

State Employees' PPO Plan

Group Health Insurance

Plan Booklet and
Benefits Document
Effective January 1, 2007



DSGI
WE'VE GOT YOU COVERED

Department of Management Services
Division of State Group Insurance
P.O. Box 5450
Tallahassee, FL 32314-5450

State Employees' PPO Plan
Group Health Insurance

Plan Booklet and Benefits Document
Effective January 1, 2007

This Plan Booklet and Benefits Document replaces any other brochure or booklet printed prior to January 1, 2007, relative to the Plan and shall remain in effect until further notice. The State Employees' PPO Plan is further subject to federal and State of Florida laws, and rules promulgated pursuant to law, including, but not limited to, Title 60 of the Florida Administrative Code.

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

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

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Important Information About the Plan

Plan Administrator

Division of State Group Insurance
Post Office Box 5450
Tallahassee, FL 32314-5450
1-850-921-4600; 1-800-226-3734
SunCom 291-4600

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

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

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

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

Medical Claim Administrator

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2896
Jacksonville, FL 32232-0079
1-800-825-2583
www.bcbsfl.com

Blue Cross and Blue Shield of Florida, Inc. (BCBSF) provides claim processing services, customer service, provider network access, and utilization and benefit management services. Benefits are available through BCBSF's Preferred Patient CareSM

PPO, which is a network of preferred providers established by BCBSF. BCBSF does not assume any financial risk or obligation with respect to claims.

Prescription Drug Program Claim Administrator

Caremark Inc.
1-800-378-4408
www.caremark.com

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

Plan Documents

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

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

Rights to Employment

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

Rights to Amend or Terminate the Plan

The State has arranged to sponsor this Plan indefinitely, but reserves the right to amend, suspend, or terminate it for any reason. Plan fee schedules, allowed amounts, allowances, physician network participation status, medical policy guidelines, and premium rates are subject to change at any time without the consent of Plan participants. You will be given notice of any changes that affect your benefit levels as soon as administratively possible.

Introduction

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

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

1. deductibles;
2. copayments;
3. coinsurance (as applicable, a percentage of the network allowed amount or non-network allowance for the service provided);
4. admission fees;
5. non-covered services;
6. amounts above the Plan's allowance for non-network services;
7. amounts above the Plan's limitations; and
8. penalties for not certifying hospital admissions or stays.

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

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

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

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

Who to Call for Information

If you need information about...	Contact...
Benefits or claims (other than prescription drug claims) under the PPO Plan, or finding a network provider within the state of Florida	Blue Cross and Blue Shield of Florida, Inc. P.O. Box 2896 Jacksonville, FL 32232-0079 1-800-825-2583 www.bcbsfl.com
PPO Plan Pre-Admission Certification	1-800-955-5692
Finding a PPO network provider outside the state of Florida – BlueCard® PPO Program	1-800-810-2583 or www.bluecares.com
Healthy Additions® Pre-Natal Program	1-800-825-2583 or www.bcbsfl.com
Health Dialog®	1-877-789-2583 (TTY 877-900-4304)
Prescription drug program information	Caremark Inc. www.caremark.com 1-800-378-4408 For paper claims only: Caremark Inc. P.O. Box 52192 Phoenix, AZ 85072-2192
Enrollment, eligibility, or changing coverage	People First 1-866-663-4735 https://peoplefirst.myflorida.com/logon.htm
Medicare eligibility and enrollment	The Social Security Administration office in your area

Section 1: Standard PPO Option Summary of Benefits

This summary provides an overview of the Standard PPO Option. For further information on the coverage and benefits of this Plan as well as applicable limitations and exclusions, please refer to sections 3 (Covered Services), 4 (Pre-existing Condition Limitations) and 5 (Exclusions) of this booklet. **If you are enrolled in the Health Investor PPO Option, please refer to section 2, entitled “Health Investor PPO Option Summary of Benefits”.**

Benefit Description	Network	Non-Network
Calendar Year Deductible/Copays/Limits		
Calendar Year Deductible (CYD) Per person Family aggregate	\$250 \$500	\$750 \$1500
Coinsurance Maximum (OOP) Per person Family aggregate	\$2500 \$5000	
Emergency Room Facility Services Copay (per visit)	\$50 copay (waived if admitted)	Coinsurance only; no copay or CYD
Per Admission Deductible (PAD) Inpatient Hospital	\$250 per admission	\$500 per admission
Physician Office Per Visit Fee (PVF) Primary Care Physician (PCP) Specialist	\$15 PVF \$25 PVF	Coinsurance only; no CYD or PVF
Hospital Services		
Room and Board (R&B) (semi-private) Admission Certification/ Hospital Stay Certification (AC/ HSC) required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Intensive/Progressive Care AC/HSC required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Emergency Room	100% of Allowed Amt after ER copay	60% of Allowance (No copay or CYD)
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, OR, etc.)	80% of Allowed Amt after PAD	60% of Allowance after PAD
Outpatient Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physician Services		
Hospital Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Office Visit	100% of Allowed Amt after applicable PVF	60% of Allowance (no PVF/CYD)
Outpatient Services (outpatient visits, consultations, maternity care, etc.)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Pathology/Radiology/ Anesthesiology	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network
Preventive Care-Adult (Mammograms are not included in Preventive Adult Care)	100% of Allowed Amt	100% of Allowance
Preventive Care-Children	100% of Allowed Amt	100% of Allowance
Surgery (Inpatient/Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Urgent Care Center	100% of Allowed Amt after PCP (\$15) PVF	60% of Allowance (no PVF/CYD)
Other Covered Facility Services		
Ambulatory Surgical Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Birthing Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Osteopathic Hospital (Inpatient) AC/HSC required except for physical rehab admissions.	80% of Allowed Amt after PAD	60% of Allowance after PAD
Outpatient Facility	80% of Allowed Amt after CYD	60% of Allowance after CYD
Rehab Hospital (Inpatient) AC/HSC not required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Rehab Hospital (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Skilled Nursing Facility Not subject to PAD; AC/HSC not required	70% of Allowed Amt	70% of Allowance
Specialty Facility (Inpatient) AC/HSC required	80% of Allowed Amt after PAD	60% of Allowance after PAD; limited to alcohol/drug treatment for an active employee only; DSGI approval required.
Specialty Facility (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD; limited to Alcohol/Drug only
Home Health Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Other Covered Services		
Ambulance	100% of Allowed Amt	100% of Covered Charge
Acupuncture	80% of Allowed Amt after CYD	60% of Allowance after CYD
Cleft Lip and Cleft Palate	80% of Allowed Amt after CYD	60% of Allowance after CYD
Contraceptives, supplies and related services	Paid according to the type of service rendered as noted above for physician office visits, other physician services, durable medical equipment, and prescription drug	
Dental Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Durable Medical Equipment (DME)/Supplies	80% of Allowed Amt after CYD	60% of Allowance after CYD
Eye Glasses or Contacts	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network
Other Covered Services		
Fertility Testing and Treatment	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hearing Tests	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mammograms	80% of Allowed Amt after CYD	60% of Allowance after CYD
Manipulative Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mastectomy and Reconstructive Surgery	80% of Allowed Amt after CYD	60% of Allowance after CYD
Maternity Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Midwife Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physical/Massage Therapy	80% of Allowed Amt after CYD	60% of Allowance after CYD
Prescription Drugs (Caremark) Participating Retail Pharmacy Mail Order	Generic/Preferred Brand/ Non-Preferred Brand \$10 / \$25 / \$40 \$20 / \$50 / \$80	You pay in full and file claim (see section 9 for reimbursement information)
Prostheses	80% of Allowed Amt after CYD	60% of Allowance after CYD
Surgical Sterilization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Transplants	80% of Allowed Amt after CYD	60% of Allowance after CYD
Weight Loss Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Wigs	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hospice Care		
Hospice Inpatient	70% of Allowed Amt	70% of Allowance
Hospice Outpatient/Home	80% of Allowed Amt	80% of Allowance

Note: Certain categories of network providers may not currently be available in all geographic regions. Additionally, certain providers (e.g., radiologists, anesthesiologists, pathologists, emergency room physicians) rendering care at network facilities may not be network providers and are, therefore, subject to non-network benefits.

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

Plan Maximums

Enteral Formulas per person per calendar year \$2,500
(up to age 25)

Hospice Care days per person per lifetime. 210

Lifetime Benefit Maximum per person per lifetime (does not include Rx) \$2,000,000

Manipulative Services per person per calendar year 26 treatments or \$500
whichever occurs first

Massage and/or Physical Therapy

Treatments per day; and 4
Days per 6-month period 21

Mental/Nervous and Alcohol/Drug Treatment Services (Inpatient)

Detoxification treatment services (included in calendar year maximum below) 6
Combined days per person per calendar year 31

Note: Inpatient care in a non-network specialty facility is only covered for the treatment of alcohol or drug abuse and is only covered for an active State employee. In order to be covered DSGI approval is required

Room and Board Allowance Limits for Non-Network Facilities

Semi-Private Room \$190 per day
Progressive Care Unit \$285 per day
Intensive Care Unit \$380 per day
Skilled Nursing Facility. \$95 per day

Skilled Nursing Facility days per person per calendar year. 60

Weight Loss Services (non-surgical) per person per 12-month period \$150

Wigs per person per event \$40

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Office Visits

For office visits, the amount you pay depends on whether you use a network or non-network physician. You pay a set copayment per visit for network physicians, while coinsurance applies for most office visits to non-network physicians.

If you use non-network physicians, you will pay any amount above the non-network allowance. See page 1-7 for more information about the network allowed amount and the non-network allowance.

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

Emergency Room Visits

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

1. Network Facility

You pay a set copayment per visit for the facility charges. This copayment is waived if you are admitted to the hospital directly from the emergency room. If the ER physician is a network provider, the Plan pays the network coinsurance level, a percentage of the network allowed amount, after you meet the calendar year deductible.

If the ER physician is not a network provider, benefits for physician services will be paid at the non-network coinsurance level, a percentage of the non-network allowance, after you meet the calendar year deductible. You are responsible for your share of coinsurance and any amount above the non-network allowance. It is not uncommon to receive ER physician services from a non-network provider within a network facility.

The per visit ER copayment does not count toward meeting the Plan's calendar year deductible or the calendar year out-of-pocket limit.

2. Non-Network Facility

This Plan pays the non-network coinsurance level, a percentage of the non-network allowance, for covered facility services. You pay the remaining coinsurance and any amounts above the non-network allowance.

Deductible for Hospital Stays

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

Deductible for Most Other Covered Care

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

Once the calendar year deductible is met, this Plan pays a percentage of the network allowed amount for network providers and a percentage of the non-network allowance for non-network providers. Please refer to page 1-7 for more information regarding your share of expenses for non-network providers.

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

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

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

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

How the Deductible Works

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

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

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

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

Calendar Year Limit on Your Share of Covered Expenses

There is a limit on the amount of coinsurance you pay out of your pocket toward covered expenses in any one calendar year for network and non-network care combined. Once your share of out-of-pocket coinsurance expenses reaches the annual limit, this Plan begins paying 100% of the network allowed amount for care from network providers and 100% of the non-network allowance for care from non-network providers, after any required copayments or deductibles, for the rest of the calendar year. You meet the family out-of-pocket coinsurance limit (if applicable) when the coinsurance expenses of at least two of your covered family members add up to the family maximum.

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

1. calendar year and inpatient hospital deductibles;
2. copayments for office visits and network emergency room visits;
3. hospice care expenses;
4. charges for services and supplies that are not covered by this Plan;
5. charges greater than the non-network allowance for non-network providers;
6. charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment; and
7. pre-admission certification or other penalties.

The Plan Pays a Major Share of Covered Expenses

Benefits are paid at two different levels. The level you receive depends on whether your care is provided by network providers or non-network providers.

This Plan pays benefits for covered services based on the network allowed amount for network care and the non-network allowance for non-network care. The network allowed amounts are preferred rates BCBSF has negotiated with network providers, and network providers are not allowed to charge you for any amounts above the network allowed amounts. When you use network providers, you take advantage of the preferred rates of the network allowed amounts and the Plan pays the highest level of benefits, keeping your cost down.

When you go to non-network providers, this Plan pays benefits based on the non-network allowance. If your provider charges more than the non-network allowance, you are responsible for any amounts above the non-network allowance. In addition, because the Plan pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care.

In selecting BCBSF as the Medical Claim Administrator for the State Employees' PPO Plan, DSGI agreed to accept the non-network allowance schedule used by BCBSF to make payment for specific healthcare services submitted by non-network providers.

Keep in mind that you will receive benefits at the non-network level whenever you use non-network providers, even if a network provider is unavailable.

See section 6 for more information about the PPCSM network.

Section 2: Health Investor PPO Option Summary of Benefits

This summary provides an overview of the Health Investor PPO Option. For further information on the coverage and benefits of this Plan as well as applicable limitations and exclusions, please refer to sections 3 (Covered Services), 4 (Pre-existing Condition Limitations) and 5 (Exclusions) of this booklet.

If you are enrolled in the Standard PPO Option, please refer to section 1, entitled Standard PPO Option Summary of Benefits.

Benefit Description	Network	Non-Network
Calendar Year Deductible/Copays/Limits		
Calendar Year Deductible (CYD)		
Individual Purchaser	\$1250	\$2500
Family Purchaser	\$2500	\$5000
Coinsurance Maximum (OOP)		
Individual Purchaser	\$3000	\$7500
Family Purchaser	\$6000	\$15,000
Emergency Room Facility Services Copay (per visit)	No copay, subject to CYD	
Per Admission Deductible (PAD)	No PAD; subject to CYD	\$1000 after CYD
Inpatient Hospital		
Physician Office	subject to coinsurance and CYD	
Hospital Services		
Room and Board (R&B) (semi-private)		
Admission Certification/ Hospital Stay Certification (AC/ HSC) required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Intensive/Progressive Care AC/HSC required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Emergency Room	80% of Allowed Amt after CYD	60% of Allowance after CYD
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, OR, etc.)	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Outpatient Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physician Services		
Hospital Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Office Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Outpatient Services (outpatient visits, consultations, maternity care, etc.)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Pathology/Radiology/ Anesthesiology	80% of Allowed Amt after CYD	60% of Allowance after CYD

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

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

Note: Certain categories of network providers may not currently be available in all geographic regions. Additionally, certain providers (e.g., radiologists, anesthesiologists, pathologists, emergency room physicians) rendering care at network facilities may not be network providers and are, therefore, subject to non-network benefits.

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

Plan Maximums

Enteral Formulas per person per calendar year \$2,500
(up to age 25)

Hospice Care days per person per lifetime. 210

Lifetime Benefit Maximum per person per lifetime (includes Rx) \$2,000,000

Manipulative Services per person per calendar year 26 treatments or \$500
whichever occurs first

Massage and/or Physical Therapy

Treatments per day; and 4

Days per 6-month period 21

Mental/Nervous and Alcohol/Drug Treatment Services (Inpatient)

Detoxification treatment services (included in calendar year maximum below) 6

Combined days per person per calendar year 31

Note: Inpatient care in a non-network specialty facility is only covered for the treatment of alcohol or drug abuse and is only covered for an active State employee. In order to be covered DSGI approval is required

Room and Board Allowance Limits for Non-Network Facilities

Semi-Private Room \$190 per day

Progressive Care Unit \$285 per day

Intensive Care Unit \$380 per day

Skilled Nursing Facility. \$95 per day

Skilled Nursing Facility days per person per calendar year. 60

Weight Loss Services (non-surgical) per person per 12-month period \$150

Wigs per person per event \$40

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Office Visits

For office visits, the amount you pay depends on whether you use a network or non-network physician. You pay a percentage of the network allowed amount for network providers and a percentage of the non-network allowance for non-network providers, after the calendar year deductible is satisfied.

If you use non-network physicians, you will pay any amount above the non-network allowance. See page 2-6 for more information about the network allowed amount and the non-network allowance.

Emergency Room Visits

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

1. Network Facility

The Plan pays a percentage of the network allowed amount, after you meet the calendar year deductible, for both the facility and the network ER physician. You pay the remaining coinsurance percentage.

If the ER physician is not a network provider, benefits for physician services will be paid at the non-network coinsurance level, a percentage of the non-network allowance, after you meet the calendar year deductible. You are responsible for your share of coinsurance and any amount above the non-network allowance. It is not uncommon to receive ER physician services from a non-network provider within a network facility.

2. Non-Network Facility

This Plan pays the non-network coinsurance level, a percentage of the non-network allowance, for covered facility services, after you meet the calendar year deductible. You pay the remaining coinsurance and any amounts above the non-network allowance.

Deductible

Before this Plan pays benefits for covered expenses, you must meet a calendar year deductible. Both health and prescription expenses are applied to the calendar year deductible on the Health Investor PPO Option. The calendar year deductible applies each January 1 to December 31.

Once the calendar year deductible is met, this Plan pays a percentage of the network allowed amount for network providers and a percentage of the non-network allowance for non-network providers. Please refer to page 2-6 for more information regarding your share of expenses for non-network providers.

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

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

If you have family coverage, the family aggregate amount must be met by one or a combination of your covered family members before this Plan begins paying a percentage of your eligible expenses.

Once your family satisfies the family aggregate deductible, this Plan begins paying a percentage of covered expenses for you and all your covered dependents for the rest of the calendar year.

How the Deductible Works

Assume Joe and his family are covered under the Health Investor PPO Option, and had the following covered medical expenses during the first three months in a calendar year. All the expenses are for care from network providers.

Joe	\$ 1200
Wife	\$ 1125
Daughter	\$ 100
Son	+ \$ 75
network family deductible	\$ 2500

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

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

Calendar Year Limit on Your Share of Covered Expenses

There is a limit on the amount of coinsurance you pay out of your pocket, toward covered expenses in any one calendar year for network and non-network care combined. Once your share of out-of-pocket coinsurance expenses reaches the annual limit, this Plan begins paying 100% of the network allowed amount for care from network providers and 100% of the non-network allowance for care from non-network providers, for the rest of the calendar year. You meet the family aggregate out-of-pocket coinsurance limit (if applicable) when the coinsurance expenses of one, or a combination of your covered family members, add up to the family maximum. This Plan will not pay any claims at 100% of the non-network allowance or network allowed amount until the family aggregate out-of-pocket limit has been met.

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

1. calendar year and inpatient hospital deductibles;
2. hospice care expenses;

3. charges for services and supplies that are not covered by this Plan;
4. charges greater than the non-network allowance for non-network providers;
5. charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment; and
6. pre-admission certification or other penalties.

The Plan Pays a Major Share of Covered Expenses

Benefits are paid at two different levels. The level you receive depends on whether your care is provided by network providers or non-network providers.

This Plan pays benefits for covered services based on the network allowed amount for network care and the non-network allowance for non-network care. The network allowed amounts are preferred rates BCBSF has negotiated with network providers, and network providers are not allowed to charge you for any amounts above the network allowed amounts. When you use network providers, you take advantage of the preferred rates of the network allowed amounts and the Plan pays the highest level of benefits, keeping your cost down.

When you go to non-network providers, this Plan pays benefits based on the non-network allowance. If your provider charges more than the non-network allowance, you are responsible for any amounts above the non-network allowance. In addition, because the Plan pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care.

In selecting BCBSF as the Medical Claim Administrator for the State Employees' PPO Plan, DSGI agreed to accept the non-network allowance schedule used by BCBSF to make payment for specific healthcare services submitted by non-network providers.

Keep in mind that you will receive benefits at the non-network level whenever you use non-network providers, even if a network provider is unavailable.

See section 6 for more information about the PPCSM network.

Section 3: Covered Services

Covered Service Categories

Acupuncture

Services must be provided by a medical doctor, a doctor of osteopathy, a chiropractor certified in acupuncture, or a certified acupuncturist.

Ambulance

Ambulance services must be medically necessary to transport:

1. from a hospital unable to provide care to the nearest hospital that can provide proper care;
2. from a hospital to a home or skilled nursing facility; or
3. from the place of an emergency to nearest hospital that can provide appropriate care.

Air, helicopter, and boat transport are covered if

1. the pick-up point is inaccessible by ground;
2. speed in excess of ground speed is critical; or
3. the travel distance is too far for medical safety.

Cleft Lip and Cleft Palate

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

Contraceptives

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

Dental

Dental care is limited to the following:

1. Care and treatment rendered within 120 days of an accidental dental injury, unless an extension is requested and approved by BCBSF, provided such services are for the treatment of damage to sound natural teeth. No services will be covered if provided more than 120 days after the termination of the person's coverage.

2. Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to you or your covered dependent in a hospital or ambulatory surgical center if:
 - a. the covered dependent is under 8 years of age and it is determined by a dentist and the covered dependent's physician that:
 - i. dental treatment is necessary due to a dental condition that is significantly complex; or
 - ii. the covered dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
 - b. you or your covered dependent have one or more medical conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Diabetes Outpatient Self-Management

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

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

Durable Medical Equipment (DME)

Rental or purchase is limited to:

1. the standard model unless an upgraded model is determined to be medically necessary;
2. purchase is covered only if the purchase price is less than rental cost; and
3. if DME is rented first and purchased later, the amount the Plan would pay is reduced by any amount already paid toward rental costs.

Reimbursement Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be covered only if you own the equipment or are purchasing the equipment. The network allowed amount or non-network allowance for durable medical equipment will be the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) the network allowed amount or non-network allowance. The total network allowed amount for such rental equipment will not exceed the total purchase price. Durable medical equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of durable medical equipment due to growth of a child or due to a change in your Condition is covered.

Enteral Formulas

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

Coverage to treat inherited diseases of amino acid and organic acids, for you up to your 25th birthday, shall include coverage for food products modified to be low protein, in an amount not to exceed \$2,500 per calendar year.

Eye Glasses or Contacts

Coverage is limited to the first pair of eyeglasses or contacts following an accident to the eye or cataract surgery.

Fertility Testing and Treatment

Some fertility tests and treatments are covered services. Certain fertility tests and treatments are considered experimental or investigational and are not covered. Please refer to the exclusions section for further information.

Hearing Tests

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

Newborn Screening for the Detection of Hearing Loss

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

Hospitals are required to screen newborns for the detection of hearing loss prior to discharge, but no later than 30 days after discharge. If your child is born at a birthing center, the birthing center is required to refer your newborn, within 30 days after discharge, for these hearing screenings. If your child is born at home, the attending health care provider will refer your newborn, within three months after your child's birth, for these hearing screenings. A licensed audiologist, physician, hospital or other newborn hearing-screening provider can provide hearing screenings.

You, as the parent or legal guardian, may object, in writing, to the health care provider attending your child and prevent your child from receiving these hearing screenings.

Home Health Care

Services provided by a home healthcare agency for nursing services, treatment, therapy, equipment, medication and supplies if you are confined and

convalescing at home. Occupational therapy is covered only as a component of home health care and hospice care.

Hospice Care

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

Coverage includes the following services:

In-home care

1. physician services;
2. physical, respiratory and occupational therapy;
3. drugs, medicines and medical supplies;
4. private duty nursing services in a series of shifts (e.g., three eight-hour shifts);
5. home health aide services;
6. rental of durable medical equipment; and
7. oxygen.

Hospice outpatient care

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

Hospice inpatient care

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

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

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

The calendar year out-of-pocket limit for coinsurance expenses does not apply to hospice expenses.

Occupational therapy is covered only under hospice and home health care.

Mammograms

Screening mammograms are covered as follows:

- age 35 through 39 - one baseline
- age 40 through 49 - one every two years
- age 50 and over - one every year

Medically necessary mammograms are covered at any age. Mammograms are not included in adult preventive services benefit.

Manipulative Services

Payment for manipulative services is limited to 26 treatments per calendar year, not to exceed payment of \$500, whichever occurs first.

Mastectomy and Reconstructive Services

Coverage includes:

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

Maternity Care

Maternity care is only covered for female employees, retirees, or COBRA participants and spouses of male employees, retirees, and COBRA participants. Maternity care is not covered for dependent children who become pregnant except for certain pregnancy complications as defined on page 5-2 of this booklet.

Maternity coverage includes covered hospital stays for the mother and newborn, newborn care and one assessment, including initial exam from a pediatrician, medically necessary clinical tests and immunizations, routine nursery charges, midwife services, and birthing centers.

About Maternity Care: Coverage for Mothers Newborns

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

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

Coverage for care for a mother and her newborn infant includes coverage for a post-partum and newborn assessment. In order for such services

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

Mental/Nervous and Alcohol/Drug Treatment

Inpatient mental/nervous and alcohol/drug treatment is limited to a combined 31 days per calendar year. Detoxification services are limited to 6 days per calendar year, which counts towards the 31-day inpatient maximum. Inpatient care in a non-network specialty facility is not covered, except for the active employee's treatment of an alcohol/drug condition only; DSGI approval is required.

Outpatient treatment in a non-network specialty facility is not covered for mental/nervous conditions.

Nursing Services

Nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) is covered, including inpatient private duty nursing only when medically necessary.

Physical Therapy and Massage Therapy

Payment for physical and massage therapy is limited to a combined maximum of 4 treatments per day, not to exceed 21 treatment days during any six-month period, counting backwards from the date of each treatment. Massage therapy requires a physician's prescription noting medical necessity and specifying the number of treatments required, however, not to exceed the physical and massage therapy maximum noted above.

Physical therapy may be provided by a physician, chiropractor, or a licensed physical therapist. Massage therapy may be provided by a physician, a chiropractor, a licensed physical therapist or a licensed massage therapist.

Physician Services

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

1. Preventive Care Services

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

If you use a network provider, you will have no out-of-pocket expenses for eligible services and immunizations. If you use a non-network provider, you will be responsible for the total amount above the non-network allowance. You will be responsible for any costs for services and immunizations in excess of those covered under this provision.

a. Preventive Care - Adult

Preventive health care and immunization benefits for all covered members over age 16 shall be age and gender based in accordance with the prevailing medical standards and recommendations of the American Academy of Physicians and the U.S. Preventive Task Force. Current immunization and health care service schedules can be found at <http://www.aafp.org/x28209.xml>

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

b. Preventive Care - Child

Preventive health care and immunization benefits for children through age 16 are age and gender based in accordance with the prevailing medical practice as established by the American Academy of Pediatrics. Current immunization and health care service schedules can be found at <http://www.cispimmunize.org> and <http://www.aap.org/visit/prevent.htm>

Covered child preventive care services are not subject to a PVF or CYD.

2. There are some special limits on how doctor visits will be covered by this Plan.
 - a. Whenever you are receiving medical care related to surgery, additional inpatient visits from your doctor are covered only if:
 - i. you need medical care that is not related to your surgery and is not part of your pre-operative or post-operative care; and
 - ii. you are hospitalized for medical care and the need for surgery develops after you are first admitted to the hospital. In this case, payment for doctor visits for other medical care will generally end on the date of surgery.
 - b. Non-surgical inpatient doctor visits are limited to one visit by one doctor each day. Visits from other doctors may be covered, however, if needed because of the severity or complexity of your condition.
 - c. Inpatient or outpatient visits to one doctor for a non-surgical condition, or related conditions, are limited to one visit per day.
 - d. Outpatient doctor visits on the same day you have inpatient surgery will not be covered unless the outpatient visit is unrelated to your surgery or is with a doctor who is not performing your surgery.
3. Outpatient office visits on the same day you have outpatient surgery will not be covered if the charge for the office visit is determined by BCBSF to be included in the surgery charge. An office visit to a doctor who is not performing your surgery will be covered, provided the services rendered are covered services as described in this section.

Prostheses

Artificial limbs or eyes may be covered, limited to the first such permanent prosthesis. Replacement must be medically necessary, based on medical review by BCBSF, in order to be covered.

Skilled Nursing Facility

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

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

Surgical Procedures

1. Surgery for Breast Reduction

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

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

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

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

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

- a. sends a written request for approval to BCBSF, before the surgery is performed, documenting the physical problems and estimating the amount of tissue to be removed;
- b. documents the medical reason why the actual amount of tissue was less than the guidelines; and

- c. BCBSF recommends approval and DSGI approves the lesser amount.

2. Surgical Sterilization

Tubal ligations and vasectomies are covered, whether elective or medically necessary.

Reimbursement Guidelines for Surgical Procedures

If more than one surgical procedure is performed at the same time, the primary procedure will be covered at the usual benefit level for the type of provider; meaning the percentage payable for network or non-network providers. For the secondary procedure, however, this Plan will pay the lesser of:

1. 50% of the network allowed amount for network care, or 50% of the non-network allowance for non-network care; or
2. 100% of the doctor's fee.

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

Transplants

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

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

Weight Loss Services (Non-surgical)

In the event that your surgeon requires you to lose weight before a medically necessary covered surgical procedure can safely be performed, office visits and non-surgical weight loss services may be covered. Coverage for non-surgical weight loss services is limited to \$150 per person in any 12-month period.

Wigs

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

Section 4: Pre-existing Condition Limitations

Pre-existing Conditions

A pre-existing condition under this Plan is any condition for which you or your eligible dependents received medical advice or treatment within six months of:

1. your date of hire if you enroll as a new hire;
2. January 1 if you are enrolling during the annual open enrollment period; or
3. the date your coverage becomes effective if you are enrolling because of a qualified status change event or special enrollment event.

Pre-existing conditions do not include covered services related to domestic violence, pregnancy or medical treatment of a newborn or newly adopted child of a covered employee or dependent, as long as the child is enrolled in this Plan within 31 days of its birth, adoption or placement for adoption.

This Plan does not pay benefits for pre-existing conditions that would otherwise be considered a covered service until:

1. you have been employed for 12 months, or 365 days, if you enroll as a new hire; or
2. your coverage has been effective for 12 months, or 365 days, if you add coverage during the annual open enrollment period or because of a change in status qualifying event or special enrollment event.

Credit for Previous Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that group health plans give credit for prior coverage when applying pre-existing condition limitations. You will receive credit for previous healthcare coverage, as long as you do not have a break in coverage of 63 or more days. This is called "creditable coverage". Your creditable coverage equals the number of days you were covered by your previous plan. COBRA coverage also counts as creditable coverage, as long as you do not have a break in coverage of 63 or more days between the time COBRA coverage ends and the time you become covered by this Plan.

Waiving some or all of the Pre-existing Condition Limitations

If you enroll as a new hire, this Plan does not cover pre-existing conditions until you have been employed for 12 months, or 365 days. When you add coverage during the annual open enrollment or because of a change in status (qualifying event) or special enrollment event, this Plan does not cover pre-existing conditions for 12 months from the effective date of coverage. Creditable coverage from a previous health insurance plan, however, can reduce or eliminate this 12-month pre-existing condition limitation.

An Example: This example shows how creditable coverage under a previous plan can reduce the pre-existing condition limitation under this Plan. For this example, assume this employee:

1. is hired as an eligible employee 1/1/2007;
2. enrolls for coverage under the Plan, effective 3/1/2007;
3. was treated for a knee injury several times during the six months before date of hire; and
4. has four months of creditable coverage without a break in coverage under a previous health plan:

Regular pre-existing condition for this Plan	12 months
Minus	
Creditable coverage under previous health plan	- 4 months
Equals	
Pre-existing condition limitation for this employee	8 months

Because this employee has four months of creditable coverage, the limitation on coverage for the pre-existing condition, the knee injury, is reduced to eight months. This means this Plan will cover the knee injury starting 9/1/2007, eight months from this employee's date of hire.

Proving Creditable Coverage

Generally, when your coverage under a previous healthcare plan ends, you will receive a *Certificate of Creditable Health Insurance Coverage (or Portability)*. This certificate should include the name of each person covered by the policy, the beginning and ending dates of coverage, and whether the coverage is still in effect. If you do not receive a certificate of creditable coverage from your previous plan within a reasonable length of time after coverage ends, contact your previous plan administrator.

Some health plan providers, including Medicaid, the Indian Health Service and CHAMPUS, do not automatically provide a certificate when your coverage ends. In this case, you should contact the plan administrator and request a certificate of creditable coverage.

If you do not receive a certificate of creditable coverage from your previous plan, you can show creditable coverage by providing:

1. a schedule of benefits or summary of benefits for the previous health insurance coverage; and
2. a dated letter from your previous employer, insurance company or plan administrator showing a list of the persons covered by the insurance and a beginning and ending date of coverage for each person. If the coverage is still in effect, the letter must state that the coverage has not ended.

Requesting a Pre-existing Condition Waiver

You can submit your request for a pre-existing condition waiver to People First. Waiver requests should be mailed to the attention of the "Pre-existing Waivers Coordinator". To request a pre-existing condition waiver, you must include:

1. the employee's Social Security number;
2. the name of each person for whom the waiver is requested; and
3. the *Certificate of Creditable Health Insurance Coverage (or Portability)* – or the schedule of benefits or summary of benefits and a letter from the previous employer, insurance company or plan administrator as described above.

Once People First has determined your creditable coverage and how it affects the pre-existing condition limitation, People First will notify you by letter and modify your enrollment records to reflect a full or partial waiver. The medical claims administrator, BCBSF, will review your claims history and reprocess any claims related to a pre-existing condition if necessary. If you know you have a pre-existing condition, submit your request for a waiver as soon as you enroll in this Plan so claims can be paid correctly.

Section 5: Exclusions

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

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

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

Autopsy or post mortem services.

Complementary or Alternative Medicine

including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; mind expansion or elective psychotherapy such as, but not limited to, Gestalt Therapy, Transactional Analysis, Transcendental Meditation, Z-therapy and Erhard Seminar Training, manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications resulting from non-covered services, except complications of pregnancy defined in the exclusion for maternity services, in this section.

Continuous bedside nursing services provided by one nurse to one patient either in a hospital, hospice or patient's home will not be covered.

Cosmetic services, including any service to improve the appearance or self-perception of an individual, including without limitation: cosmetic surgery and procedures or supplies to correct hair loss/baldness or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants, unless the service is:

1. a result of a covered accident and the surgery or treatment is performed while the person is covered by this Plan;
2. for correction of a congenital anomaly for an eligible dependent and performed while the dependent is covered by this Plan;
3. a medically necessary procedure to correct an abnormal bodily function;
4. for reconstruction to an area of the body that has been altered by the treatment of a disease; or
5. for breast reconstructive surgery and the prosthetic devices related to a mastectomy. "Mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician, and "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts.

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

Dental services and supplies including dental work, dental treatment, or dental examinations unless:

1. necessary as a result of an accident; or
2. it is medically necessary that services be provided in a hospital, ambulatory surgical center, outpatient healthcare facility or skilled nursing facility. Only facility charges are covered in this circumstance; physician services (including general and specialty dentists and oral surgeons) are not covered.

Services must be provided within 120 days of the accident unless a written explanation from the dentist or physician stating any extenuating circumstances requiring treatment over a longer period of time is received and approved by BCBSF as medically necessary within 120 days. In no instance will any services be covered unless provided within 120 days of the termination of the person's coverage. Orthodontia is never covered, even if necessary as a result of an accident.

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

Electrolysis

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

Experimental or Investigational services and procedures as determined by BCBSF and DSGI, or services and procedures not in accordance with generally accepted professional medical standards, including complications resulting from these non-covered services.

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

Fertility testing and treatment including in-vitro fertilization, artificial insemination, ovum or embryo placement or transfer, gamete intrafallopian transfer, cryogenic and/or other preservation techniques used in such and/or similar procedures.

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

Hearing aids or the examination, including hearing tests, for the prescription or fitting of hearing

aids. Hearing tests associated with a covered ear surgery, in accordance with child and adult preventive health care benefits, or for the diagnosis of a covered condition are covered.

Home health care:

1. homemaker or domestic maid services;
2. sitter or companion services;
3. services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
4. speech therapy provided for a diagnosis of developmental delay;
5. custodial care except for any such care covered under this subsection when provided on a part-time or intermittent basis (as defined above) by a home health aide;
6. food, housing, and home delivered meals; and
7. services rendered in a hospital, nursing home, or intermediate care facility.

Immunizations except those immunizations provided as part of the child preventive care services, adult preventative care benefits or when necessary as a result of an accident.

Marriage counseling

Maternity services related to the pregnancy of eligible dependent children, except medically necessary services for the following complications of pregnancy:

1. conditions not related to pregnancy but adversely affected by pregnancy;
2. conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
3. a non-elective Cesarean section;
4. an ectopic pregnancy which is terminated; or
5. a spontaneous termination of pregnancy that occurs before the twenty-second week.

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

Mental or nervous disorder and/or alcoholism or drug addiction inpatient services provided by a hospital, specialty institution, residential facility or any other facility while you or your eligible dependent are confined for treatment of a mental or nervous disorder and/or alcoholism or drug addiction above the 31-day per calendar year limit.

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

Microprocessor controlled or myoelectric artificial limbs (e.g. C-legs); and cosmetic enhancements to artificial limbs.

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

Occupational therapy except when received as part of home health care services or hospice services. Recreational, educational, vocal and sleep therapy are also not covered.

Orthoptics

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

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

1. diabetes mellitus;
2. peripheral neuropathy;
3. medical endocrine causes of impotence;

4. arteriosclerosis/postoperative bilateral sympathectomy;
5. spinal cord injury;
6. pelvic-perineal injury;
7. post prostatectomy;
8. post priapism; or
9. epispadias and exstrophy.

Personal Comfort, Hygiene or Convenience

Items and services deemed to be not medically necessary and not directly related to your treatment including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than medically necessary ambulance services);
8. motel/hotel accommodations;
9. equipment which is primarily for your convenience and/or comfort, or the convenience of your family or caretakers; modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; electric scooters; water therapy devices such as Jacuzzis, hot tubs, swimming/lap pools or whirlpools; membership to health clubs, exercise, physical fitness and/or massage equipment; hearing aids; air conditioners and purifiers, furnaces, air filters, humidifiers; dehumidifiers, water softeners and/or purifiers; pillows, mattresses or waterbeds; escalators, elevators, stair glides; emergency alert equipment; blood pressure kits, handrails and grab bars; heat appliances and dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. heating pads, hot water bottles, or ice packs; and
11. massages except as described in section 3.

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

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

Residential facility services and supplies provided by a specialty facility or residential facility except as described in section 3.

Reversal of voluntary surgical sterilization procedures including the reversal of tubal ligations and vasectomies.

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

Skilled nursing facility services and supplies provided by a skilled nursing facility for:

1. custodial care, including but not limited to, assistance with the activities of daily living;
2. alcoholism, drug addiction or mental and nervous disorders; or
3. the convenience of the covered person or covered person's family.

Smoking Cessation Programs including any service or supply to eliminate or reduce a dependency on, or addiction to, tobacco, including, but not limited to, nicotine withdrawal programs, nicotine gum (e.g., Nicorette) or nicotine patch.

Speech therapy except for the treatment of cleft lip or cleft palate for children under 18 years old and speech evaluations.

Telephone Consultations

Testicular prosthesis services or supplies.

Weight reduction services including all services, supplies, and prescription drugs related to obesity except:

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

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

Additional Exclusions include, but are not limited to:

1. Services and supplies to diagnose or treat a condition which, directly or indirectly resulted from or is in connection with:
 - a. war or act of war while in any active military, naval or air service, whether declared or not; or
 - b. the covered person's participation in a crime punishable as a felony or illegal occupation.
2. Services, supplies or treatment provided without charge.
3. Services or supplies that are not medically necessary, as determined by BCBSF clinical staff and DSGI.
4. Services, supplies, care or treatment provided by:
 - a. a person who usually lives in the covered person's home; or
 - b. a person or facility that is not included as covered in this Plan Booklet and Benefits Document.

5. Services for any occupational condition, ailment or injury arising out of or in the course of employment by any employer. The covered person will not be eligible for benefits from this Plan, even if the covered person waives rights to the benefits or services mentioned above.
6. Services provided to a covered person under the laws of the United States or any state or political subdivision. The covered person will not be eligible for benefits from this Plan, even if the covered person waives rights to the benefits or services mentioned above.
7. Services of a covered provider that are not patient specific. Such non-patient-specific services include, but are not limited to, the oversight of a medical laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, testing equipment, or laboratory technicians.
8. Any health care service received prior to your effective date or after the date your coverage terminates;
9. Claims for services that have been submitted for payment to BCBSF or Caremark more than 16 months after the date the services, prescription drugs or supplies were received.

Section 6: About the Provider Network

The Blue Cross and Blue Shield of Florida Preferred Patient CareSM (PPCSM) network is this Plan's preferred provider organization (PPO) network. The PPCSM network is a preferred provider network of independent doctors, hospitals and other healthcare specialists and facilities that have agreements with BCBSF to provide health care services to Plan participants. Network providers offer a broad range of services, such as, family practice, internal medicine, Obstetrics and Gynecology and pediatrics.

BCBSF, as the PPCSM network manager, evaluates the credentials of providers for membership in the PPCSM network. The responsibility of selecting the providers and facilities that make up the network and for addressing network-provider related issues and concerns rests with BCBSF as the PPCSM network manager.

In an effort to contain healthcare costs and keep premiums down, BCBSF has negotiated with PPCSM network healthcare providers to provide services to health Plan participants at reduced amounts. PPCSM network providers have agreed to accept as payment a set amount for covered services. You are responsible for any applicable copayment and/or a percentage of the network allowed amount as your coinsurance. The network provider cannot bill you for the difference between the provider's charges and the network allowed amount for the service (called balance-billing).

Non-network providers will bill you their regular charges. You will be responsible for a larger coinsurance and/or copayment, and you will be responsible for paying the difference between the provider's charges and the amount established as the non-network allowance for the service. The non-network allowance may be considerably less than the amount the non-network provider charges.

There are two ways you can avoid unexpected charges above the amount the Plan will pay for covered services.

1. Use the PPO network

When you go to PPO network providers, you will not be billed for charges above the network allowed amount. Network providers are sometimes called Preferred Patient CareSM (PPCSM) Providers.

2. If you are going to receive services from a non-network provider, go to a non-network provider that is a BCBSF participating Traditional Program provider.

BCBSF has agreements with providers throughout the state, including doctors, hospitals, and other healthcare specialists, who are not in the PPO network but have agreed to charge within a negotiated limit that is not higher than the non-network allowance. These providers are sometimes called Traditional Program providers and include Payment for Professional Services (PPS) and Payment for Hospital Services (PHS) providers. These providers can be identified by asking the provider or by calling BCBSF customer service. When you go to a participating Traditional Program provider who is not in the PPO network, this Plan pays at the lower non-network level of benefits, but you are protected from being balance-billed for charges above the non-network allowance.

How to Use the PPCSM Network

Once you are enrolled in the Plan, use the PPCSM network by contacting a provider listed in the PPCSM Provider Directory. You can obtain a directory from:

- BCBSF Customer Service at 1-800-825-2583
- BCBSF Website, www.bcbsfl.com

Because the network is extensive, you may find that the healthcare professionals you already use are part of the network. However, before you use a provider under this Plan, be sure the provider is a member of the network by calling the provider's office and BCBSF customer service, to confirm that the provider is still in the network. A provider's network status may change at any time without notice.

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

An Important Note About Using Non-Network Providers

To make sure you receive the highest level of benefits from the Plan, it's important to understand when non-network benefits are paid. When you use non-network providers, you receive non-network benefits. Here are some examples.

1. In some situations, your network provider may use, or recommend that you receive care from, a non-network provider. For example, your network family doctor says you need to see another doctor and recommends a non-network doctor. It is your choice; you decide whether to go to the recommended non-network doctor or to ask your doctor for another recommendation to a network doctor. In this example, even though your family doctor is a network doctor, you will receive non-network benefits if you go to the recommended non-network doctor.
2. Sometimes the healthcare professional you need to see is not in the network. You receive non-network benefits when you use non-network providers, even if no network provider is available.
3. Not all healthcare professionals offering services at a network facility are network providers. **For instance, an anesthesiologist,**

nurse anesthetist, pathologist, radiologist, or emergency room doctor working at a network hospital might be a non-network provider. In that case, the non-network provider's services will be paid at the non-network benefit level.

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

Continuity of Care

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

Pregnancy – when in the 2nd trimester as of the date the provider's participation status changed.

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

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

Outpatient rehabilitation services, initiated prior to the date of the provider's change in participation status, when approved through 30 days as of the date the provider's participation status changed.

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

Section 7: Pre-Admission Certification for Hospital Stays

All non-emergency admissions to a non-network hospital must be pre-certified. This means that BCBSF must certify the hospital admission and approve the number of days for which certification is given, before the services are provided. Pre-certification of non-network hospital stays is your responsibility, even if the doctor admitting you to the hospital is a network provider.

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

BCBSF will review requests for hospital admission and for extended hospital days in accordance with national hospital admission standards. Only a medical doctor can deny a hospital admission or request for additional hospital days.

See "If You Do Not Pre-certify Your Stay" in this section for information on penalties if you do not pre-certify your stay.

Pre-certifying Your Non-Network Hospital Admission

To pre-certify your stay in a non-network hospital, ask your doctor to call BCBSF at 1-800-955-5692 before your hospital admission and provide the reason for hospitalization, the proposed treatment or surgery, testing, and the number of hospital days anticipated.

BCBSF will review your doctor's request for admission certification and immediately notify your doctor or the hospital if your admission has been certified and the number of days for which certification has been given. If the admission is not certified, your doctor may submit additional information for a second review.

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

If You Have an Emergency Admission to a Non-Network Hospital

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

If You Do Not Pre-certify Your Stay

1. If you are admitted to a participating hospital (PHS) that is not part of the PPCSM network and admission certification has not been requested on your behalf, the request is denied, benefits for covered services will be reduced by 25% of the covered charges, not to exceed a maximum benefit reduction of \$500.
2. If your hospital admission is denied, but you are admitted to a non-network hospital anyway, the Plan will not pay room and board benefits for your first two days of hospitalization.
3. If you are admitted to a non-network hospital without having your doctor call first, the Plan will not pay room and board benefits for your entire hospital stay.
4. If your hospital admission is certified but your stay is longer than the number of days for which the admission was certified, the Plan will not pay room and board benefits for days that were not certified.

Section 8: Special Plan Features

Healthy Additions® Pre-Natal Education Program

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

To participate in the Healthy Additions® program, call BCBSF at 1-800-825-2583. A member of the prenatal nursing team will contact you or your spouse to begin helping you with your new family addition.

Health Dialog®

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

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

On the phone and online, access to Health Dialog® is easy. Call toll-free 1-877-789-2583 (for hearing and speech impaired assistance, dial 1-877-900-4304) or get additional information online at www.bcbsfl.com.

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

Medical Case Management Program

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

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

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

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

The case management alternative treatment plan will end if:

1. the patient's condition changes and the level of care provided under case management is no longer necessary;
2. the patient has reached the Plan's \$2,000,000 maximum lifetime benefit;
3. the case management approach costs more than traditional benefits; or
4. the patient is no longer eligible to take part in this Plan.

Care Profile Program – A Payer-Based Health Record Program

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

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

5. More efficient health care delivery for State Employees PPO Plan participants.

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

However, if for some reason you, or any of your family members, choose not to provide your treating physician access to your claim history, the use of this information may be restricted. Should you choose not to participate call 1-800-825-2583 and inform a service representative of your decision.

Patient-Auditor Program

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

1. a charge for a covered service or supply that the covered person did not receive;
2. a charge higher than the amount previously agreed to in writing by the provider in a pre-treatment estimate, other than charges for complications or procedures that were not anticipated; or
3. a charge that is part of an arithmetic billing error,

you may receive 50% of any amount the Plan recovers, up to a maximum of \$1,000 per inpatient stay or outpatient claim. Report any suspected overcharges to DSGI.

Worldwide Coverage

This Plan will pay benefits for covered services anywhere in the world you receive them. When you receive medical care while traveling in another country, you must submit a claim to receive benefits and the claim form must include a description of services in English and charges in US dollars.

See section 11 for information on filing claims, including time limits.

BlueCard® Program

The BlueCard® Program is a national Blue Cross and Blue Shield Association program available to you through BCBSF. Subject to the program's rules, you and your covered family members can take advantage of the provider discounts of other Blue Cross and/or Blue Shield PPO Plans across the country.

When you are outside of BCBSF's service area and need health care, call 1-800-810-BLUE (2583) for the name of a participating Blue Cross and/or Blue Shield Plan PPO provider in the area. When you present your ID card, the provider will verify your coverage and handle any claims-related paperwork. When you use a local Blue Cross and/or Blue Shield Plan's PPO provider through the BlueCard® PPO Program, this Plan pays network level benefits for covered services. You are responsible for any applicable deductibles, copayments, coinsurance, and charges for non-covered services. Providers who participate in the BlueCard® PPO Program have agreed to accept negotiated amounts for covered services, so you will not receive an unexpected bill for amounts above those negotiated amounts.

When you obtain health care services through BlueCard® outside the geographic area BCBSF serves, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to BCBSF.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be prospectively adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods for you that differ from the usual BlueCard® method noted in the above paragraph of this section or require a surcharge, BCBSF would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

In a limited number of areas, the local Blue Cross and/or Blue Shield Plan may not have a PPO network available. Please call 1-800-810-BLUE (2583) to verify availability before receiving services.

Section 9: Prescription Drug Program

How the Program Works

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

Retail pharmacies

Use for short-term medications, or medications that you need immediately, like antibiotics for a sick child, up to a 30-day supply at one time.

Mail order program

Use for maintenance or long-term medications you take regularly, like high blood pressure medication, up to a 90-day supply at one time, as long as the prescription is written to allow dispensing of a 90-day supply.

Purchasing Prescriptions at Retail Pharmacies

When your doctor prescribes a medication, you may have your prescription filled at any pharmacy, although there are advantages to using pharmacies that participate in the pharmacy network such as:

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

Participating pharmacies include most major drug chains, with over 60,000 pharmacies nationwide. To find out if your pharmacy participates call 1-800-378-4408 or visit www.caremark.com. For new enrollees, a list of the nearest pharmacy locations will be included in your prescription drug benefit kit. You can also use this toll-free number to locate a participating pharmacy if you are traveling anywhere in the United States.

Using a Participating Pharmacy

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

Standard PPO Option

- \$10 for a generic drug
- \$25 for a preferred brand name drug
- \$40 for a non-preferred brand name drug
- The copayment *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your doctor, request the brand name drug.

Health Investor PPO Option

- 30% generic drugs (subject to CYD)
- 30% preferred brand drugs (subject to CYD)
- 50% non-preferred brand drugs (subject to CYD)
- The calendar year deductible and/or coinsurance *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your doctor, request the brand name drug.

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

What if You Request a Brand Name at a Participating Pharmacy?

If your prescription is filled with a generic, you pay only the applicable copayment or coinsurance. If a generic isn't available, or if your doctor writes on the prescription "dispense as written" or "brand name medically necessary," you pay the applicable copayment or coinsurance for the brand name. However, if you request a brand name instead of an available generic, you will pay the lesser of:

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

Take a look at the following example, showing how this works.

In this example, on the Standard PPO Option, you are using a network pharmacy. At network pharmacies, the Plan's cost for a drug is less than the full retail price. Assume you request a preferred brand name drug that costs the Plan \$50 instead of the available generic substitute that costs the Plan \$25. In this case, you would pay:

Preferred Brand name copayment		\$25
Plan's cost difference between preferred brand name and generic	Brand	\$50
	Generic	-\$25
	+	\$25
Your cost		\$50

Using a Non-Participating Pharmacy

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

If you fill your prescriptions at a non-participating pharmacy you will be reimbursed at 80% of the average wholesale price (AWP) for brand name drugs or 60%, on average, of the maximum allowable cost for generic drugs, plus a \$4.28 dispensing fee, minus your copayment or coinsurance amount. You pay any amount above the AWP or maximum allowable cost. A dispensing fee is a fee that every pharmacist is paid for filling a prescription under the Plan in addition to the cost of the drug.

See the following example for more on how reimbursement works when you use a non-participating pharmacy.

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

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

80% of \$50 (AWP)		\$40.00
<i>plus</i> the dispensing fee	+	\$4.28
<i>minus</i> your copayment	–	\$25.00
Total reimbursement		\$19.28

In this example, the cost to you for using a non-participating pharmacy is \$65.72 (\$85.00 retail price minus reimbursement of \$19.28). If you had filled this prescription at a participating pharmacy and your physician requested the brand name drug, you would have paid only the \$25 copayment, on the Standard PPO Option.

What are Generics?

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

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

Ask your doctor if a generic can be substituted for its brand name equivalent.

Using the Mail Order Program

If you are taking a maintenance drug, blood pressure medication, for example, you may want to use the prescription drug mail order program to order up to a 90-day supply. To use mail order, you:

- complete a mail order form available from Caremark at 1-800-378-4408 or www.caremark.com
- enclose your prescription written for a 90-day supply, and the appropriate copayment.
- your medication will be mailed within 10-14 days after your order is received by Caremark
- the copayment or coinsurance will be based on the date the prescription is filled, not on the date the prescription is received by Caremark.

Standard PPO Option

The copayments for the mail order program are up to a 90-day supply for a single copayment, as long as the prescription is written to allow a 90-day supply to be dispensed. The copayments are:

- \$20 for a generic drug
- \$50 for a preferred brand name drug
- \$80 for a non-preferred brand name drug.
- The copayment plus the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your doctor, request the brand name drug.

Health Investor PPO Option

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

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

Your medication will be mailed to your home within one to two weeks after your order is received.

How You Can Save With Mail Order

If you are on the Standard PPO Option and use a drug regularly, you can save on copayments through mail order. For instance, if the drug you use is a preferred brand name, here is the resulting impact to you on the Standard PPO Option:

Mail Order	Participating Pharmacy
up to a 90-day maximum supply	up to a 30-day maximum supply
\$50 copayment	\$25 copayment
You pay \$50 for 90 days and order once	You pay \$75 for 90 days and make three trips to the pharmacy

Drugs that are Covered by the Prescription Drug Program

Covered drugs include:

1. Federal legend drugs;
2. State restricted drugs;
3. Compounded medications;
4. Insulin and other covered injectable medications;
5. Needles and syringes for insulin and other covered injectables; and
6. FDA-approved glucose strips, tablets and lancets.

Some medications require prior authorization before your prescription can be filled. Your pharmacist will let you know if your prescription requires prior authorization. If your prescription requires prior authorization, Caremark will work with your physician to determine medical necessity. Approval or denial of coverage will be determined within 72 hours after contacting your physician.

Prior authorizations are valid for a one-year period and must be renewed after expiration.

Drugs that are Not Covered by the Prescription Drug Program

The prescription drug program does not cover:

1. Retin-A for cosmetic purposes;
2. Anti-obesity drugs and amphetamines and/or anorexiant for weight loss;
3. Devices or appliances;
4. Non-federal legend, or over-the-counter, drugs;
5. Drugs labeled "Caution: Limited by Federal Law to Investigational Use"; or experimental drugs;
6. Nicorette and similar drugs to deter smoking;
7. Immunization agents;
8. Medication that is covered by Workers' Compensation or Occupational Disease Laws or by any state or governmental agency;
9. Medication furnished by any drug or medical service for which no charge is made;

10. Viagra and similar drugs, for psychosexual disorders, for females and males under the age of 18; or
11. Enteral formulas exceeding \$2500 per calendar year or for individuals 25 years of age or older.

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

Important Information about the Prescription Drug Program

1. The Preferred Drug List (PDL) is updated and subject to change on a quarterly basis. Contractually, Caremark has full authority over the development of the PDL; therefore, DSGI cannot require that specific drugs be included.
2. Generic Substitution: Prescriptions written for brand name drugs that have a generic alternative will be automatically substituted unless the prescribing physician writes "dispense as written" or "DAW" on the prescription. Generally, even if the prescription includes "DAW"; Caremark will still contact the physician to ask if the generic equivalent may be substituted.
3. Only the prescribing physician or an authorized agent of the physician can authorize changes or provide clarifications to a prescription. Authorizations may be obtained verbally or in writing. If Caremark is unable to contact the physician or an authorized agent of the physician, the prescription may be returned, unfilled, to the member.
4. Caremark mail order facilities will only substitute with generic drugs that have received an "A" or "AB" rating by the Federal Drug Administration (FDA). Other pharmacies may choose to dispense drugs with a different FDA rating.
5. Certain medications, including most biotech drugs, are only available through Caremark Specialty Pharmacy Services. Generally, these drugs are for chronic or genetic disorders including, but not limited to, multiple sclerosis, growth deficiency and rheumatoid arthritis and may require special delivery options, (i.e. temperature control). Caremark Specialty Pharmacy provides 24/7 access and can be contacted at 1-800-237-2767.

6. Caremark may contact the prescribing physician when a prescription for a non-preferred brand name drug is submitted and a therapeutically equivalent preferred drug is available. If the physician or an authorized agent of the physician authorizes a change to the preferred drug, Caremark will dispense the alternative drug and provide written notification of the change to the member.
7. Caremark will contact the prescribing physician if the prescribed dosage differs from the dosage recommended by the FDA or the manufacturer's guidelines. Dosage is the number of units, the strength of such units, and the length of time to take the medicine. If the physician or an authorized agent of the physician authorizes a change to the dosage, Caremark will change the dosage amount, dispense the new dosage, and provide written notification of the change to the member.
8. During the prescription review process, your mail order and retail pharmacy prescription history, age, self-reported allergies, and self-reported disease states are reviewed along with the FDA drug indications and manufacturer's guidelines to determine if there are any interactions, side effects, and/or contraindications. Caremark will contact the prescribing physician if any questions, conflicts or issues are identified. Caremark may contact the prescribing physician if any indication of fraud or excessive usage is identified. If the physician or an authorized agent of the physician authorizes any changes, Caremark will change the prescription accordingly, dispense the drug accordingly, and provide written notification of the change to the member.
9. For mail order, Caremark will contact the prescribing physician to verify the prescription if the prescription is illegible, written in different pen and/or penmanship, or altered in any way. If Caremark cannot reach the physician or an authorized agent of the physician, the prescription will be returned to the member unfilled.
10. Prescriptions for treatment of conditions for unapproved indications or "off-label" use will not be filled if not proven safe and effective for the treatment of the condition based on the most recently published medical literature of the United States, Canada or Great Britain, using generally accepted scientific, medical or public health methodologies or statistical practices.
11. Approximately 70% of the previous prescription or fill must be utilized, if used as prescribed, before a request for a refill will be processed. Requests for refills that are received within 60 days of the "too soon to fill" date (based on the previous sentence) will be held and filled when eligible to be filled. Requests for refills that are received 61 days or more prior to the "too soon to fill" date will be returned to the member. You may check your medication label for the next available refill date or if the prescription was filled through mail order you may log on to www.caremark.com for the next available mail order refill date.
12. As part of the Caremark Specialty Services, Caremark will administer the Advanced Guideline Management program for the State Employees' PPO Plan. Advanced Guideline Management is intended to optimize outcomes and promote the safe, clinically appropriate and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for Advanced Guideline Management during the respective use review will result in denial of medication coverage for the Plan participant and discontinuation of medication coverage for the Plan participant in the case of the concurrent use review.

The Advanced Guideline Management Program is a process by which authorization for a specialty medication is obtained based on the application of currently acceptable medical guidelines and consensus statements for the appropriate use of the medication in a specific disease state. Therapies subject to the Advanced Guideline Management program include the following: Allergic Asthma, Growth Hormone, Hepatitis C, Psoriasis, Rheumatoid Arthritis, Respiratory Syncytial Virus. Additional therapies may be added to the Advanced Guideline Management Program from time to time.

Section 10: Enrollment and Eligibility

Who is Eligible to Participate in the Plan?

Employees

You are eligible for the Plan if you are a full-time or part-time State officer or State employee in a salaried position. Anyone paid from Other Personal Services (OPS) funds for full-time or part-time work is not eligible for Plan coverage.

Retirees

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

1. retire under a State of Florida retirement system, or a State optional annuity or retirement program or go on disability retirement under the State of Florida retirement system, as long as you were covered by the Plan at the time of your retirement and you begin receiving retirement benefits immediately after you retire, or maintained continuous coverage under the State Plan from termination until receiving retirement benefits; or
2. retired before January 1, 1976, under any State retirement system, and you are not eligible to receive any Social Security benefits.

Dependents

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

1. your spouse under a legally valid marriage;
2. your unmarried children through the end of the month in which they reach age 19;
3. your unmarried children age 19 through the end of the calendar year in which they reach age 25 if:
 - a. you are financially responsible, as defined in section 15, for such dependent and the dependent lives with you; or
 - b. you are financially responsible, as defined in section 15, for such dependent and the dependent is enrolled in any school, college, or university certified or licensed by a state or foreign country.

Note: You will be asked by BCBSF to provide verification of eligibility for covered dependents between the ages of 19 and 25 on an annual basis. Failure to respond or to meet eligibility requirements will result in disenrollment of such dependent.

Your mentally or physically disabled children who are enrolled in the Plan are eligible to continue coverage after reaching the age limits listed above if they are incapable of self-sustained employment and you are financially responsible, as defined in section 15, for such dependent.

If you have a mentally or physically disabled child over age 25 at the time you first enroll in the Plan, you may enroll that child in the Plan. However, any expenses for treatment of the child's disabling condition will not be covered by the Plan.

The disabled child's treating physician must provide documentation supporting the mental or physical disability. You must submit the documentation to BCBSF for review and confirmation. Disability status will be verified annually. Failure to respond or to meet disability requirements will result in disenrollment of the dependent.

For this Plan, the term "children" includes your:

1. natural children;
2. legally adopted children;
3. children placed in your home for adoption pursuant to Chapter 23, *Florida Statutes*;
4. stepchildren you are eligible to claim as dependents on your federal income tax return;
5. foster children for whom you have been granted court-ordered temporary custody or other custody; and
6. children for whom you are legal guardian or have court-ordered temporary custody or other custody.

Other Eligible Dependents

If you have a covered dependent child with a newborn child, the newborn child is eligible for coverage for 18 months after the child's birth, or until

the covered dependent becomes ineligible, provided the newborn is added within 60 days of birth.

Surviving spouses are also eligible for coverage. The term “surviving spouse” means:

1. the surviving spouse of an employee or retiree, if the spouse was enrolled in the Plan as a dependent when the employee or retiree died;
2. the surviving spouse of an employee or retiree who died before July 1, 1979; or
3. the surviving spouse of a retiree who retired before January 1, 1976, under any State retirement system and who is not eligible for any Social Security benefits.

Coverage for a surviving spouse will end on the first of the month following his or her remarriage.

People First may require that you provide documentation verifying the eligibility of any dependent. Failure to provide the requested documentation will result in immediate cancellation of coverage. You will be responsible for refunding amounts paid by the State of Florida for claims of ineligible dependents.

When Coverage Begins

How to Enroll

Before Plan coverage can begin, you must enroll. There are four different times when you may enroll:

1. initial enrollment period as a new hire;
2. annual open enrollment period for all eligible employees;
3. enrollment after a change in status that is a qualifying event; or
4. enrollment after a legislatively mandated special enrollment period event.

As A New Hire – Initial Enrollment Period

All eligible new hires have an opportunity to enroll in the Plan when they begin employment. You have 60 days from your date of hire, or 60 days from the start of a new term in office if you are a State officer, to submit your enrollment election information. To enroll:

1. Log on to the People First web-site or contact People First for enrollment forms.
2. Enter the requested information on the web-site or complete the necessary enrollment forms. If you are enrolling your dependents, you must provide the necessary dependent information too.
3. If using paper forms, return the completed forms to People First within 60 days of your date of hire, or start of new term in office for State officers.

If you do not return the forms within 60 days of your date of hire, or start of a new term for State officers, you cannot enroll in Plan until the next annual open enrollment period, unless you have a change in status that is a qualifying event or a special enrollment event during the year.

As an Eligible Employee – Annual Open Enrollment Period

Each year during the annual open enrollment period, eligible employees may enroll themselves and their eligible dependents in the Plan. During this time, you are also able to make other changes in your health insurance coverage, such as enrolling in an available health maintenance organization (HMO) or dropping coverage for yourself or dependents.

Any changes you make during the annual open enrollment period will become effective on January 1 of the next calendar year.

Please review all enrollment or change forms carefully prior to signing. You are responsible for ensuring that your selection(s) are processed correctly. Further, you must check any deductions made from your pay to assure that any coverage selection(s) are reflected in your payroll deductions.

Change in Status – Qualified Status Change Events Enrollment

You may enroll in or drop coverage for yourself and eligible dependents during the year if you experience a change in status that is a qualifying event. Any change you make to your coverage must be consistent with the change in status. A Qualified Status Change (QSC) event includes

events such as a change in employment status (e.g., beginning or terminating employment with a new employer), a loss of insurance coverage and certain changes in personal status (e.g., marriage, birth, or acquiring other new dependents). Any change you make to your coverage must be consistent with the change in status. You may obtain enrollment change forms from People First.

If you experience a change in status, you must notify People First and complete the required forms within 31 days of the event. If you do not enroll within 31 days of the qualifying event, you must wait until the next annual open enrollment period to make changes in your coverage. This includes enrolling new dependents even if you already have family coverage, for example, newborn children must be enrolled within 60 days of birth even if you already have family coverage. If you lose other coverage because your COBRA coverage ends, you have 31 days from the date your COBRA coverage ends to enroll in the Plan.

Special Enrollment Periods

If you decline medical coverage through the State's health insurance Plan for yourself or your eligible dependents because you have other medical coverage and you later lose that coverage due to:

1. eligibility for the other coverage ends;
2. you reach or exceed the maximum of all lifetime benefits under other health coverage;
3. employer contributions for the other coverage ends; or
4. COBRA coverage available through the other coverage ends because it has been completely used.

then you can enroll in the Plan, as long as you complete an enrollment form and return it to People First within 31 days of the date your other coverage ends. If your other coverage was through COBRA, you have until 31 days from the date your COBRA coverage ends to enroll in the Plan.

If you acquire a new dependent because of marriage, birth, adoption or placement for adoption, you can enroll yourself, your new family

members and any other eligible dependents in the Plan by completing an enrollment form and returning it to People First within 31 days of the marriage, birth or adoption.

When Coverage Becomes Effective

As a New Hire

Your coverage begins on the first day of the month after the month in which a full month's coverage cost, or premium, has been payroll deducted/ received by People First. One month's premium must be paid through automatic deductions from your paycheck before coverage can begin. People First can give you information about your starting date for coverage. Coverage will always begin on the first day of a month.

An example: Assume you are hired July 20 and People First receives your enrollment information before August 1. Your coverage would begin September 1, after one full month's premium has been deducted from your paycheck.

When you apply for health insurance as a new hire, your health insurance will be effective beginning the first day of the month following payment of a month's premium and for the rest of the calendar year, as long as premiums are paid, and you remain eligible. You cannot change your coverage until the next annual open enrollment period or special enrollment period unless you experience a change in status that is a qualifying event.

During Annual Open Enrollment

Each year during the annual open enrollment period, you will have an opportunity to enroll yourself and eligible dependents in the Plan. At this time, you can also drop Plan coverage, add or drop eligible dependents, or change to an available HMO Plan. Any change you make during the annual open enrollment period will take effect on January 1 of the following calendar year, and will remain in effect for the calendar year if your premiums are paid and you remain eligible, unless you make changes because of a qualified status change event or special enrollment period event.

Qualified Status Change Events or Special Enrollment Events

If you enroll yourself or eligible dependents during the year because of a qualified status change event or a special enrollment event, coverage will begin on the first day of the month following the month in which a full month's coverage cost, or premium, has been payroll deducted and received by People First. One month's premium must be paid through automatic deductions from your paycheck before coverage can start. People First can give you information about the earliest possible starting date for coverage. Coverage will always begin on the first day of a month.

Important Reasons to Contact People First

There are several important events that may affect your Plan coverage. Contact People First within 31 days if:

1. your spouse becomes employed by or ends employment with the State;
2. you go off the payroll for any reason;
3. you transfer to another agency;
4. you move; or
5. you or your spouse become eligible for Medicare, in this case, contact People First as well.

You should also contact People First 31 days before you plan to retire.

When Coverage Ends

Your coverage under the Plan ends on the last day of the month in which:

1. your employment is terminated;
2. you do not make the required contributions for coverage, including the months when you are on leave without pay, suspension or layoff status; or
3. you remarry, if you have coverage as a surviving spouse of an employee or retiree.

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

1. your coverage is terminated;
2. your spouse remarries after your death (see "Other Eligible Dependents"; in this section for details on surviving spouse coverage); or
3. you and your spouse divorce.

Your dependent children's coverage under the Plan ends on the last day of the month in which:

1. your coverage is terminated;
2. your child marries; or
3. your child no longer meets the definition of an eligible dependent.

Certificate of Creditable Coverage

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

Coverage Continuation

Family and Medical Leave

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

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

condition of a family member (child, spouse or parent) or a personal serious health condition. Under the laws of the State of Florida, this leave may be extended up to 6 months. Call People First if you need further details.

As a participant in the Plan, you have, while on leave under family medical leave, the option to continue your health benefits on the same terms and conditions as immediately prior to your taking family medical leave. The State of Florida will continue to pay its share of the premium (if any) throughout your family medical leave. You will still be responsible for your portion of the premium (if any). Premium payments will be collected by People First. You and your eligible dependents shall remain covered under this Plan while you are on family medical leave as if you still were at work. Your coverage will be maintained until you return to work or, if earlier, you notify People First that you will not return to work. If you choose not to remain covered under the Plan while on family medical leave, and subsequently return to work before or at the end of family medical leave, you and your eligible dependents shall immediately become covered under the Plan without regard to pre-existing conditions that arise while on family medical leave.

Coverage Continuation When you are Off Payroll

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

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

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

COBRA

The Consolidated Omnibus Budget Reconciliation Act is referred to as COBRA. Under COBRA, you can continue healthcare coverage that would otherwise end because of a change in employment status from permanent status to Other Personal Services (OPS) or because of voluntary or involuntary termination for reasons other than gross misconduct. You may also continue healthcare coverage that would otherwise end because you did not return to work after an unpaid leave under the Family and Medical Leave Act. This continuation coverage may be kept for up to 18 months. You must pay the required cost of the continued coverage. The premium is 102% of the cost of coverage.

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

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

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

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

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

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

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

When People First is notified that one of these events has occurred, an enrollment form for COBRA continuation coverage will be sent to the eligible individual along with notification of the premium. The eligible individual must complete the enrollment form and return it to People First within 60 days of:

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

If an individual does not complete the COBRA election form and return it to People First within the 60-day period, coverage will end on the last day of the month in which the event that caused you to lose coverage took place.

If an eligible individual chooses COBRA continuation coverage, the State must provide coverage identical to that provided to comparably situated employees. An eligible individual's COBRA continuation coverage will end when:

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

Converting Health Insurance Plan Coverage to a Private Policy

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

case, you must still apply in writing and pay the first month's premium within 63 days of the date your COBRA coverage ends.

Continuation of Benefits if you are Disabled

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

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

For this continuation of benefits, total disability means:

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

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

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

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

Extension of Benefits if the Plan is Terminated

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

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

Section 11: How to File a Claim

Medical Claims

Network Providers

When you go to a network provider or non-network provider participating in the Traditional Program, you do not need to file a claim. This includes providers in the PPCSM Network, the BlueCard[®] Program, and non-network providers who are BCBSF Traditional Program providers, including PPS or PHS providers. The provider will file the claim for you and you will be responsible for paying any coinsurance, deductibles, copayments and non-covered services. Claims for services or supplies received from a network provider must be filed within 16 months of the date you receive the services or supplies. The third party administrator, BCBSF, will process the claim in accordance with Plan benefits, usually within 30 days of receipt. BCBSF will send you an "Explanation of Benefits," also called an EOB form, which will give you important information about your claim.

Non-Network Providers

If you go to a non-network provider, you will be responsible for filing your own claim. You must file the claim within 16 months of the day you received services or supplies. Benefits will be paid directly to you. Except as specified below, benefits payable to you under this health Plan may not be assigned or otherwise alienated in any manner to a non-network provider. No attempted assignment or alienation of benefits to a non-network provider will be recognized under the State Employees' PPO Plan, unless either: 1) BCBSF and the non-network provider have entered into an agreement in writing permitting such an assignment; 2) the provider is in a category of providers that are not eligible to participate as network providers; or 3) is a licensed hospital, physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required. You can get medical claim forms from BCBSF.

To submit the claim:

1. Complete all information on the claim form, as indicated.

2. Attach original bills to the claim form; make sure the bills include the patient's name, date, place and nature of treatment, procedure and diagnosis codes, and the physician's name and federal tax ID number.

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

Keep in mind that when you use non-network providers, you are responsible for any charges above the non-network allowance as well as any coinsurance, deductibles, copayments and non-covered services.

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

Explanation of Benefits Statement

You will receive an Explanation of Benefits (EOB) statement for each health care claim filed. If your claim is approved, the EOB will show:

1. the amount paid by this Plan;
2. any deductibles or copayments applied to the claim; and
3. the amount the patient must pay, if any.

If your claim is denied, the EOB will show:

1. the reason(s) the claim was denied;
2. a description of additional information necessary to complete your claim and why the information is necessary; and
3. an explanation of steps to take if you want BCBSF to review a claim denial.

No Intended Third Party Beneficiary

The State Employees' PPO Plan has been established by the State, and is administered by DSGI, solely for the benefit of enrolled Plan participants. No third party shall have any right

or interest in the coverage or benefits provided under the Plan or described in this Plan Booklet and Benefits Document, nor shall any third party have a right to enforce against the State, the Department of Management Services, DSGI, BCBSF or Caremark Inc., any right under the Plan as a third party beneficiary of the Plan or this Plan Booklet and Benefits Document, including any right to payment for the benefits hereunder.

Prescription Drug Claims

Participating Pharmacies

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

Non-Participating Pharmacies

If you use a non-participating pharmacy, you will be responsible for filing your own claim. You must file the claim within 16 months of the day you fill your prescription. Benefits will be paid directly to you. You can get prescription claim forms from Caremark at 1-800-378-4408 or at www.caremark.com.

To submit the claim:

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

Send the claim to Caremark Inc., the company that provides prescription claims payment services, at:

Caremark Inc.
P.O. Box 52192
Phoenix, AZ 85072-2192

Section 12: Appealing a Denied Claim

If your benefit claim is totally or partially denied, BCBSF or Caremark Inc. will send you a written notice on an Explanation of Benefits (EOB) statement indicating the specific reason(s) for the denial within 30 days of receiving your claim. The notice will include a list of any additional information needed to appeal the denial to BCBSF or Caremark Inc.

Appealing to the Third Party Administrator – A Level I Appeal

Within 90 days of the date of the EOB denial notice, you or your authorized representative can appeal a claim that is denied. Your appeal must be in writing and should include any information, questions or comments you think are appropriate. Mail your written appeal to the third party administrator: BCBSF, P.O. Box 2896 Jacksonville, Florida, 32232-0079 for medical claims, or Caremark Inc. for prescription drug claims at: Caremark Inc., Appeals Department, MC109, P.O. Box 52084, Phoenix, Arizona, 85072-2084. The third party administrator will review your claim and provide you with a written notice of the review decision. On this notice, you will also receive information about appealing the decision to DSGI.

Appealing to DSGI – A Level II Appeal

If you are not satisfied with the first appeal decision given by the third party administrator, you may make a second appeal through DSGI. After you have asked the third party administrator to review your claim and you have received their written notification, you may submit a second appeal to DSGI. Your Level II Appeal must be in writing and must be received by DSGI not later than 60 days after the date of the written notice of the third party administrator decision regarding your Level I Appeal and must include:

1. a copy of the EOB;
2. a copy of your letter requesting the third party administrator to review the claim;
3. a copy of the third party administrator's written notice of their review decision;
4. a letter to DSGI appealing the decision; and
5. any other information or documentation you think is appropriate.

Mail your written appeal to DSGI at:

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

Any Level II Appeal received without, at a minimum, the information requested above, will be returned to you or your representative submitting the appeal.

Requesting an Administrative Hearing

If you want to contest the second appeal decision, you must submit a petition for an administrative proceeding that complies with section 28-106.201 or 28-106.301, *Florida Administrative Code*. Your petition must be received within 21 days after you received the written decision on your second appeal.

Section 13: Coordinating Benefits with Other Coverage

Coordination with Other Group Insurance Plans

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

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

1. an employer;
2. the trustees of a fund established by an employer or by several employers;
3. employers for one or more unions according to a collective bargaining agreement;
4. a union group; or
5. any other group to which a group master policy may be legally issued in the State of Florida or any other jurisdiction for the purpose of insuring a group of individuals.

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

In order to ensure claims processing accuracy and appropriate coordination of benefits, DSGI requires that BCBSF verify if you, your spouse, or your other dependents have other insurance coverage or other carrier liability (OCL). Each year, approximately 365 days from the previous verification, you will be notified by BCBSF, in writing, that you should contact its office, by mail telephone (800-477-3736, ext. 34743), or BCBSF’s website at www.bcbsfl.com to verify

OCL information. BCBSF will automatically process or reprocess any claims, which may have been denied or suspended, once you have provided the requested OCL information.

How Coordination Works

The plan that considers expenses first is the primary plan. The plan that considers expenses after the primary plan pays benefits is the secondary plan.

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

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

For All Covered Individuals

1. The plan covering a person as an employee or member, rather than as a dependent, pays first.
2. The plan covering a person as an active employee, or that employee’s dependent, pays before the plan that covers a person as a laid-off or retired employee, or that employee’s dependent. In a case where the other policy or plan does not have this rule and the plans do not agree on the order of benefits, this rule will not apply.

For Eligible Dependent Children

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

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

...unless a court decrees otherwise.

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

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

Coordination with Medicare

It is important for you or your dependents to enroll for Medicare coverage when you first become eligible.

Active Employees

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

For active employees with a dependent who is disabled for reasons other than end-stage renal disease, this Plan will pay benefits first for the disabled dependent until he or she reaches age 65. At age 65, Medicare becomes the primary plan and

will pay benefits first for any disabled dependent other than the spouse. If the disabled dependent is your spouse, your spouse's coverage under this Plan will continue to be primary, paying benefits first, as long as you are an active employee.

If you or your covered dependent requires treatment for end-stage renal disease, this Plan will pay benefits first for the first 30 months of treatment and Medicare will pay second. After that, Medicare will pay benefits first and this Plan will pay benefits second. If you become eligible for Medicare because of age or disability, before becoming eligible due to end-stage renal disease, however, Medicare would continue to pay first as your primary carrier and this Plan would pay second.

Retired Employees

If you are a retiree, the spouse of a retiree, or the surviving spouse of a retiree enrolled in Medicare, Medicare will pay benefits for you first. This Plan will pay benefits second. If you are eligible for Medicare Parts A and B but you have not enrolled, benefits from this Plan will still be paid as if Medicare had paid first as the primary plan.

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

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

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

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

...whichever is less.

Here are two examples showing how coordination of benefits with Medicare works. In both examples,

assume that the provider accepts Medicare assignment, meaning the provider agrees to accept the Medicare allowance as full payment and will not bill the patient for any amount above the Medicare allowance.

Example 1 – Network Office Visit – Standard PPO Option

Assume you go to the doctor for an office visit that includes an x-ray.

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

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

Next, Medicare benefits are calculated.

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

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

Example 2 – Non-network Office Visit – Standard PPO or Health Investor Option

For this example, assume the person goes to the doctor for minor surgery and lab work.

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

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

Next, Medicare benefits are calculated.

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

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

An Important Note for Retirees

If you are not yet eligible for Medicare but your spouse is, the provider will file claims for your spouse directly to Medicare. Once your spouse receives the Explanation of Medicare Benefits statement showing that the claim has been processed by Medicare, your spouse then must file a separate claim with BCBSF until you, the retiree and former employee of the State of Florida, become eligible for Medicare.

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

Coordination of Prescription Drug Benefits with Medicare Part B:

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

Medicare Part B requires that the retail or mail order pharmacy obtain a signed Assignment of Benefits/Medical Release Authorization form from you prior to accepting any claims for eligible prescription drugs. Since some drugs are only eligible under Medicare Part B for specific diagnoses, Medicare Part B requires that each prescription include a written diagnosis. There may be other situations when Medicare Part B requires additional specific documentation before accepting a prescription drug claim for payment. In most cases, Medicare Part B will only accept claims for a prescription fill up to a 30-day dosage. Generally, Medicare eligible items are covered under Medicare Part B and are subject to the Medicare calendar year deductible.

Using a Mail Order Pharmacy:

1. All appropriate documentation must be on file or presented with the prescription as appropriate.
2. You must mail the prescription, with the appropriate diagnosis, to Caremark along with 20% of the Medicare Part B allowed amount. Keep in mind, you will be allowed to file a claim for secondary carrier benefits under this Plan after Medicare Part B processes your claim.
3. Caremark will fill the prescription, within all appropriate prescription guidelines, and file a claim to Medicare Part B on your behalf.
4. You will receive an Explanation of Medicare Benefits (EOMB) after Medicare Part B processes the claim indicating Medicare's

payment, amount applied to the deductible, and your responsibility.

5. Now you can submit a claim to Caremark for secondary carrier benefits under this Plan. Attach a copy of the Medicare Part B EOMB to a claim form and mail to Caremark. Caremark will process the claim for secondary payment consideration and reimbursement, if applicable. In most cases, after this Plan has paid secondary carrier benefits and Medicare Part B has paid primary benefits, you will have zero out of pocket expense.

Using a Participating Medicare Part B Retail Pharmacy

1. All appropriate documentation must be on file or presented with the prescription as appropriate.
2. You must present the prescription, with the appropriate diagnosis, to the participating Medicare Part B retail pharmacy along with 20% of the Medicare Part B allowed amount. Keep in mind, you will be allowed to file a claim for secondary carrier benefits under this Plan after Medicare Part B processes your claim.
3. The Participating Medicare Part B Retail Pharmacy will fill the prescription, within all appropriate prescription guidelines, and file a claim to Medicare on your behalf.
4. You will receive an Explanation of Medicare Benefits (EOMB) after Medicare Part B processes the claim indicating Medicare Part B's payment, amount applied to the deductible, and your responsibility.
5. Now you can submit a claim to Caremark for secondary carrier benefits under this Plan. Attach a copy of the Medicare Part B EOMB to a claim form and mail to Caremark. Caremark will process the claim for secondary payment consideration and reimbursement, if applicable. In most cases, after this Plan has paid secondary carrier benefits and Medicare Part B has paid primary benefits, you will have zero out of pocket expenses.

Using a Non-Participating Medicare Part B Retail Pharmacy

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

Coordination of Prescription Drug Benefits with Medicare Part D

If you enroll in or are automatically enrolled in a Medicare Part D Prescription Drug Plan, then this Plan will pay as your secondary prescription coverage. The Medicare Part D Plan will pay as your primary prescription coverage.

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

If you are receiving State or Federal assistance, you might be automatically enrolled in a Medicare Part D Plan without your knowledge. If you were enrolled in a Medicare Advantage Plan through previous insurance coverage, you were automatically enrolled in a Medicare Part D Plan. If you elected or were automatically enrolled in a Medicare Part D Plan, it is your responsibility to opt out or disenroll from such Medicare Part D coverage. If you elect to disenroll, you must contact the Medicare Part D Plan that you are enrolled in, or contact Medicare at 1-800-663-4227

IMPORTANT NOTE: Medicare automatically notifies the State of Florida of any of its Plan members that are enrolled in a Medicare Part D

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

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

State's Right of Subrogation and Reimbursement

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

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

In addition to its right of subrogation, the State has the right to be reimbursed in full, and in first priority, by you or your dependents (out of any judgment or settlement proceeds that may be obtained) for any benefits paid under the Plan in connection with a condition caused, directly or indirectly, by an intentional act or from the negligence or fault of any third person or entity.

These rights of subrogation and reimbursement apply to any judgment or settlement of a claim, regardless of whether there is a lawsuit, and will not be offset by any premiums that have been paid under the Plan. These rights extend to benefits which may be payable through any type of insurance coverage, including, but not limited to, uninsured/underinsured motorist's coverage.

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

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

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

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

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

Section 15: Definitions

Here are definitions of selected terms used by this Plan.

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

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

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

Acupuncturist...a person who is legally qualified and licensed to perform acupuncture.

Ambulance...any licensed land, air or water vehicle designed, constructed, or equipped for and used for transporting persons in need of medical or surgical attention.

Ambulatory surgical center...a facility:

1. licensed by the appropriate state agency to provide elective surgical care;
2. to which the patient is admitted and discharged within the same working day; and
3. that is not part of a hospital.

A facility existing mainly for performing abortions, an office maintained by a doctor for the practice of medicine or an office maintained for the practice of dentistry is not an ambulatory surgical center.

Birth center...any facility, institution or place where births are planned to occur following a normal, uncomplicated, low risk pregnancy. The facility must be licensed under state law. A facility is not considered a birth center if it is an ambulatory surgical center, a hospital or part of a hospital.

Child Preventive Care Services...doctor-delivered or doctor-supervised services that include a history, a developmental assessment and anticipatory guidance, and appropriate immunizations and

laboratory tests based on prevailing medical standards under the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

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

Complications of pregnancy...complications of pregnancy include:

1. conditions not related to pregnancy but adversely affected by pregnancy;
2. conditions caused by pregnancy, like acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
3. non-elective Cesarean section;
4. ectopic pregnancy which is terminated; and
5. spontaneous termination of pregnancy that occurs before the twenty-second week.

Complications of pregnancy do not include:

1. false labor;
2. occasional spotting;
3. physician-prescribed rest during pregnancy;
4. morning sickness;
5. hyperemesis gravidarum; or
6. pre-eclampsia and similar conditions associated with a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Condition...any disease, illness, injury, accident, bodily dysfunction, pregnancy, drug addiction, alcoholism or mental or nervous disorder.

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

Covered services and supplies...healthcare services and supplies, including pharmaceuticals and chemical compounds, for which reimbursement is covered under this Plan. The Division of State Group Insurance (DSGI) has final authority to determine if a service or supply is covered, limited or excluded by the Plan.

Custodial care or services...care or services that are maintenance in nature that serve to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered or administered by a trained home care giver. Custodial care essentially is care that does not require the continuing attention of trained medical or paramedical personnel and that can be provided by or taught to home caregivers. In determining whether a person is receiving custodial care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

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

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

Dialysis center...an outpatient facility certified by the US Health Care Financing Administration and the Florida Agency for Health Care Administration to provide hemodialysis and peritoneal dialysis services and support.

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

Durable Medical Equipment (DME) provider...a person or entity licensed under state law to provide home medical equipment, oxygen therapy services or dialysis supplies in the patient's home under a physician's prescription.

Doctor/Physician...a doctor of medicine (M.D.), doctor of osteopathy (D.O.), doctor of surgical chiropody (D.S.C.) or doctor of podiatric medicine (D.P.M.), who is legally qualified and licensed to practice medicine and perform surgery at the time and place the service is rendered. Doctor also means:

1. a licensed dentist who performs surgical or non-dental procedures covered by this Plan, or provides treatment of injuries resulting from accidents;
2. a licensed optometrist who performs procedures covered by this Plan;
3. a licensed psychologist or licensed mental health professional, as defined by state law, who provides covered services; and
4. a licensed chiropractor that performs procedures covered by this Plan.

To be considered a doctor/physician by this Plan, any healthcare professional must be providing covered services that are within the scope of his or her professional license.

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

1. cannot be lawfully marketed without approval of the US Food and Drug Administration or the Florida Department of Health, and approval for marketing in the United States has not been given at the time the service is provided to the covered person; or
2. is the subject of ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or is under study to determine the maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the condition; or

3. is generally regarded by experts in the United States as requiring more study to determine maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the condition; or
4. has not been proven safe and effective for treatment of the condition based on the most recently published medical literature of the United States, Canada or Great Britain using generally accepted scientific, medical or public health methodologies or statistical practices; or
5. is not accepted in consensus by practicing doctors in the United States as safe and effective for the condition; or
6. is not regularly used by practicing doctors in the United States to treat patients with the same or a similar condition.

BCBSF and DSGI determine whether a service or supply is experimental or investigational.

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

Home health aide...a person legally certified under state law as having completed an approved course of study and employed by a state-licensed institution or agency.

Home healthcare agency...an agency or institution licensed by the appropriate state agency to provide an approved plan of service for people who are confined and convalescing at home instead of in the hospital. A home healthcare agency may operate independently or as part of a hospital. Organizations or other persons providing home hemodialysis services are not home healthcare agencies.

Hospice...an autonomous, centrally administered, nurse-coordinated program providing home, outpatient and inpatient care for a covered person who is terminally ill and members of that person's family. At a hospice, a team of healthcare providers assists in providing palliative and supportive care to meet the special needs arising during

the final stages of illness, and during dying and bereavement. This team of providers includes a doctor and nurse and may also include a social worker, a clergy member or counselor and volunteers.

Hospital...a licensed institution providing medical care and treatment to a patient as a result of illness, accident or mental or nervous disorders on an inpatient/outpatient basis and that meets all the following:

1. It is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities. Licensed institutions in rural, sparsely populated geographic regions, however, may not be required to be accredited.
2. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed doctors. A facility may be considered a hospital if it does not have major surgical facilities but provides primarily rehabilitative services for treatment of physical disability.
3. It continuously provides 24-hour-a-day nursing service by or under the supervision of registered nurses.

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

Illness...physical sickness or disease, pregnancy, bodily injury or congenital anomaly. For this Plan, illness includes any medically necessary services related to non-emergency surgical procedures performed by a doctor for sterilization.

Independent clinical laboratory...a facility properly licensed under state law where human materials or specimens are examined for the purpose of diagnosis, prevention or treatment of a condition.

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

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

Massage therapist...a person licensed under Florida law to practice massage therapy.

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

Medically necessary...services required to identify or treat the illness, injury, condition, or mental and nervous disorder a doctor has diagnosed or reasonably suspects. The service must be:

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

The fact that a service is prescribed by a doctor does not necessarily mean that the service is

medically necessary. BCBSF and DSGI determine whether a service or supply is medically necessary.

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

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

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

Midwife...a person licensed under state law to assist in childbirth. A nurse midwife has received special training in obstetrics and is qualified to deliver infants.

Network allowed amount (allowed amount)...the maximum amount this Plan will approve for covered services and supplies received from a covered provider who is a member of BCBSF's PPCSM preferred provider organization network.

Network provider...covered providers who are members of BCBSF's PPCSM Network, or members of another Blue Cross and/or Blue Shield Plan's preferred provider network available to covered individuals under the rules of the BlueCard[®] Program.

Non-network allowance (allowance)...the maximum amount this Plan will approve for covered services and supplies received from a covered provider who is not a member of the preferred provider organization network.

Non-network provider...covered providers who are not members of BCBSF's PPCSM Network or another Blue Cross and/or Blue Shield Plan under the BlueCard[®] Program.

Nurse anesthetist...a registered nurse who administers anesthesia to patients in the operating and delivery room. Anesthesia causes partial or complete loss of sensation and is usually administered by injection or inhalation.

Outpatient healthcare facility...a licensed facility other than a doctor's, physical therapist's or midwife's office that provides outpatient services for treatment of an illness or accident, other than mental or nervous disorders, drug addiction or alcoholism.

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

1. any charge paid under this Plan for a covered service and/or supply when such service or supply is not received by the covered participant;
2. any charge by a covered provider for a covered service or supply which is paid under this Plan and exceeds the amount previously agreed to by the provider, in writing, to furnish the participant such service or supply; however, in no case shall an overcharge include any amount above the Plan's allowed amount or allowance for such service or supply nor shall it include any additional charges resulting from complications or other medically necessary procedures which were not previously apparent; or
3. any amount paid under this Plan because of a billing error by a covered provider.

Payment for Hospital Services (PHS)

Providers...providers not in the Preferred Patient CareSM Network but who have a hospital services agreement with BCBSF to provide services, as BCBSF PHS providers, at a negotiated fee. These providers are also called BCBSF Traditional Program participating providers.

Payment for Professional Services (PPS)

Provider...providers not in the Preferred Patient CareSM Network but who have a provider agreement with BCBSF to provide services, as BCBSF PPS providers, at a negotiated fee. These providers are also called BCBSF Traditional Program participating providers.

Palliative care...reduction or abatement of pain and other troubling symptoms through services provided by members of the hospice team of healthcare providers.

Physical therapist...a person licensed under Florida law to engage in the practice of physical therapy.

Physician assistant...a specially trained individual licensed under state law to perform tasks ordinarily done by a physician. Physician assistants work under the supervision of a physician.

Preferred Patient CareSM Network (PPCSM)...a registered trademark name for BCBSF's preferred provider organization network.

Primary care physician...any covered physician with a primary practice in Family Practice, General Practice, Internal Medicine, or Pediatric Medicine.

Prosthetist/Orthotist...a person or entity licensed under state law to provide services for the design and construction of medical devices such as braces, splints and artificial limbs under a physician's prescription.

Registered dietician...a person who is legally certified to provide nutrition counseling for diabetes outpatient self-management services.

Registered nurse (RN) or licensed practical nurse (LPN)...a person licensed under state law to practice nursing.

Registered nurse first assistant...a registered nurse who works with a surgeon and has specific knowledge and training in surgical practices.

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

Skilled nursing facility...a licensed institution, or a distinct part of a hospital, primarily engaged in providing to inpatients:

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

Specialty physician or specialist...any covered health care provider not considered a primary care physician.

Specialty facility or residential facility...a licensed facility providing an inpatient rehabilitation program for the treatment of alcohol or drug abuse or mental or nervous conditions. The program must be accredited by the Joint Commission of the Accreditation of Hospitals (JCAH) and licensed by the Department of Children and Family Services. Specialty and residential facilities may also provide outpatient rehabilitation services.

Terminally ill...means a person has a life expectancy of six months or less because of a chronic, progressive illness that is incurable according to the person's doctor.

Traditional Program Providers...providers that are not in the Preferred Patient CareSM (PPCSM) network but that have participation agreements with BCBSF and have been designated by BCBSF as Traditional Program providers, including PPS and PHS providers.

Section 16

Notices

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, includes virtually all individually identifiable health information held by plans, whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for the State of Florida's Flexible Spending Account, and discusses administrative activities performed by the State for the State of Florida Employees' Group Health Self-Insurance Plan (the self-insured Plan) and for insurance companies and HMOs in the State Group Insurance Program (the insured Plans).

The Plans covered by this notice, because they are all sponsored by the State of Florida for its employees, participate in an "organized health care arrangement". The Plans may share health information with each other to carry out Treatment, Payment, or Health Care Operations (defined below).

The Plans' duties with respect to health information about you

The Plans are required by law to maintain the privacy of your health information and to provide you with a notice of the Plans' legal duties and privacy practices with respect to your health information. Participants in the self-insured Plan will receive notices directly from BlueCross Blue Shield of Florida (BCBSF), and Caremark (which provide third-party medical and pharmacy support to the self-insured Plan); the notices describe how BCBSF and Caremark will satisfy the requirements. Participants in an insured Plan option will receive similar notices directly from their insurer or HMO.

It's important to note that these rules apply only with respect to the health 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 activities, and Health Care Operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. 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, other 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 the HIPAA rules. The Plans may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plans may share your health information with the State

The Plans will disclose your health information without your written authorization to the State for Plan administration purposes. The State needs this health information to administer benefits under the Plans. 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 if requested, 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

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.

The Plans are also allowed to use or disclose your health information without your written authorization for uses and disclosures required by law, for public health activities, and other specified situations, including:

1. Disclosures to Workers’ Compensation or similar legal programs, as authorized by and necessary to comply with such laws.
2. Disclosures related to situations involving threats to personal or public health or safety.
3. Disclosures related to situations involving judicial proceedings or law enforcement activity.
4. Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
5. Disclosures related to organ, eye or tissue donation, and transplantation after death
6. Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances by researchers regarding necessity of using your health information and treatment of the information during a research project.
7. Certain disclosures related to health oversight activities, specialized government or military functions and US Department of Health and Human Services investigations.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. 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 Plan has 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 Flexible Spending Account and for the State activities relating to the self-insured Plan and insured Plans. Contact Division of State Group Insurance, PO Box 5450, Tallahassee, FL 32314-5450 to obtain any necessary forms for exercising your rights. The notices you receive from BCBSF, Caremark, and your insurer or HMO (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 Plan's 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. And 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:

1. The access or copies you requested;
2. 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
3. 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:

1. Make the amendment as requested;
2. Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
3. 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, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

1. For Treatment, Payment, or Health Care Operations;
2. To you about your own health information;
3. Incidental to other permitted or required disclosures;
4. Where authorization was provided;
5. To family members or friends involved in your care (where disclosure is permitted without authorization);
6. For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
7. 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 (1) 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 have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plans 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 takes effect on April 14, 2003. However, the Plans reserve the right to change the terms of its 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 changes are made to a Plan's privacy policies as described in this notice, you will be provided with a revised Privacy Notice through posting on the DSGI website, or mailed to your last known home address.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plans and to the US Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. Complaints about activities by your insurer or HMO, or by BCBSF or Caremark, can be filed by following the procedures in the notices they provide. To file other complaints with the Plans, contact DSGI for a complaint form. It should be completed, to include a description of the nature of the particular complaint, and mailed to Division of State Group Insurance, PO 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 Division of State Group Insurance at PO Box 5450, Tallahassee, FL 32314-5450.

Notice About Medicare Prescription Drug Coverage

Name of Entity: State Group Health Insurance Program / State of Florida, Department of Management Services

Contact: People First Service Center (866) 663-4735

Date: September 1, 2006

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.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The State of Florida Department of Management Services has determined that the prescription drug coverage offered by the State Employees' Health Insurance Program (State Health Program) is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. As such, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your State Health Program coverage, be aware that you and your dependents will be dropping your hospital, medical and prescription drug coverage. **If you choose to drop your State Health Program coverage, you will NOT be able to enroll back in the State Health**

Program unless a special Open Enrollment period for non-enrolled State of Florida retirees is mandated by the Florida Legislature.

Your State Health Program covers hospital and medical services in addition to prescription drug. If you enroll in a Medicare prescription drug plan and you DO NOT drop your State Health Program coverage, you and your eligible dependents will still be eligible to receive all of your current health and prescriptions drugs benefits.

You should also know that if you drop or lose your coverage with the State Health Program and don't 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.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll. Additional information about Medicare prescription drug plans is available from:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage, contact People First Service Center at 1-866-663-4735.

NOTE: You may receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if your coverage under your State Health Programs changes. **Keep this notice.** If you enroll in one of the new plans approved by Medicare that offers prescription drug coverage, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

