment, or Services are rendered, in lieu of a face-to-face visit, through the use of medical information exchanged remotely through a two-way interactive electronic device that includes both audio and visual communication."

Pages
16-1 – 16-5 Delete and replace with the following:

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

Summary of Plan Description
Material Modification

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, Humana, SurgeryPlus, Healthcare Bluebook, 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 toa 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 maybe 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

healthcare 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 maybe 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 maybe 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 maybe 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 January 1, 2021. 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.

Summary of Plan Description
Material Modification

Page 16-7 Delete and replace with the following:

Special Notice about the Medicare Part D Drug Program

January 1, 2021

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 Group Insurance 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 Group Insurance health plan 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 Group Insurance health plan coverage, you will not be able to re-enroll in State Group Insurance health plan.

If you enroll in a Medicare prescription drug plan and do not drop your State Group Insurance health plan coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Group Insurance Program.

If you drop or lose your coverage with the State Group Insurance 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 increase by no less than one (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 at:

- www.medicare.gov
- Your State Insurance Assistance Program through the Florida SHINE (Serving Health Insurance Needs of Elders) program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number); and,

- (800) MEDICARE or (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 visit 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).

Pages 17-1 First column, first paragraph, line two, after "Enrollees" insert "at no additional cost"

APPENDIX 2:

Plan Summary of Material Modifications, effective January 1, 2020

The Division of State Group Insurance, Department of Management Services, has amended the State Employees' PPO Plan, a self-insured health insurance plan, effective January 1, 2020. Accordingly, certain provisions in your *State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document* have been clarified to describe and explain the PPO Plan, as amended. The description below adds to or replaces the information in the Benefit Document as indicated.

Page 1 Top of page, line four, delete "2019" and insert "2020"

First paragraph, line two, delete "2019" and insert "2020"

Page VI Second column, row seven, line two, after www.Caremark.com" insert "or www.Caremark.com/sofrxplan"

Page 1-1 "Global Network (OOP) Maximum," second column, delete "$7,900" and insert "$ 8,150" and delete "$15,800" and insert "$16,300"

Page 2-1 "Calendar Year Deductible", second column, delete "$1,350" and insert "$1,400" and delete "$2,700" and insert "$2,800"

"Global Network (OOP) Maximum, second column, delete "$4,350" and insert "$4,400"; and delete "$8,700" and insert "$8,800"; and delete "$6,750" and insert "$6,900"

Page 2-5 Second column, in blue box, delete "$300" and insert "$400"; and delete "$2,700" and insert "$ 2,800"

Page 3-3 Second column, "Enteral Formulas", line one, before "Prescription" insert "Medically necessary"

Summary of Plan Description
Material Modification

Second column, "Enteral Formulas", line one, after "formulas" insert "and amino-acid based elemental formulas"

Second column, "Enteral Formulas", line two, after "use" insert ", regardless of the method of delivery or intake,"

Second column, "Enteral Formulas", line two, after "when" insert "ordered or"

Second column, "Enteral Formulas", insert new last paragraph, "Coverage for enteral formulas and amino-acid based elemental formulas are subject to the provisions as set forth in ss. 110.12315 and 627.42395, Florida Statutes."

Page 3-5 Second column, number "1.", line two delete "advanced registered nurse practitioner" and insert "advanced practice registered nurse"

Page 3-6 First column, Physical Therapy and Massage Therapy, third paragraph, line one, delete "Advanced Registered Nurse Practitioner's" and insert "Advanced Practice Registered Nurse's"

Page 5-2 First column, "Food, Medical Food Products or Substitutes", line five, after "pursuant to" insert "ss. 110.12315 and"

First column, "Food, Medical Food Products or Substitutes", line five, after "pursuant to" delete "s."

First column, "Food, Medical Food Products or Substitutes", line six, after "Dietary" insert "supplements,"

First column, "Food, Medical Food Products or Substitutes", line six, after "nutritional" insert "supplements,"

First column, "Food, Medical Food Products or Substitutes", line seven, after "drugs" insert ","

Page 9-3 Second column, "Covered by the Prescription Drug Program", after "1. Federal legend drugs" insert "subject to the Plan's general limitations and exclusions in section 5 and the provisions of the following subsection Not Covered by the Prescription Drug Program;"

Page 10-3 Second column, first paragraph "If you have a child" delete entire paragraph and insert new paragraph "Upon your initial enrollment in a State Group Insurance health plan, if you have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria, you may enroll that child in the Plan at that time. If you do not enroll the child at your initial enrollment, you will not be able to add the child to your Plan at a later date."

Page 10-4 Second column, second paragraph, line four after "People First" insert new sentences "Or you may elect an early effective date and coverage can be effective as soon as the first day of the month following the month you elect coverage in People First. If a premium underpayment occurs because of an early effective date, the premium (up to

Summary of Plan Description
Material Modification

$180 bi-weekly or $360 monthly) will be deducted from your next payroll in addition to the regular premium deduction for the next coverage month."

Second column, third paragraph "An example", line six, after "August 1," delete everything and insert "the premium (up to $180 bi-weekly or $360 monthly) will be deducted from your next payroll in addition to the regular premium deduction for the next coverage month."

Page 10-5 First column, third paragraph, line six, after "People First" insert new sentences "Or you may elect an early effective date and coverage can be effective as soon as the first day of the month following the month you elect coverage in People First. For births and adoptions, call People First to request coverage for the child effective on his or her date of birth or on the date that he or she is placed in the home for adoption, respectively. If a premium underpayment occurs because of an early effective date, the premium (up to $180 bi-weekly or $360 monthly) will be deducted from your next payroll in addition to the regular premium deduction for the next coverage month."

Second column, "Option 4 – Spouse Program", delete "number "2." and renumber rest of list

Second column, last paragraph, line fourteen, after "unless" insert "the dependent is a stepchild of the primary spouse or"

Page 15-2 Second column, Convenient Care Center, number "4.", line one, delete "Advanced Registered Nurse Practitioner (ARNP)" and insert "Advanced Practice Registered Nurse"

Pages
16-1 – 16-5 Delete and replace with the following:

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.

Summary of Plan Description
Material Modification

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, Humana, SurgeryPlus, Healthcare Bluebook, 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 maybe 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 healthcare 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 maybe 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 maybe 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 maybe 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 January 1, 2021. 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.

Page 16-7 Delete and replace with the following:

Special Notice about the Medicare Part D Drug Program

January 1, 2020

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.

Summary of Plan Description
Material Modification

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 Group Insurance 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 Group Insurance health plan 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 Group Insurance health plan coverage, you will not be able to re-enroll in State Group Insurance health plan.

If you enroll in a Medicare prescription drug plan and do not drop your State Group Insurance health plan coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Group Insurance Program.

If you drop or lose your coverage with the State Group Insurance 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 increase by no less than one (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 at:

- www.medicare.gov
- Your State Insurance Assistance Program through the Florida SHINE (Serving Health Insurance Needs of Elders) program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number); and,
- (800) MEDICARE or (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 visit www.socialsecurity.gov for more information. TTY users call 800-325-0778.

Summary of Plan Description
Material Modification

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).

Pages 17-1 Second column "Orthopedic", fourth bullet, after "Ankle" delete "/Wrist/Elbow"

Second column "Orthopedic", insert new fifth bullet "Wrist/Elbow Replacement"

Second column "Orthopedic", eighth bullet, after "Carpal Tunnel" delete "Bunionectomy"

Second column "Orthopedic", insert new ninth bullet "Bunionectomy"

STATE EMPLOYEES' PPO PLAN

Administrative Services Provided by:
Florida Blue
P.O. Box 2896
Jacksonville, FL 32232-0079

Florida Blue

Your local Blue Cross Blue Shield

 90889-1221R