Plan Document and Summary Plan Description
for
State of Florida Employees'
Group Insurance Program
Health Maintenance Organization (HMO) Plan

- **STANDARD HEALTH PLAN**
- **HEALTH INVESTOR HEALTH PLAN**

Effective: January 1, 2014

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SERVICE AREAS AND WHO TO CALL FOR INFORMATION

HMO CORPORATE OFFICE
Coventry Health Care of Florida, Inc.
1340 Concord Terrace
Sunrise, Florida 33323

HMO MEMBER SERVICES - ALL AREAS
1-866-575-1875

HMO SERVICE AREA

Broward
Dade
Escambia
Hendry
Madison
Palm Beach
Santa Rosa
St. Lucie

If you need information about…	**Contact…**
Medical benefits or claims under the HMO Plan, or finding a medical Network Provider within the State of Florida	**HMO MEMBER SERVICES** 1-866-575-1875
Pre-Admission Hospital Certification*	1-800-447-3725
Prescription drug program information	Express Scripts (877) 531-4793 http://www.express-scripts.com/ **For paper claims only:** Express Scripts Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512
Enrollment, eligibility, or changing coverage People First	(866) 663-4735 https://peoplefirst.myflorida.com/logon.htm
Medicare eligibility and enrollment	The Social Security Administration office in your area

* Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

I. INTRODUCTION

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 Plan Document and Summary Plan Description (also called Plan Booklet and Benefits Document.) Your coverage cannot be changed based upon statements or representations made to you by anyone, including employees of the Division of State Group Insurance (DSGI), this HMO plan, Express Scripts, People First or your employer. This document is a Summary Plan Description (SPD) of the medical benefits provided to you by the State of Florida under the State Employees' Group Health Maintenance Organization Plan (hereinafter, the 'Plan'). This Summary Plan Description (SPD) is made available for your reference and is subject to various legal requirements, including the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The State Employees' HMO 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. Unless otherwise noted in this document, if the terms of this document and the terms of the Plan conflict, the Plan document shall control.

The State of Florida may designate any other third-party administrators or claims administrators to carry out certain Plan duties and responsibilities. The State of Florida is responsible for formulating and carrying out all rules and procedures necessary to administer the Plan. The State of Florida, as Plan Sponsor, has the discretionary authority to (1) make decisions regarding the interpretation or application of Plan provisions (2) determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan (3) review claims under the Plan. The State of Florida may delegate to a third party any or all such discretionary authority described above. Benefits under the Plan will be paid only if the State of Florida, as Plan Sponsor, or its designee or delegate decides in its discretion that the Participant is entitled to them.

This HMO, in arranging for the delivery of Medical Services or benefits, does not directly provide these Medical Services or benefits. This HMO arranges for the provision of said services in accordance with the covenants and conditions contained in this Summary Plan Description.

This HMO benefit 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 (if applicable, e.g., HIHP Plan);
2. Copayments;
3. Coinsurance (as applicable and is a percentage of the Network Allowed Amount for the service provided);
4. Admission fees;
5. Non-covered services;
6. Amounts above or beyond the Plan's limitations;
7. Penalties for not certifying Hospital admissions or stays in a non-network Hospital; and
8. Non-emergency services in a non-network hospital, facility or office unless authorized in advance by the HMO, not the Primary Care Physician (i.e., anesthesiology, nurse anesthetists, radiology, pathology, laboratory, and/or emergency room physician services.)

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

The State of Florida has contracted with this HMO to arrange for the provision of Medical Services or benefits which are Medically Necessary for the diagnosis and treatment of Participants through a network of contracted independent physicians and Hospitals and other health care providers.

In arranging for the delivery of Medical Services or benefits, the HMO does not directly provide these Medical Services or benefits. The HMO arranges for the provision of said services in accordance with the covenants and conditions contained in this Summary Plan Description

You Must Enroll to Receive Benefits! You must affirmatively enroll to receive benefits under the Plan, as explained in the section within this document titled 'Eligibility, Enrollment and Effective Date'. If you do not take the actions outlined in this document to affirmatively enroll to receive benefits, you will **not** be entitled to any benefits of any kind under this Plan.

Medical Claims

The Plan is not intended to and does not cover or provide any Medical Services or benefits that are not Medically Necessary for the diagnosis and treatment of the Participant. The determination as to which services are Medically Necessary shall be made by the HMO, subject to the terms and conditions of the Plan. Claims for benefits are to be sent to this HMO.

Sometimes medical providers make a mistake and over charge for the service. Please report any suspected billing errors to the HMO.

Prescription Drug Claims

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

The Medical and Hospital Services covered by the Plan shall be provided without regard to the race, color, religion, physical handicap, or national origin of the Participant in the diagnosis and treatment of patients; in the use of equipment and other facilities; or in the assignment of personnel to provide services, pursuant to the provisions of Title VI of the Civil Rights Act of 1964, as amended, and the Americans with Disabilities Act of 1990.

If you have questions about your coverage after reading this booklet, you may call any of the telephone numbers listed on the WHO TO CALL FOR INFORMATION section at the beginning of this document and talk with a member service representative.

Important - Timely Filing of Claims

All claim forms must be submitted within 12 months after the date of service. Otherwise, we will not pay any benefits for that eligible expense or benefits will be reduced as determined by State of Florida. For inpatient stays, the date of service is the date your inpatient stay ends. This 12-month requirement does not apply if you are legally incapacitated.

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

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

PATIENT PROTECTION NOTICE

Members are not required to select a Primary Care Physician (PCP). However Coventry encourages each Member to select a PCP to be responsible for providing and managing their primary health care. The Member has the right to change his/her PCP. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her PCP. For a list of Participating Primary Care Physicians, contact the HMO at the Customer Service number printed on your ID card or visit their website identified in the contact section within this document.

II. DEFINITIONS

As used in this Summary Plan Description (SPD), each of the following terms shall have the meaning indicated:

Accidental Dental Injury means an injury to sound natural teeth caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental and/or investigational or not Medically Necessary; and including a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Applied behavior analysis services shall be provided by an individual certified pursuant to Section 393.17, *Florida Statutes*, or an individual licensed under Chapter 490 or Chapter 491, *Florida Statutes*.

Attending Physician means the Participating Physician primarily responsible for the care of a Participant with respect to any particular injury or illness.

Autism Spectrum Disorder means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic disorder;
- Asperger's syndrome;
- Pervasive developmental disorder not otherwise specified.

Claim means a request for benefits under the Plan made by a Participant in accordance with the HMO's procedures for filing benefit claims, including Pre-Service Claims and Post-Service Claims.

Claimant means a Participant or a Participant's authorized representative acting on behalf of the Participant. The HMO may establish procedures for determining whether an individual is authorized to act on behalf of the Participant. If the Claim is an Urgent Care or Pre-Service Claim, a Health Professional, with knowledge of the Participant's medical condition, shall be permitted to act as the Participant's authorized representative and will be notified of all approvals on the Claimant's behalf. In the event of an Adverse Benefit Determination, the HMO will notify both the Participant and the Heath Professional.

Co-insurance means the amount a Participant must pay once the Deductible has been met, if applicable, and is expressed as a percentage of the contracted rate for the covered benefit.

Concurrent Care means an ongoing course of treatment to be provided over a period of time or number of treatments that was previously approved by the HMO.

Contract Year means the period of 12 consecutive months commencing on the effective date of the Plan.

Benefit Period, however, refers to a calendar year of January 1st through December 31st. Such Benefit Period will terminate on the earliest of the following dates:

- the last day of each calendar year; or
- the day the Participant ceases to be covered for health care benefits under the Plan.

Copayment means the portion of the cost, in addition to the prepaid premium amounts, which the Participant is required to pay at the time certain health services are provided under the Plan. The Copayment may be a specific dollar amount or a percentage of the cost. The Participant is responsible for the payment of any Copayments directly to the provider of the health services at the time of service.

Covered Dependent means any dependent of a Covered Employee's family who meets all applicable requirements of the Plan and is enrolled in the Plan.

Covered Employee means an employee of the State of Florida who meets all of the applicable requirements of the Plan and is enrolled in the Plan. Covered Employee may also be referred to herein as 'subscriber.'

Custodial Care means services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking and taking oral medications. 'Custodial Care' also means services and supplies that can be safely and adequately provided by persons other than licensed health professionals, such as dressing changes and catheter care, or that ambulatory patients customarily provide for themselves, such as ostomy care, administering insulin and measuring and recording urine and blood sugar levels.

Deductible means the first payments up to a specified dollar amount which a Participant must make in the applicable calendar year for covered benefits. The Deductible applies to each Participant, subject to any family Deductible listed on the Schedule of Benefits. For purposes of the Deductible, 'family' means the Covered Employee and Covered Dependents. The Deductible must be satisfied once each calendar year.

Dental Care means dental x-rays, examinations and treatment of the teeth or any services, supplies or charges directly related to:

- the care, filling, removal or replacement of teeth, or
- the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, that are customarily provided by dentists (including orthodontics reconstructive jaw surgery, casts, splints and services for dental malocclusion).

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

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or fetus.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman:

- That there is inadequate time to effect safe transfer to another Hospital prior to delivery;
- That a transfer may pose a threat to the health and safety of the patient or fetus; or

- That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Examples of Emergency Medical Conditions include, but are not limited to: heart attack, stroke, massive internal or external bleeding, fractured limbs or severe trauma.

Emergency Medical Services and Care means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the Hospital.

Employer means State of Florida, Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL 32314-5450. The Employer may also be referred to herein as the 'Plan Administrator'.

In-area emergency does not include elective or routine care, care of minor illness or care that can reasonably be sought and obtained from the Participant's Primary Care Physician. The determination as to whether or not an illness or injury constitutes an emergency shall be made by the HMO and may be made retrospectively based upon all information known at the time the patient was present for treatment.

Out-of-area emergency does not include care for conditions for which a Participant could reasonably have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area. The determination as to whether or not an illness or injury constitutes an emergency shall be made by the HMO and may be made retrospectively based upon all information known at the time the patient was present for treatment.

Essential Health Benefits means any or all of the following, to the extent they may be provided by the Plan:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative services and devices
- laboratory services;
- preventive and wellness services and chronic disease management;
- pediatric services, including oral and vision care; and
- any additional health benefits defined as constituting Essential Health Benefits in regulations or other binding guidance issued by the Secretary of Health and Human Services.

Exclusion means any provision of the Plan whereby coverage for a specific hazard or condition is entirely eliminated.

Experimental and/or Investigational. For the purposes of this Plan a medication, treatment, device, surgery or procedure may be determined by the HMO in its discretion, to be Experimental and/or Investigational if any of the following applies:

- The FDA has not granted the approval for general use; or
- There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

- There is no consensus among practicing physicians that the medication, treatment, therapy, procedure or device is safe or effective for the treatment in question or such medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or a similar condition; or
- Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.

Full-Time Student or Part-Time Student means one who is attending a recognized and/or accredited college, university, vocational, or secondary school and is carrying sufficient credits to qualify as a Full-Time or Part-Time Student in accordance with the requirements of the school.

Group Health Insurance (for purposes of Coordination of Benefits section within this document) means that form of health insurance covering groups of persons under a master Group Health Insurance policy issued to any one of the groups listed in Sections 627.552 (employee groups), 627.553 (debtor groups), 627.554 (labor union and association groups), and 627.5565 (additional groups), *Florida Statutes*.

- The terms 'amount of insurance' and 'insurance' include the benefits provided under a plan of self-insurance.
- The term 'insurer' includes any person, entity or governmental unit providing a plan of self-insurance.
- The terms 'policy', 'insurance policy', 'health insurance policy' and 'Group Health Insurance policy' include plans of self-insurance providing health insurance benefits.

Health Professionals means physicians, osteopaths, podiatrists, chiropractors, physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health care services, who are licensed and practice under an institutional license, individual practice association or other authority consistent with State law and who are Participating Providers of the HMO.

Home Health Care Services (Skilled Home Health Care) means services that are provided for a Participant who does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under the Plan. A visit is limited to a period of two hours or less.

Hospice means a public agency or private organization that is duly licensed by the State to provide Hospice services and with whom the HMO has a current provider agreement. Such licensed entity must be principally engaged in providing pain relief, symptom management and supportive services to terminally ill Participants.

Hospital means any general acute care facility which is licensed by the State and with which the HMO has contracted or established arrangements for inpatient Hospital Services and/or Emergency Medical Services and Care, and shall at times be referred to as a '**Participating Hospital**'.

Hospital Services (except as expressly limited or excluded by the Plan) means those services for registered bed patients that are:

- generally and customarily provided by acute care general Hospitals in accordance with the standards of acceptable community practice;
- performed, prescribed or directed by Participating Providers; and
- Medically Necessary for conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.

Hospitalist/Admitting Panelist means a physician who specializes in treating inpatients and who may coordinate a Participant's health care when the Participant has been admitted for a Medically Necessary procedure or treatment at a Hospital.

Injectable Medication means a medication that has been approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intramuscular injection, intravenous injection, intravenous infusion, subcutaneous injection, intrathecal injection, intra-articular injection, intracavernous injection or intraocular injection. Prior authorization is required for Injectable Medications.

Limitation means any provision, other than an Exclusion, which restricts coverage under the Plan.

Maximum Allowable Payment means the maximum amount that this HMO will pay for any covered service rendered by a Non-participating Provider or supplier of services, medications or supplies.

Medically Necessary means the use of any appropriate medical treatment, service, equipment and/or supply as provided by a Hospital, skilled nursing facility, physician or other provider which is necessary for the diagnosis, care and/or treatment of a Participant's illness or injury, and which is:

- consistent with the symptom, diagnosis, and treatment of the Participant's condition;
- the most appropriate level of supply and/or service for the diagnosis and treatment of the Participant's condition;
- in accordance with standards of acceptable community practice;
- not primarily intended for the personal comfort or convenience of the Participant, the Participant's family, the physician or other health care providers;
- approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Participant's condition; and
- not experimental or investigational.

Medical Office means any outpatient facility or physician's office.

Medical Services (except as limited or excluded by the Plan) means those professional services of physicians and other Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services that are:

- generally and customarily provided in the Service Area;
- performed, prescribed or directed by Participating Providers; and
- Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness.

Network means the providers and facilities that have contracted with the HMO to provide covered services to Participants. The Participants' Copayment, Deductible and/or Co-insurance responsibilities are outlined in the Schedule of Benefits.

Non-participating Provider means any Health Professional or group of Health Professionals, Hospital, Medical Office or Other Health Care Facility with whom this HMO has neither made arrangements nor contracted to render the professional health services set forth herein as a Participating Provider.

Other Health Care Facility(ies) means any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services such as skilled nursing care and rehabilitative services, with which this HMO has contracted or established arrangements for providing these services to Participants.

Participant means any Covered Employee or Covered Dependent as described in the Definitions section of this SPD.

Participating Physician means any Participating Provider licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*.

Participating Provider means any Health Professional (or group of Health Professionals), Hospital, Medical Office or Other Health Care Facility with whom this HMO has made arrangements or contracted to render the professional health services set forth herein, and at times shall be referred to as 'Plan Provider'.

Plan Administrator see Employer.

Post-Service Claim means any Claim for benefits under the Plan that is not a Pre-Service Claim.

Pre-Service Claim means any Claim for benefits under the Plan for which (in whole or in part), a Participant must obtain authorization from this HMO in advance of such services being provided to or received by the Participant.

Primary Care Physician means any Participating Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, or any specialty physician from time to time designated by this HMO as a 'Primary Care Physician' in this HMO's current list of physicians and Hospitals.

Private Duty Nursing means services provided by registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular Participant by arrangements between the Participant and the private-duty nurse or attendant. Such persons are engaged or paid by an individual Participant or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the Participant for reimbursement for such services.

Relevant Document means any documentation that:

- was relied upon in making a benefit determination;
- was submitted, considered or generated in the course of making a benefit determination, without regard to whether it was relied upon in making the determination;
- demonstrates compliance with the Plan's administrative process; and
- constitutes a statement of policy or guidance with respect to the Plan concerning the Adverse Benefit Determination for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

Service Area means those counties in the State of Florida where this HMO has been approved to conduct business by the Agency for Health Care Administration (AHCA).

Sound Natural Tooth means a tooth that is whole or properly restored (restoration with amalgams only) and is not in need of the treatment provided for any reason other than an Accidental Dental Injury. For purposes of this Plan, a tooth previously restored with a crown inlay, onlay or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Specialty Health Care Physician means any Participating Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, other than the Participant's Primary Care Physician.

Total Disability means a totally disabling condition resulting from an illness or injury which prevents the Participant from engaging in any employment or occupation for which he may otherwise become qualified by reason of education, training or experience, and for which the Participant is under the regular care of a physician.

Urgent Care Claim means any Claim for medical care or treatment that could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain

that cannot be adequately managed without the care or treatment requested. Generally, the determination of whether a Claim is an Urgent Care Claim shall be made by an individual acting on behalf of the HMO applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Participant's medical condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.

Urgent Medical Condition means a medical condition manifesting itself by acute symptoms that are of lesser severity than that recognized for an Emergency Medical Condition, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the illness or injury to place the health or safety of the Participant or another individual in serious jeopardy, in the absence of medical treatment within 24 hours. Examples of Urgent Medical Conditions include, but are not limited to: high fever, dizziness, animal bites, sprains, severe pain, respiratory ailments and infectious illnesses.

Urgent Medical Services and Care means medical screening, examination and evaluation in an ambulatory setting outside of a hospital emergency department, including an Urgent Care Center, Retail Clinic or PCP office after-hours, on a walk-in basis and usually without a scheduled appointment; and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

Utilization Management Program means those comprehensive initiatives that are designed to validate medical appropriateness and to coordinate covered services and supplies. These include, but are not limited to:

- concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate;
- case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a skilled nursing facility) and for outpatients when deemed appropriate; and
- the Benefit Coordination Program which is designed to conduct prospective reviews for select medical services to ensure that services are covered and Medically Necessary. The Benefit Coordination Program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.

Ventilator Dependent Care Unit means care received in any facility which provides services to ventilator dependent patients other than acute Hospital care, including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers and all other like facilities, whether maintained in a free standing facility or maintained in a Hospital or skilled nursing facility setting.

III. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

All State of Florida employees as defined in Section 110.123*2)(c), and (f), *Florida Statutes*, qualify for coverage under the active employee benefit plans described in this guide. State officers or state employees may continue to participate in the State Group Insurance Program if they 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. They must have been covered by the Program at the time of retirement and received retirement benefits immediately after retirement or maintained continuous coverage under the Program from termination until receiving retirement benefits.

Employees thinking of retirement should review the State Group Insurance Benefits Package for New Retirees, available at www.myflorida.com/mybenefits under *Forms and Publications*. Employees who do not continue health and life insurance coverage at the time of retirement will not be allowed to enroll in state health or life insurance at a later date as a retiree.

Important Reasons to Call People First, the State of Florida's third-party administrator for insurance administration

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

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

Dependents Eligible for Coverage

State Group Insurance Program subscribers may cover their eligible dependents. Subscribers must:

1. Register their dependents online in People First at https://peoplefirst.myflorida.com, and
2. Select the correct family coverage tier for each plan selected to cover dependents, and
3. Enroll each dependent in the appropriate plan, and
4. Click the *Complete Enrollment* button in People First.

In accordance with Chapter 60P, Florida Administrative Code, your dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. Eligible dependents include:

- Your legal spouse
- Your children from birth through the end of the calendar year in which they turn age 26:
    - Natural children, legally adopted children and children placed in the home for the purpose of adoption in accordance with chapter 63, *Florida Statutes*
    - Stepchildren, provided the subscriber is still married to the children's parent
    - Foster children
    - Children for whom the subscriber has established legal guardianship under chapter 744, *Florida Statutes*, or court-ordered temporary custody
    - Children with a qualified medical support order requiring the subscriber to provide coverage
- Children ages 26 to 30 as over-age dependents if:

- They are unmarried, and
- They have no dependents of their own, and
- They are dependent on the subscriber for financial support, and
- They live in Florida or attend school in another state, and
- They have no other health insurance, and
- You pay an additional monthly premium.

Over-Age Dependent (ages 26-30) Coverage is individual health coverage for an additional monthly premium. You and your eligible over-age dependents must be enrolled in the same health plan. The amount of financial support you provide determines if the monthly premium for coverage comes out of the active employee's paycheck pretax or if you must mail in payment post-tax. If you are interested in this program, please call the People First Service Center at (866) 663-4735 for more information.

- Children with permanent intellectual or physical disabilities after they reach age 26 if:
  - They are enrolled and remain covered in a State Group Insurance health plan before they turn age 26, and
  - They are unmarried, and
  - The required documentation supporting the intellectual or physical disability has been received and confirmed by the HMO prior to their 26th birthday; and
  - They are incapable of self-sustaining employment because of intellectual or physical disability, and
  - They are dependent on you for care and financial support, and
  - The treating physician provides documentation supporting the intellectual or physical disability while the dependent is still covered under the Plan. You must submit documentation to the health plan upon request for review and confirmation. Disability status is verified at least every five years. If you fail to provide the required documentation or your dependent no longer meets eligibility requirements, you may be liable for medical and prescription drug claims or premiums back to the date you enrolled your dependent.

  Subscribers who have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria may enroll that child in the Plan the **first** time they enroll in a State Group Insurance health plan.

- Dependent of a dependent – you may cover your dependent's newborn from birth up to age 18 months if:
  - The baby is born while the your dependent is covered under the Plan, and
  - The dependent remains covered under the Plan, and
  - You add the newborn within 60 days of the birth.

You may be asked to provide documentation for your eligible dependents. Failing to provide the required documentation may make you liable for medical and prescription claims or premiums back to the date of enrollment. You must fax required documentation to (800) 422-3128 or mail to People First Service Center, P.O. Box 6830, Tallahassee, Florida 32314. Please include your People First ID number on the top right corner of each page of your fax or other documentation.

Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.

When Coverage Ends

Your coverage in the Plan ends:

- When your employment is terminated. Active employees pay premiums one month in advance, so coverage ends on the last day of the month following the month they end employment. For example, if their last day of work is April 23, their coverage ends May 31 because they already paid for May coverage.
- On the last day of the month in which you do not make the required contributions for coverage, including the months when you are on leave without pay, suspension or layoff status. Payment is due the tenth of the month prior to the month of coverage. For example, payment for July coverage is due June 10.
- On the last day of the month in which you remarry, if you have coverage as a surviving spouse of an employee or retiree.

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

- Your coverage is terminated.
- You and your spouse divorce. You are required to notify People First within 60 days of the divorce.
- Your spouse dies.

Coverage for dependent children (as defined above) ends:

- On the last day of the month in which your coverage ends.
- The end of the calendar year in which the children turn 26 (30 for over-age health coverage).
- On the last day of the month the children no longer meet the definition of an eligible dependent (e.g., if you divorce the children's parent, you may no longer cover stepchildren).
- On the last day of the month in which they die.

If dependents become ineligible for coverage, you must go to the People First website to remove them from all applicable plans or call the People First Service Center at (866) 663-4735 within 60 days of the ineligibility, including for death. Service Center hours are 8 a.m. to 6 p.m. Eastern Standard Time. You must also send required documentation to People First to remove ineligible dependents from coverage (e.g., a divorce decree). Failing to provide the required documentation means you risk losing coverage or paying for more coverage than you need.

Enrolling and Making Changes

Chapter 60P, Florida Administrative Code, governs eligibility and enrollment for the State Group Insurance Program. In addition, this Program falls under Internal Revenue Code cafeteria plan guidelines. Consequently, you are required to stay in the health insurance plan you select. Per the Internal Revenue Code, you can only make changes during Open Enrollment or if you have an appropriate Qualifying Status Change event, such as a birth, marriage, or change in employment status. (Retirees may decrease or cancel coverage at any time. Those who cancel will not be allowed to reenroll as a retiree.)
Five options are available to enroll or change coverage.

Option 1 – Hired as a New Employee

Newly-hired employees have 60 days from the date of hire to enroll in State Group Insurance benefits. New employees should enroll online at peoplefirst.myflorida.com. Employees who do not enroll within 60 days of their hire date can only enroll during the next Open Enrollment period or if they experience a Qualifying Status

Change (QSC) event (see Option 2 below). New employees should choose their health insurance plan carefully. Once you make new-hire elections, you can only make changes during the next Open Enrollment unless you have an appropriate QSC event.

Coverage begins on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and continues for the rest of the calendar year, as long as you pay premiums on time and remain eligible.

For example, assume an employee is hired July 20. If People First receives the enrollment information before August 1, coverage begins September 1, after the state deducts one full month's premium from the paycheck. *For health insurance only*, new employees can elect an early effective date, provided they submit the full month's employee share by check. For example, if an employee is hired July 20, health insurance can start on August 1 if the employee sends a check for the full month's employee premium to People First and makes the election before August 1.

For OPS/variable hour employees, the earliest health coverage will start is the first day of the third month following and including the month of hire.

Option 2 – Qualifying Status Change (QSC) Event

To make an enrollment change based on a Qualifying Status Change (QSC) event, federal law requires that the event result in a gain or loss of eligibility for, and elections must meet general consistency rules. For example, if you have individual health insurance coverage and get married, you may change from individual to family coverage and enroll your spouse in coverage. However, you cannot change health insurance plans because the QSC event only changes the level of coverage eligibility. In this case, changing plans is not consistent with the nature of the QSC event.

QSC events allow you 60 days (unless otherwise noted) from the date of the event to make allowable changes to your health insurance. Depending on the type of QSC event, changes may include enrolling or cancelling, increasing or decreasing coverage, or adding or removing dependents. You may be asked to submit all required documentation to People First within 60 days of the change. The complete list of QSC events, required documentation and important time frames is available at myflorida.com/mybenefits in the *Forms and Publications* section, QSC Matrix.

If you have a QSC event and want to change your health insurance election, you must:

- Make the change online at peoplefirst.myflorida.com within 60 days of the event. If the specific QSC event is not listed, call the People First Service Center within 60 days of the event. You must make an allowable change within 60 days, unless otherwise noted, even if you do not yet have the supporting documentation.
- Provide the supporting documentation to People First (e.g., marriage license, birth certificate, divorce decree, etc.) before a change is processed.

Changes made during the year because of a QSC event are effective on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and continues for the rest of the calendar year, as long as you pay premiums on time and you and your covered dependents remain eligible.

Option 3 – Open Enrollment

Held in the fall, the annual Open Enrollment period gives you the opportunity to review available health insurance options to make any changes needed for the next plan year, which starts January 1 and goes through December 31. Any changes you make remain in effect for the entire calendar year, as long as you pay premiums on time and you and your eligible dependents remain eligible, unless you experience a QSC event.

Option 4 – Spouse Program

If both you and your spouse are active state employees, you are eligible for health insurance coverage at a reduced monthly premium. You can enroll in the Spouse Program during Open Enrollment or within 60 days of an appropriate QSC event; for example, if your spouse becomes employed full-time with the state or you marry another state employee, you are eligible to enroll. Both employed spouses must take the following steps to enroll in the Spouse Program:

- Complete and sign the Spouse Program Election Form located at myflorida.com/mybenefits in the *Forms and Publications* section and list all eligible dependents, and
- Attach a copy of your marriage license to the Spouse Program Election Form when you submit it to the People First Service Center. Include both you and your spouse's People First ID numbers on each page, and
- Enroll in the same health plan, and
- Agree to notify the People First Service Center within 60 days of becoming ineligible for the Spouse Program. The employed spouse becomes ineligible for the Spouse Program if:
    - One or both end employment with the state, including retirement, or
    - You divorce, or
    - Your spouse dies.

It is your responsibility to notify the People First Service Center if you become ineligible for the Spouse Program. Failing to do so within 60 days of one of the listed events may make you liable for claims or premiums back to the date you lost eligibility. In addition, you may have to pay for a higher level of coverage than you need; for example, you may be required to pay for family coverage instead of individual coverage. Upon notification of ineligibility for the Spouse Program, the People First Service Center adds covered, eligible dependents to the primary spouse's plan, unless otherwise requested.

Option 5 – Surviving Spouse

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

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

The surviving spouse and dependents, if any, must have been covered at the time of the participant's death. To enroll, the surviving spouse has 60 days to notify the People First Service Center of the death and 31 days to enroll after receipt of the enrollment package. Coverage is effective retroactively once the enrollment form and premiums have been received. Coverage begins the first of the month following the last month of coverage for the deceased; in other words, coverage must be continuous.

Coverage for surviving spouses ends on the first of the month following remarriage; however, they are eligible to continue coverage under COBRA for a limited time, provided they provide a copy of the marriage certificate within 60 days of the marriage.

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.

Certificate of Creditable Coverage

If you or a dependent loses coverage under the Plan, you will receive a certificate showing your creditable coverage under this HMO. 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 and Job-Protected Leave

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

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

In addition, the FMLA provides special unpaid, job-protected leave for up to 12 weeks if you have a family member called to active military duty and for up to 26 weeks when such family member is injured while on military duty.

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

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

If you cancel this Plan while on any of these leave types and subsequently return to work before or at the end of the leave, you and your eligible dependents may enroll under the Plan without regard to pre-existing Conditions that arise while on job-protected leave, provided you cancelled your coverage within 60 days of going out on leave. If you do not cancel coverage within 60 days of going out on leave and your coverage is

subsequently canceled for non-payment, you will only be able to enroll during the next Open Enrollment period.

Coverage Continuation When You Are Off Payroll

Active employees who go off the payroll must pay their share of the health insurance premium by personal check, cashier's check or money order to continue coverage. Employees may be required to pay the full premium cost—their share and the state's share - depending on the reason they are not working. Employees should call People First for more information at (866) 663-4735.

Employees who do not want to continue insurance coverage while off the payroll must call People First to cancel within 60 days of their leave date. This notice ensures you can enroll in coverage upon returning to work. Employees who do not cancel and are later cancelled because they did not pay their health insurance premiums will only be allowed to enroll during the next Open Enrollment.

COBRA

The Consolidated Omnibus Budget Reconciliation Act is referred to as COBRA. Under COBRA, you can continue healthcare coverage that would otherwise end because dependent eligibility and 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. You may keep this continuation coverage t for up to 18 months, provided you pay the required cost of the continued coverage. The monthly premium is 102 percent of the cost of coverage (you pay the full premium plus 2% administrative fee).

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

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

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

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

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

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

Under COBRA, the employee or spouse is responsible for notifying People First of a divorce, legal separation, death or a child's losing dependent status under the Plan. Notice must be given within 60 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 60 days of the event, the dependent will not be entitled to choose continuation coverage.

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

1. the date coverage is lost because of one of the events described above; or

2. the date the form is received from People First, whichever is later.

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

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

2. on the last day of the month following the month you were terminated.

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

1. the state stops providing group health coverage for employees;

2. payment for continuation coverage is not made by the deadline, or your check is returned for insufficient funds;

3. the individual later becomes covered by another group health plan. If the new group plan excludes benefits because of a pre-existing Condition, however, you may continue your COBRA continuation coverage through the end of the COBRA eligibility period or until the other plan's pre-existing Condition limits no longer apply, whichever is earlier;

4. the individual later becomes entitled to Medicare;

5. if the employee became entitled to Medicare before employment termination, coverage for other covered dependents may be continued for 18 months or for up to 36 months from the date the employee became entitled to Medicare, whichever is longer; or

6. the 18-, 29-, or 36-month COBRA period ends.

Converting Health Insurance Plan Coverage to a Private Policy

If coverage under the Plan ends for you or your eligible dependents for reasons other than your choice to cancel coverage or your failure to pay your share of the premium cost, you may convert to a private policy. You must apply in writing to the HMO 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 HMO conversion policy. The benefits provided by the conversion policy may be different from the benefits provided under the State Employees' HMO 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. Call this HMO at number listed in the contact section within this document for information.

Continuation of Benefits if You are Disabled

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

1. the disability is a result of a covered Illness or Accident; and

2. the Plan's claims administrator 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.

IV. SCHEDULE OF BASIC BENEFITS – STANDARD HEALTH PLAN

This summary provides an overview of the Standard HMO Plan. For further information on the coverage and benefits of this plan, as well as applicable limitations and exclusions, please refer the following sections within this document: Definitions, Medical Benefits, and Limitations and Exclusions. This HMO is committed to arranging for comprehensive prepaid health care services rendered to Participants through its network of contracted independent physicians and Hospitals and other independent health care providers, under reasonable standards of quality health care. The professional judgment of a physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, concerning the proper course of treatment for a Participant shall not be subject to modification by the HMO or its Board of Directors, Officers or Administrators. However, this Section is not intended to and shall not restrict any Utilization Management Program established by the HMO.

It is the Participant's responsibility when seeking benefits under the Plan to identify himself as a Plan Participant and to assure that the services received by the Participant are being rendered by Participating Providers. Participants must understand that services will not be covered if they are not, in the HMO's opinion, Medically Necessary. Any and all decisions made by the HMO in administering the provisions of this Contract, including without limitation, the provisions of the Definitions, Medical Benefits and Limitations and Exclusion sections are made only to determine whether payment for any benefits will be made by the Plan.

Any and all decisions that pertain to the medical need for, or desirability of, the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Participant and his physician in accordance with the normal patient/physician relationship for purposes of determining what is in the best interest of the Participant. The HMO does not have the right of control over the medical decisions made by the Participant's physician or health care providers. The ordering of a service by a physician, whether participating or non-participating, does not in itself make such service Medically Necessary. The State of Florida and Participants acknowledge that it is possible that a Participant and his physician may determine that such services or supplies are appropriate even though such services or supplies are not covered and will not be arranged or paid for by the Plan. Any covered service for which the Participant is seeking reimbursement, must be submitted to this HMO within one year from the date of service to be considered.

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Deductibles/Copayments payable by Plan Participants

Copayments are dollar amounts the Plan Participant must pay to the Provider before the Plan pays. A Copayment is the amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services while other services will not have any Copayments.

A Deductible is an amount of money that is paid once a Benefit Year per Plan Participant. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1, a new Deductible amount is required to be met.

Calendar Year Limit on Your Share of Covered Expenses

There is a limit on the amount you pay out of your pocket toward covered expenses in any one calendar year for network care. Once your share of out-of-pocket expenses reaches the annual limit, this Plan begins paying 100% of the claims for care from Network Providers for the rest of the calendar year. You meet the family aggregate out-of-pocket limit for family coverage when the expenses of one, or a combination of your covered

family members, add up to the family maximum out-of-pocket limit. This HMO will pay claims at the applicable cost share until the aggregate out-of-pocket limit is met. Preventive services are paid at 100%.

The following expenses do not count toward the out-of-pocket limit:

1. Charges for services and supplies that are not covered by this Plan;
2. Prescription copayments; and
3. Charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment.

Participants should remember services that are provided or received without advance authorization from the HMO, or when the service is beyond the scope of practice authorized for that provider under State law, are not covered unless such services otherwise have been expressly authorized under the terms of the Plan or when required to treat an Emergency Medical Condition. Except for Emergency Medical Services and Care, all services must be received from Participating Providers. Any Participant requiring medical, Hospital or ambulance services for emergencies as described in the Definitions section, either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive emergency benefits.

Services that require prior authorization from this HMO include, but are not limited to:

- All inpatient admissions (including but not limited to Hospital and observation stays, skilled nursing facilities, ventilator dependent care and/or acute rehabilitation);
- Complex diagnostic testing, therapeutic, and sub-specialty procedures (including but not limited to CT, CTA, MRI, MRA, PET Scans, Nuclear Cardiac Studies and Nuclear Medicine);
- Surgical procedures or services performed in an outpatient Hospital, Hospital-affiliated ambulatory surgery center or free-standing ambulatory surgery center;
- All medications administered in an outpatient Hospital or infusion therapy setting
- Select medications administered in a physician's office;
- Non-emergency transportation;
- Care rendered by Non-participating Providers (except for Emergency Medical Services and Care);
- Transplant services; and
- Dialysis services

For more information about which services require prior authorization, contact the HMO at the number listed in the contact section within this document.

Within the Service Area, Participants are entitled to receive the covered services and benefits only as herein specified and appropriately prescribed or directed by Participating Physicians. The covered services and benefits listed in the Medical Benefits section, are available only from Participating Providers within the Service Area and, except for Emergency Medical Services and Care, the Plan shall have no liability or obligation whatsoever on account of services or benefits sought or received by any Participant from any Non-participating Provider or other person, institution or organization, unless prior arrangements have been made for the Participant and confirmed by written referral or authorization from the HMO.

Members are not required to select a Primary Care Physician (PCP). However Coventry encourages each Member to select a PCP to be responsible for providing and managing their primary health care. The Member has the right to change his/her PCP. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her PCP. For a list of the participating PCPs, contact this HMO member services. The list of Participating Providers may also be accessed from this HMO's website identified within the contact section. The names and addresses of Participating Providers on file with this HMO at any given time shall constitute the

official and controlling list of Participating Providers. Health Professionals may from time to time cease their affiliation with this HMO. In such cases, Participants will be required to receive services from another participating Health Professional.

If a Participant does not follow the access rules they risk having the services and supplies received not covered under the Plan. In such a circumstance, any payment that the HMO may make will not exceed the Maximum Allowable Payment and the Participant will be responsible for reimbursing the HMO any Maximum Allowable Payment made for the services and supplies received.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS WHICH MUST BE PAID TO HEALTH CARE PROVIDERS FOR CERTAIN SERVICES, AT THE TIME SERVICES ARE RENDERED, AS SET FORTH IN THE SCHEDULE OF BENEFITS. THE SCHEDULE OF BENEFITS IS A SEPARATE DOCUMENT AVAILABLE FROM DSGI's WEBSITE OR THIS HMO's MEMBER SERVICES AND IS INTENDED TO ACCOMPANY THIS SPD IN EXPLAINING THE BENEFITS AVAILABLE UNDER THE PLAN.

Benefit Summary (Standard Plan)		
	Schedule of Copayments	**Cost to Member**
Deductible (Per Calendar Year)		None
Out of Pocket Maximum (Per Calendar Year)		$1,500 Individual $3,000 Family
Preventive Care • Not Subject to Deductible	Preventive care services include, but are not limited to: • Well-woman examinations, including Pap smears and prenatal care • Annual physical examinations • Immunizations • Well-child care and immunizations, including routine vision and hearing screenings by a pediatrician for children under 18 • Screening mammograms • Colorectal cancer screening, including colonoscopies • HIV screening	No Charge
Primary Care Physician	Services at participating doctors' offices include, but are not limited to: • Routine office visits • Minor surgical procedures • Hearing examinations	$20 per visit

Specialty Care Physician Services	No referral or Pre-admission required for: • Office visits, consultation, diagnosis and treatment	$40 per visit
Hospital	Pre-authorization required for Inpatient Care. Inpatient Care at participating hospitals includes: • Room and board – unlimited days (semi-private) • Physician's, specialist's and surgeon's services • Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication • Intensive care unit and other special units, general and special duty nursing • Laboratory and diagnostic imaging • Required special diets • Radiation and inhalation therapies	$250 per admission; 100% coverage thereafter
Surgery	• Outpatient • Inpatient	No Charge $250 per admission; 100% coverage thereafter
Vision Benefits	Annual eye exam • Primary Care Physician Services • Specialist Services	$20 copayment $40 copayment
Outpatient Laboratory and X-ray	• Diagnostic Tests • CAT scan, PET scan, MRI • Outpatient Laboratory Tests • Mammograms	No Charge
Emergency Services	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Copayment waived if admitted)	$100 copayment

	• Emergency room at participating hospitals, facilities and/or Physicians HMO must be notified within 24 hours of emergency admission or as soon as reasonably possible.	
Urgent/Immediate Care	• Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office • Medical services at a participating retail clinic • Medical services at a non-participating Urgent/ Immediate Care facility or non-participating retail clinic	$25 copayment
Mental Health	• Inpatient • Outpatient	$250 per admission, 100% coverage thereafter $20 per visit
Alcohol/Drug Treatment	• Inpatient • Outpatient	$250 per admission, 100% coverage thereafter $20 per visit
Family Planning	Family planning services • Primary Care Physician Services • Specialist Services • Contraceptives, supplies and related services • Sterilization Maternity Care • Outpatient • Inpatient	$20 per visit $40 per visit Your copayment is based on type of services as noted within this chart for Preventive Adult Care, Physician office visits, other Physician services, Durable Medical Equipment, and prescription drugs. $40 copay/first visit only for prenatal and postnatal services; 100% thereafter. $250 per admission, 100% coverage thereafter
Allergy Treatments	Injections	

	• Primary Care Physician Services • Specialist Services Skin Testing • Primary Care Physician Services • Specialist Services	$20 per visit $40 per visit $20 per visit $40 per visit
Ambulance	When pre-authorized or in the case of an emergency	No Charge
Diagnosis and Treatment of Autism Spectrum Disorder	• Applied Behavior Analysis Services • Physical, speech or occupational therapy	$40 per visit, limited to $36,000 annually ($200,000 lifetime) for all services related to treatment of Autism Spectrum Disorder
Home Health Care	Per Occurrence	No Charge
Durable Medical Equipment	Per Device	No Charge
Rehabilitative Services	Outpatient Services limited to 60 visits per injury	$40 per visit
Skilled Nursing Facilities	Pre-authorization required • Up to 60 days maximum per calendar year	No Charge
Prosthetic or Orthotic Devices	Per Device	No Charge
Prescription Medication	Retail (up to a 30-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name Mail Order (up to a 90-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name	 $7 $30 $50 $14 $60 $100

V. SCHEDULE OF BASIC BENEFITS – HEALTH INVESTOR HEALTH PLAN (HIHP)

This summary provides an overview of the Health Investor HMO Plan. For further information on the coverage and benefits of this plan, as well as applicable limitations and exclusions, please refer to the following sections within this document: Definitions, Medical Benefits, and Limitations and Exclusions. This HMO is committed to arranging for comprehensive prepaid health care services rendered to Participants through its network of contracted independent physicians and Hospitals and other independent health care providers, under reasonable standards of quality health care. The professional judgment of a physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, concerning the proper course of treatment for a Participant shall not be subject to modification by the HMO or its Board of Directors, Officers or Administrators. However, this Section is not intended to and shall not restrict any Utilization Management Program established by the HMO.

It is the Participant's responsibility when seeking benefits under the Plan to identify himself as a Plan Participant and to assure that the services received by the Participant are being rendered by Participating Providers. Participants must understand that services will not be covered if they are not, in the HMO's opinion, Medically Necessary. Any and all decisions made by the HMO in administering the provisions of this Contract, including without limitation, the provisions of the Definition, Medical Benefits, and Limitations and Exclusion sections are made only to determine whether payment for any benefits will be made by the Plan.

Any and all decisions that pertain to the medical need for, or desirability of, the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Participant and his physician in accordance with the normal patient/physician relationship for purposes of determining what is in the best interest of the Participant. This HMO does not have the right of control over the medical decisions made by the Participant's physician or health care providers. The ordering of a service by a physician, whether participating or non-participating, does not in itself make such service Medically Necessary. The State of Florida and Participants acknowledge that it is possible that a Participant and his physician may determine that such services or supplies are appropriate even though such services or supplies are not covered and will not be arranged or paid for by the Plan. Any covered service for which the Participant is seeking reimbursement, must be submitted to the HMO within one year from the date of service to be considered.

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Deductibles and certain Copayments are payable by Plan Participants.

Deductibles and applicable Copayments or Coinsurance are dollar amounts that the Plan Participant must pay before the Plan pays. See the Schedule of Benefits for details.

Deductible

A Deductible is an amount of money that is paid once per Benefit Year per Plan Participant or Family Unit. Each Benefit Year, a new Deductible amount is required. **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.

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 HMO Plan Option. Each January 1, a new Deductible amount is required to be met.

Once the calendar year deductible is met, this Plan pays a percentage of the claims for Network Providers. The calendar year deductible on the Health Investor HMO Plan 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 you pay out of your pocket toward covered expenses in any one calendar year for network care. Once your share of out-of-pocket expenses reaches the annual limit, this Plan begins paying 100% of the claims for care from Network Providers for the rest of the calendar year. You meet the family aggregate out-of-pocket limit for family coverage when the expenses of one, or a combination of your covered family members, add up to the family maximum. This HMO will pay claims at the applicable cost share until the aggregate out-of-pocket is met. Preventive services are paid at 100%.

The following expenses do not count toward the out-of-pocket limit:

1 . Charges for services and supplies that are not covered by this Plan; and
2 . Charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment.

Participants should remember services that are provided or received without advance authorization from the HMO, or when the service is beyond the scope of practice authorized for that provider under State law, are not covered unless such services otherwise have been expressly authorized under the terms of the Plan or when required to treat an Emergency Medical Condition. Except for Emergency Medical Services and Care, all services must be received from Participating Providers. Any Participant requiring medical, Hospital or ambulance services for emergencies as described in the Definitions section, either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive emergency benefits.

Services that require prior authorization from the HMO include, but are not limited to:

- All inpatient admissions (including but not limited to Hospital and observation stays, skilled nursing facilities, ventilator dependent care and/or acute rehabilitation);
- Complex diagnostic testing, therapeutic, and sub-specialty procedures (including but not limited to CT, CTA, MRI, MRA, PET Scans, Nuclear Cardiac Studies and Nuclear Medicine);
- Surgical procedures or services performed in an outpatient Hospital, Hospital-affiliated ambulatory surgery center or free-standing ambulatory surgery center;
- All medications administered in an outpatient Hospital or infusion therapy setting;
- Select medications administered in a physician’s office;
- Non-emergency ambulance transportation;
- Care rendered by Non-participating Providers (except for Emergency Medical Services and Care);
- Transplant services; and
- Dialysis services

For more information about which services require prior authorization, contact the HMO.

Within the Service Area, Participants are entitled to receive the covered services and benefits only as herein specified and appropriately prescribed or directed by Participating Physicians. The covered services and benefits listed in Medical Benefits section are available only from Participating Providers within the Service Area and, except for Emergency Medical Services and Care, the Plan shall have no liability or obligation whatsoever on account of services or benefits sought or received by any Participant from any Non-participating Provider or other person, institution or organization, unless prior arrangements have been made for the Participant and confirmed by written referral or authorization from this HMO.

Members are not required to select a Primary Care Physician (PCP), however Coventry encourages each Member to select a PCP to be responsible for providing and managing their primary health care. The Member has the right to change his/her PCP. To be seen by a Specialist, a Member will not be required to obtain a referral from his/her PCP. For a list of the participating PCPs, contact Member Services at the number listed within the contact section of this document. The list of Participating Providers may also be accessed from the HMO's website identified in the contact section. Notwithstanding the printed booklet, the names and addresses of Participating Providers on file with this HMO at any given time shall constitute the official and controlling list of Participating Providers.

Health Professionals may from time to time cease their affiliation with the HMO. In such cases, Participants will be required to receive services from another participating Health Professional.

If a Participant does not follow the access rules, they risk having the services and supplies received not covered under the Plan. In such a circumstance, any payment that the HMO may make will not exceed the Maximum Allowable Payment and the Participant will be responsible for reimbursing the HMO any Maximum Allowable Payment made for the services and supplies received.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS WHICH MUST BE PAID TO HEALTH CARE PROVIDERS FOR CERTAIN SERVICES, AT THE TIME SERVICES ARE RENDERED, AS SET FORTH IN THE SCHEDULE OF BENEFITS. THE SCHEDULE OF BENEFITS IS A SEPARATE DOCUMENT AVAILABLE FROM DSGI'S WEBSITE OR the HMO'S MEMBER SERVICES AND IS INTENDED TO ACCOMPANY THIS SPD IN EXPLAINING THE BENEFITS AVAILABLE UNDER THE PLAN.

Benefit Summary (Health Investor Health Plan)		
	Schedule of Copayments	**Cost to Member**
Deductible (Per Calendar Year)		$1,250 Individual $2,500 Family
Out of Pocket Maximum (Per Calendar Year)		$3,000 Individual $6,000 Family
Preventive Care • Not Subject to Deductible	Preventive care services include, but are not limited to: • Well-woman examinations, including Pap smears and prenatal care • Annual physical examinations • Immunizations • Well-child care and	No Charge

	immunizations, including routine vision and hearing screenings by a pediatrician for children under 18 • Screening mammograms • Colorectal cancer screening, including colonoscopies • HIV screening	
Primary Care Physician	Services at participating doctors' offices include, but are not limited to: • Routine office visits • Minor surgical procedures • Hearing examinations	20% of the contracted rate after Deductible
Specialty Care Physician Services	No referral or Pre-admission required for: • Office visits, consultation, diagnosis and treatment	20% of the contracted rate after Deductible
Hospital	Pre-authorization required for Inpatient Care. Inpatient Care at participating hospitals includes: • Room and board – unlimited days (semi-private) • Physician's, specialist's and surgeon's services • Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication • Intensive care unit and other special units, general and special duty nursing • Laboratory and diagnostic imaging • Required special diets • Radiation and inhalation therapies	20% of the contracted rate after Deductible
Surgery	• Outpatient • Inpatient	20% of the contracted rate after Deductible

Vision Benefits	Routine annual eye exam • Primary Care Physician Services • Specialist Services	20% of the contracted rate after Deductible
Outpatient Laboratory and X-ray	• Diagnostic Tests • CAT scan, PET scan, MRI • Outpatient Laboratory Tests • Mammograms (not subject to the deductible)	20% of the contracted rate after Deductible No Charge
Emergency Services	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Copayment waived if admitted) • Emergency room at participating hospitals, facilities and/or Physicians Plan must be notified within 24 hours of emergency admission or as soon as reasonably possible.	20% of the contracted rate after Deductible
Mental Health	• Inpatient • Outpatient	20% of the contracted rate after Deductible
Alcohol/Drug Treatment	• Inpatient • Outpatient	20% of the contracted rate after Deductible
Family Planning	• Family planning services • Maternity Care • Sterilization • Contraceptives, supplies and related services	20% of the contracted rate after Deductible
Allergy Treatments	Injections • Primary Care Physician Services • Specialist Services Skin Testing	20% of the contracted rate after Deductible

	• Primary Care Physician Services • Specialist Services	
Ambulance	When pre-authorized or in the case of an emergency	20% of the contracted rate after Deductible
Diagnosis and Treatment of Autism Spectrum Disorder	• Applied Behavior Analysis Services • Physical, speech or occupational therapy	20% of the contracted rate after Deductible, limited to $36,000 annually ($200,000 lifetime) for all services related to treatment of Autism Spectrum Disorder
Home Health Care	Per Occurrence	20% of the contracted rate after Deductible
Durable Medical Equipment	Per Device	20% of the contracted rate after Deductible
Rehabilitative Services	Outpatient Services limited to 60 visits per injury	20% of the contracted rate after Deductible
Skilled Nursing Facilities	Pre-authorization required • Up to 60 days maximum per calendar year	20% of the contracted rate after Deductible
Prosthetic or Orthotic Devices	Per Device	20% of the contracted rate after Deductible
Prescription Medication	Retail (up to a 30-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name Mail Order (up to a 90-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name	 30% 30% 50% 30% 30% 50%

VI. MEDICAL BENEFITS

This chart provides a description of services and supplies covered by the HMO under the State Group Health Insurance Plan (the Plan). Services and supplies not described here but mandated by state or federal law and applicable to the Plan will be covered by the HMO.

Coverage Access Rules

If you do not follow the coverage access rules described in this document, services and supplies may not covered by the HMO. In such a circumstance, you may be responsible for the full cost of services and supplies.

Also, covered persons shall understand that the ordering of a service by a physician does not in itself make such service a medically necessary covered service. Final decisions concerning the existence of coverage or benefits under the HMO shall not be delegated or deemed to have been delegated by the state. However, the HMOs hired by the state are responsible for processing claims in accordance with the terms of this document.

The HMO pays the cost of covered care and medical supplies, less the copayment, as long as the care or supplies are:

- Ordered by a network provider (a provider who is in the HMO's network);
- Considered medically necessary for the covered person's treatment because of a covered accident, illness, condition or mental health or nervous disorder;
- Not specifically limited or excluded under this Plan; and
- Rendered while this Plan is in effect.

Covered Services	Special Limits/Circumstances
Ambulance Transportation and Service • Ambulance service to the nearest hospital • Ambulance service to a covered person's home or skilled nursing facility • Ambulance service from a hospital which is unable to provide proper care to the nearest hospital that can provide proper care	• For services by boat, airplane or helicopter ○ When the pick-up point is inaccessible by ground transportation ○ When the travel distance involved in getting the covered person to the nearest hospital that can provide proper care is too far for medical safety ○ When speed in excess of ground vehicle speed is critical for medical safety
Anesthesia Services • Both inpatient and outpatient	

Covered Services	Special Limits/Circumstances
Autism Spectrum Disorder • Diagnosis and treatment through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services for an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger. • Coverage includes well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder, speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis. Applied Behavior Analysis is covered when provided by Applied Behavioral Analysts, psychologists, clinical social workers, and others within the scope of their license.	• Coverage limited to services prescribed by the subscriber's treating physician in accordance with a treatment plan. The required treatment plan includes, but is not limited to, a diagnosis; proposed treatment by type, frequency and duration of treatment; anticipated outcomes stated as goals; frequency with which treatment plan will be updated; and a signature from the treating physician. • Covered as required by sections 627.6686 and 641.31098, *Florida Statutes*, and as further amended by state and federal law.
Bone Marrow Transplants	• If the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration. • Includes costs associated with the donor-patient.
Cancer Services • Diagnosis and Treatment	• Includes both inpatient and outpatient diagnostic tests and treatment (including anti-cancer medications administered by network providers), including cancer clinical trials as set forth in the Florida Clinical Trial Compact. Does not include Experimental or Investigational Treatment.
Cleft Lip and Cleft Palate	• Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology and nutrition services only as required by sections 627.64193 and 641.31(35), *Florida Statutes*
Clinical Trials	• Includes routine patient care costs incurred by an insured individual who participates in an approved Phase II, III or IV clinical cancer trial if those services, including drugs, items and devices that would otherwise be covered under the plan or contract if those drugs, items, devices and services were not provided in connection with an approved cancer clinical trial program. Experimental treatment is excluded.

Covered Services	Special Limits/Circumstances
Child Health Supervision Services	• Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. • Services as defined by the Patient Protection and Affordable Care Act.
Contraceptive Supplies • Insertion and removal of IUD • Diaphragm • Insertion and removal of contraceptive implants • Contraceptive injections • Oral contraceptives	• With respect to Women's Preventive Services (see also *Preventive Services)*, coverage is limited to: o Contraceptive methods – Medical o Barrier: Diaphragm o Implanted: IUD o Sterilization: Tubal ligations o Contraceptive methods – Pharmacy o Hormonal: All generic oral contraceptives • Other contraceptives may be covered based on medical necessity. • For additional information on medical coverage, please call this HMO's Member Services Department listed in the contact section within this document. For additional information on prescription coverage, please call Express Scripts at 1-877-531-4793.
Cosmetic Surgery • Plastic and reconstructive • Reduction mammoplasty	• Repair or alleviation of damage if the result of an accident. • Correction of a congenital anomaly for an eligible dependent. • Correction of an abnormal bodily function. • For an area of the body which was altered by the treatment of a disease. • All stages of reconstruction of a breast on which a mastectomy was performed in accordance with federal law. However, if there is no evidence of malignancy, such reconstruction and initial prosthetic device shall only be covered if received within two years after the date of the mastectomy.
Dental Care	• Only in cases of dental care provided to a person under age 8 if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a hospital or surgical center is necessary.
Dermatology Services	• Direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a network dermatologist, as required by sections 627.6472(16) and 641.31(33) *Florida Statutes*.

Covered Services	Special Limits/Circumstances
Diabetes and pre-diabetes Treatment	• All medically appropriate and necessary equipment, supplies and outpatient self-management training and educational services used to treat pre-diabetes and diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary. • Certain diabetic equipment and supplies are covered through your HMO. Those not covered by the HMO may be covered by the Prescription Drug Plan. See Prescription Drug Plan section within this document for additional information.
Doctor's Care • Office visits • Medical treatment in hospital or outpatient facility or surgery (other than office visit), which includes anesthesia services, concurrent physician care (surgical assistance provided by another physician) and consultations • Child health supervision services • Adult preventive medical services • Allergy treatment – including testing, desensitization therapy and allergy immunotherapy, which includes hyposensitization serum when administered by a health care provider • Diagnostic procedures, lab tests or x-rays, including their interpretation, for the treatment of a covered condition	• For concurrent physician care and surgical assistance: ○ The additional physician must actively participate in the treatment; and ○ The condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; and ○ The physicians have different specialties or have the same specialty with different sub-specialties; and ○ Must be authorized by the covered person's PCP or the Health Plan • For consultations: ○ The ordering physician must request the consultation; and ○ Consulting physician shall prepare a written report

Covered Services	Special Limits/Circumstances
Durable Medical Equipment • For the care and treatment of a condition covered under this Health Plan, the Health Plan shall either rent or purchase medical equipment and supplies including, but not limited to: ○ Trusses, braces, walkers, canes, crutches, casts and splints ○ Occlusal guards, bite or dental splints, repositioning devices, and TMJ models for the treatment of temporomandibular joint (TMJ) syndrome ○ Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products ○ Oxygen and rental of equipment for the administration of oxygen, ventilator or other mechanical equipment for the treatment of respiratory paralysis or insufficiency ○ Ambulatory home uterine activity monitoring devices (AHUM) ○ Wheelchairs, hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment ○ Other medical equipment and supplies as determined to be medically necessary	• Durable Medical Equipment: ○ Shall not serve as a comfort, hygiene, or convenience item ○ Shall not be used for the sole purpose of exercise ○ Shall not be used by any other party ○ Shall have been manufactured specifically for medical use ○ Shall not include shoe buildups, shoe orthotics, shoe braces or shoe supports unless the shoe is attached to a brace ○ Shall not include water therapy devices, modification to motor vehicles and/or homes or similar items
Emergency Care • Coverage, without prior authorization, for screening and stabilization based on determination by either an in-network or non-network provider.	
Eye Care • Routine or refractive eye examinations as part of the adult preventive medical care or child health supervision services benefit	• For eyeglasses or contact lenses: ○ Limited to the first pair following an accident to the eye or cataract surgery ○ Includes the examination for the prescribing or fitting thereof ○ For treatment of a covered condition: ▪ Aphakic patients and soft lenses or sclera shells ▪ Following an injury, disease or accident

Covered Services	Special Limits/Circumstances
Family Planning Services	• Includes counseling and information on birth control, sex education and the prevention of sexually transmitted diseases.
Hearing Tests	• Only when associated with a covered ear surgery, in accordance with child and adult preventive health care benefits, or for the diagnosis of a covered condition.
Hemodialysis for Renal Disease • Includes equipment, training and medical supplies for home dialysis and dialysis centers.	
Home Health Care • Services by a home health care agency for a covered person confined and convalescing at home for a covered condition • Home health care services include: ○ Part-time, intermittent or continuous nursing care by registered nurses or licensed practical nurses, nurse registries or home health agencies; ○ Physical, speech, occupational and respiratory therapy, and infusion therapy ○ Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by the treating physician and other covered services provided by or for a home health agency through a licensed nurse registry or by an independent nurse licensed under chapter 464, *Florida Statutes*, to the extent that they would have been covered if the person had been confined in a hospital	• For approval of home health care services by your PCP or the Health Plan: ○ The treating physician must submit a home health care plan of treatment to your PCP; and ○ The plan of treatment must document that home health care is medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and ○ Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility • Services which shall not be covered under this benefit include: ○ Any service that would not have been covered had the covered person been confined to a hospital ○ Services which are solely for the convenience of the covered person • Therapy is subject to outpatient limitations described under rehabilitative services

Covered Services	Special Limits/Circumstances

Hospice Care
• In-home care
  ○ Physician services
  ○ Physical, respiratory, massage, speech and occupational therapy if approved by the Health Plan
  ○ Medical supplies, drugs and appliances
  ○ Home health aide services
  ○ Part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) or private duty nursing service
  ○ Oxygen
  ○ Infusion Therapy
• Hospice Inpatient Care
  ○ Room and board and general nursing care
  ○ Inpatient care services same as inpatient hospital care
  ○ Same covered services as in-home and outpatient hospice care
  ○ Includes care for pain control or acute chronic symptom management
• Hospice outpatient care
  ○ Physician services
  ○ Laboratory, x-ray, and diagnostic testing
  ○ Ambulance service
  ○ Same covered services as in-home hospice care
	• Hospice treatment program shall:
	  ○ Meet the standards outlined by the National Hospice Association;
	  ○ Be recognized as an approved hospice program by the Health Plan;
	  ○ Be licensed, certified, and registered as required by Florida law; and
	  ○ Be directed by the covered person's PCP or the Health Plan and coordinated by a registered nurse with a treatment plan that provides an organized system of hospice facility care, uses a hospice team and has around-the-clock care available
	• For hospice care:
	  ○ Counseling of terminally ill patients whose doctor has certified that they have less than one year to live;
	  ○ Primary care physician (PCP) must submit a written hospice care plan or program; and
	  ○ PCP must submit a life expectancy certification
	  ○ All hospice care expenses shall be approved in writing by the Health Plan
	  ○ While in the hospice program, plan benefits for expenses related to the terminal illness are covered by the hospice provider.
	  ○ Limited to 210 calendar days per lifetime

Covered Services	Special Limits/Circumstances
Hospital Inpatient Care • Hospital room, board and general nursing care for a semi-private room unless the Health Plan determines that a private room is medically necessary • Room, board and treatment in an intensive, progressive, cardiac or neonatal care unit • Other necessary services and supplies, including, but not limited to: • Use of operating room, labor room, delivery room and recovery room • Drugs and medicines used by the patient • Intravenous solutions • Dressings, ordinary casts, splints and trusses • Anesthesia and related supplies • Transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced • Respiratory therapy, including oxygen • Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms • Basal metabolism examinations • X-ray, including therapy • Diathermy • All covered rehabilitative services	• Services and supplies must be furnished at a network hospital and must be authorized by the primary care physician or Health Plan in order to be covered. Exceptions to this include emergency services and other special circumstances, as approved by the Health Plan. • Excludes services and supplies provided when the covered person is admitted to a hospital or other facility primarily to provide rehabilitative services.
Immunizations • Includes flu shots	
Mammograms • Screening • Diagnostic service	• One baseline mammogram for women age 35 through 39 • One mammogram every one to two years – ages 40 through 49 • One mammogram every year – age 50 and over • At any age if deemed medically necessary (diagnostic)

Covered Services	Special Limits/Circumstances
Maternity Care • Pre-natal and post-natal care and monitoring of the mother • Delivery in a hospital or birth center • Postpartum care • Newborn care and assessment (one time), including initial exam from pediatrician • Medically necessary clinical tests and immunizations • Routine well-baby nursery services • Midwife services • Breastfeeding support, supplies and counseling	• Covered hospital stays for the mother and newborn child will be no less than: o 48 hours for a normal delivery o 96 hours for a Cesarean-section delivery unless agreed to by the provider and the patient • With respect to Women's Preventive Services, coverage for breast feeding supplies is: o Limited to one breast pump per birth.
Mental Health, Alcoholism and Substance Abuse Care • Inpatient • Outpatient	• Treatment program must be accredited by the Joint Commission or approved by the state. • Providers must be licensed in accordance with applicable law. • For inpatient care: o Alcoholism and substance abuse care includes detoxification. • For outpatient care: o Mental health and nervous disorders treatment includes diagnostic evaluation, psychiatric treatment, and individual and group therapy. ▪ For learning and behavioral disabilities or mental retardation, coverage is limited to evaluation and diagnosis.
Newborn Care • Coverage includes, but is not limited to: o Coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities or prematurity. o The transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.	• Coverage for the unenrolled newborn child of a covered eligible subscriber or dependent is limited to well-baby hospital nursery services. • Newborn must be enrolled in the Health Plan within 60 days of the birth to be covered for other services.

Covered Services	Special Limits/Circumstances
Nutrition Counseling	
Nursing Services • Nursing care by a registered nurse (RN) or licensed practical nurse (LPN)	• Includes inpatient private duty nursing when authorized by the Health Plan. • Includes home health care services and hospice services.
Oral Surgery • Surgical treatment of non-dental injury to teeth, fractured or dislocated jaw, excision of tumors, cysts, abscesses and lesions of the mouth and surgical treatment of temporomandibular joint (TMJ) syndrome • Treatment of bones or joints of the jaw or facial region as required by section 641.31094, *Florida Statutes,* when medically necessary for conditions caused by congenital or developmental deformity , disease or injury	• Does not include care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes.

Covered Services	Special Limits/Circumstances

Organ Transplants
• Services, care and treatment received for or in connection with the approved transplantation of the following human tissue and organs:
  ○ Heart
  ○ Heart/lung
  ○ Lung
  ○ Liver
  ○ Kidney
  ○ Kidney/pancreas
  ○ Bone marrow
  ○ Cornea
• Covered services include:
  ○ Organ acquisition and donor costs. However, donor costs shall not be payable under this Health Plan if they are payable in whole or in part by any other insurance health plan, organization or person other than the donor's family or estate.
• Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation
• For bone marrow transplants:
  ○ Includes the harvesting, transplantation and chemotherapy components
  ○ Donor costs are covered in the same way as costs for the covered person, including limitations and non-covered services
	• To have a transplant covered:
	  ○ Prior approval for the transplant must be obtained by the covered person's PCP from the Health Plan in advance of the covered person's initial evaluation for the procedure; and
	  ○ The Health Plan shall be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval shall be based on written criteria and procedures established by the Health Plan; and
	  ○ The facility in which the pre-transplant services, transplant procedure and post-discharge services will be performed must be licensed as a transplant facility and authorized by the Health Plan.
	• Transplant services shall not be covered when:
	  ○ Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received;
	  ○ The expense relates to the transplantation of any non-human organ or tissue;
	  ○ The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ;
	  ○ The organ is sold rather than donated to the person;
	  ○ The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan except in the case of the donor costs for bone marrow transplants; or
	  ○ A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of such transplant
	• The following services and supplies shall not be covered:
	  ○ Artificial heart devices used as a bridge to transplant;
	  ○ Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; or
	  ○ Any service or supply in connection with identification of a donor from a local, state, or national listing.

Covered Services	Special Limits/Circumstances

Outpatient Care
• Treatment as an outpatient in a hospital, a health care provider's office, an ambulatory surgical center or other licensed outpatient health care facility
• Clinical laboratory services
• Services for outpatient surgery and outpatient treatment of an injury
• Includes medically necessary supplies provided or used by the facility during the surgery or treatment, such as:
  ○ Use of operating room, and recovery room
  ○ Use of covered drugs and medicines used by the patient
  ○ Intravenous solutions, dressings, ordinary casts, splints and trusses
  ○ Anesthesia, related supplies and their administration
  ○ Transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced
  ○ Respiratory therapy, including oxygen
  ○ Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms
  ○ Basal metabolism examinations
  ○ X-ray, including therapy
  ○ Diathermy
  ○ Services provided by a birthing center licensed pursuant to section 383.30-383.335, *Florida Statutes*
• Other covered necessary services and supplies	

Pathologist Services • Both inpatient and outpatient	
Pre-admission Tests	• Tests shall be ordered or authorized by the covered person's PCP; and • Tests shall be performed in a facility accepted by the hospital and the Health Plan in lieu of the same tests which would normally be done while hospital confined.

Covered Services	Special Limits/Circumstances
Preventive Services	• Preventive medical services will be as defined by the Patient Protection and Affordable Care Act, which include: ○ Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; ○ Assessment of the risk of falls for older adults is included during the preventive care wellness examination or evaluation and management (E&M) visit ; ○ Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; ○ With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ○ With respect to Women's Preventive Health Services, coverage is provided to the extent mandated by federal law. ○ For additional information on immunizations and preventive health care services go to: ○ www.healthcare.gov ○ www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm ○ www.healthcare.gov/law/resources/regulations/womensprevention.html, and ○ www.healthcare.gov/new/factsheets/2010/09/affordable_care_act_immunization.html • Additional Women's Preventive Services: to the extent required by federal law; the following services are covered for all female members : ○ Human papillomavirus (HPV) testing; ○ Counseling for sexually transmitted infections; ○ Counseling and screening for human immune-deficiency virus (HIV); ○ Counseling and screening for interpersonal and domestic violence; ○ Screening for gestational diabetes ○ Counseling and support for breastfeeding and supplies (limited to one manual breast pump per birth) ○ Annual well woman visits expanded to include prenatal care, contraceptive counseling and methods (see *Contraceptive Services* within this table of services)

Covered Services	Special Limits/Circumstances
Prostheses and Orthotic Devices • Initial placement of the most cost effective prosthetic or orthotic device, fitting, adjustments and repair	• Replacements covered if due to growth or change and approved by the Health Plan as medically necessary. • Shoe orthotics shall be covered only when attached to a brace. • Penile prosthesis shall be covered only when necessary to treat organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, postprostatectomy, postpriapism, and epispadias and exstrophy.
Radiologist Services • Both inpatient and outpatient	
Rehabilitative Services • Spine and back disorder treatment • Manipulative services • Physical therapy • Speech therapy	• All services shall be provided by licensed therapists, chiropractors and physicians for the purpose of aiding in the restoration of normal physical function. • Requires Health Plan approval or a written plan of treatment, including documentation that the covered person's condition should improve significantly within 60 days of the date therapy begins • Outpatient rehabilitative services limited to 60 visits per injury; inpatient rehabilitative services limited to the duration of hospital confinement. • Rehabilitative services shall not be covered when: o The covered person was admitted to a hospital or other facility primarily for the purpose of providing rehabilitative services; or o The services or supplies maintain rather than improve a level of physical function, or where it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60-day period.
Respiratory Therapy • Both inpatient and outpatient • Services of respiratory or inhalation therapists • Oxygen	

Covered Services	Special Limits/Circumstances

Second Medical Opinions
• May be requested by the covered person or the Health Plan for:
  ○ Elective surgery
  ○ When the appropriateness or necessity of a covered surgical procedure is questioned
  ○ Serious injury or illness
	• The covered person:
	  ○ Must provide prior notice to the Health Plan
	  ○ The use of second medical opinions in connection with a particular diagnosis or treatment may be restricted to a maximum of three per calendar year.
	• The Health Plan shall review the second medical opinion, once rendered, and determine the treatment obligations of the Health Plan. That judgment shall be controlling. Any treatment obtained that is not authorized by the Health Plan shall be at the covered person's expense.
	• Covered expenses for the second opinion:
	  ○ If a network physician is selected, the only cost to the covered person will be the applicable copayment.
	  ○ If a non-network physician is selected, the member may be required to pay for up to 40 percent of the usual and customary charges for those services in the community where they were rendered as determined by the Health Plan.

Skilled Nursing Facility Care • Room, board and general nursing care • Services and supplies for necessary treatment	• Primary Care Physician (PCP) or HMO shall approve a written plan of treatment • Patient must require skilled care for a condition (or a related condition) which was treated in the hospital and such care can be provided at a skilled nursing facility in lieu of hospitalization or continued hospitalization • Patient shall be admitted to the facility immediately following discharge from the hospital • Skilled nursing care or services are provided on a daily basis • Limited to 60 days of confinement per calendar year • Services shall be ordered by and provided under the direction of a physician
Surgical Procedures • Both inpatient and outpatient	
Surgical Sterilization	• Limited to tubal ligations and vasectomies
Wigs	• Covered only when hair loss is caused by chemotherapy, radiation therapy, or cranial surgery. Coverage is limited to a maximum payment of $40 for one wig and fitting in the 12 months following treatment or surgery.

VII. LIMITATIONS AND EXCLUSIONS OF BASIC BENEFITS

Services Not Covered by the Health Plan

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

Abortion, which is elective, performed at any time during a pregnancy.

Acupuncture. Services, supplies, care or treatment in connection with acupuncture (except when used in lieu of an anesthetic agent for covered surgery).

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

Autologous transfusion, in which blood is removed from a donor and stored before it is returned to the donor's circulation.

Autopsy.

Biofeedback services and other forms of self-care or self-help training and any related diagnostic testing; hypnosis; meditation; mind expansion; elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard seminar training (EST)**.**

Complications of non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service**.**

Cosmetic surgery/services, including plastic and reconstructive surgery (except as noted as a covered service), and any other service and supply to improve the covered person’s appearance or self-perception.

Costs incurred by the Health Plan, related to health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy; and telephone consultations; failure to keep a scheduled appointment or complete any form and/or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services and respite care.

Dental care or any treatment relating to the teeth, jaws, or adjacent structures (e.g. periodontium), including but not limited to extraction or cleaning of the teeth; implants, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic treatment; rapid palatial expanders; continuous passive motion (CPM) devices.

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

Experimental/Investigational or Not Medically Necessary Treatment, with the exception of routine care in connection with a clinical trial in cancer, pursuant to the Florida Clinical Trial Compact.

Eye care, including:

- The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the covered benefits section;
- Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or astigmatic error; and
- Training or orthoptics, including eye exercises.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease, injury or accident. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Health Plan to be medically necessary.

Gender reassignment or modification services and supplies.

Genetic tests to determine paternity or sex of a child.

Hearing aids, (external or implantable) or the examination, including hearing tests, for the prescription or fitting of hearing aids, including tinnitus maskers.

Human Growth Hormone for diagnosis and/or treatment of idiopathic short stature.

Hypnotism, medical hypnotherapy or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such immunizations and examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

Infertility treatment and supplies, including infertility testing; treatment of infertility; diagnostic procedures and artificial insemination to determine or correct the cause or reason for infertility or inability to achieve conception; in-vitro fertilization, ovum or embryo placement or transfer; gamete intra-fallopian tube transfer; or cryogenic or other preservation techniques used in such or similar procedures.

Marriage counseling.

Massage therapy.

Non-prescription drugs and supplies, including any non-prescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods or blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.

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

Occupational therapy, unless provided as a home health service or hospice service or as treatment for Autism Spectrum Disorder.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.
Personal comfort, hygiene or convenience items, including but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than medically necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel or other housing accommodations (even if recommended or approved by a physician), air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment. Also excluded are services not directly used to provide treatment.

Recreational therapy.

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

Sexual deviations, disorders or psychosexual dysfunctions services and supplies.

Sleep therapy.

Smoking cessation products, including but not limited to Nicorette gum, patches, lozenges, inhalers or vapor and e-cigarettes. **Training and educational programs**, including programs primarily for pain management, or vocational rehabilitation unless specifically provided by law.

Volunteer services, or services which would normally be provided free of charge to a covered person.

Weight control/loss programs, including but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

Work related condition services, to the extent the covered person is covered or required to be covered by a workers' compensation law. If the covered person enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, this Health Plan shall not cover past or future medical services that are the subject of or related to that settlement. In addition, if the covered person is covered by a workers' compensation program that limits benefits if other than specified health care providers

are used and the covered person receives care or services from a health care provider not specified by the program, this Health Plan shall not cover the balance of any costs remaining after the program has paid.

Additional exclusions include, but are not limited to:

- Services or supplies that are not medically necessary as determined by the Health Plan and/or the Prescription Drug Plan clinical staff and the state.
- Court ordered care or treatment, unless otherwise covered in this Health Plan, including testing required as a condition of parole or probation; testing for aptitude, ability, intelligence or interest.
- Treatment of a condition resulting from:
    - War or an act of war, whether declared or not;
    - Participation in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony;
    - Engaging in an illegal occupation;
    - Services in the armed forces;
- Services or supplies received prior to a covered person's effective date or received on or after the date a covered person's coverage terminates under this Health Plan, unless coverage is extended in accordance with extension of benefit provisions;
- Services provided by a physician or other health care provider who normally resides in the covered person's home;
- Services rendered from a medical or dental department maintained by or on behalf of a public health entity;
- Non-medical conditions related to hyperkinetic syndromes, learning disabilities, intellectual disability, or inpatient confinement for environmental change;
- Services or supplies supplied at no charge, or determined by the Health Plan not to be the most cost-effective setting, procedure or treatment.
- The following services:
    - Social work
    - Bereavement and pastoral
    - Financial
    - Legal
    - Dietary counseling
    - Day care
    - Homemaker and chore
    - Funeral

VIII. HMO FEATURES

COVENTRY HEALTH CARE OF FLORIDA - VALUE-ADD SERVICES

- No referrals required for specialist visits - Prior authorization are still required for certain services.
- Dependent Passport Program - Dependent children who are enrolled and live outside of the service area, may obtain services from the Coventry National Network.
- $0 Copay Flu Shot Program - Present your Coventry medical ID card at any participating pharmacy (CVS, Publix, Target, Walmart).
- $40 Preventative Vision Refractive Eye Exam
- Discounts available for eyeglasses and contact lenses.
- Wellbeing Discount Fitness Program.
- Wellbeing Complementary Alternative Medicine (CAM) Program.
- Wellbeing Weight Loss Discount Programs available through Jenny Craig and Weight Watchers.
- Discounts on Lasik Eye Surgery available.
- Discounts on Hearing Aid available.

Please go to state.chchflorida.com for more information or contact member services at 1-866-575-1875.

Access to Care

Members are not required to select a Primary Care Physician (PCP). However Coventry encourages each Member to select a PCP to be responsible for providing and managing their primary health care. The Member has the right to change his/her PCP.

PCP referrals are not required to obtain Covered Services, however certain Covered Services require Preauthorization. Non-emergency Hospital admissions and ambulatory surgery require Preauthorization and approval by Coventry's Medical Management Program.

The most current listing of Network Providers is available online at http://state.chcflorida.com.

Hospital Admission and Hospital Stay Pre-Certification (network and non-network emergency only):

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Preauthorization of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided:

Refer to the Preauthorization Exhibit at the end of this document.

The attending Physician does not have to obtain Preauthorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Note: The services mentioned above must be Preauthorized or reimbursement from the Plan may be reduced.

TO PREAUTHORIZE MEDICAL SERVICES CALL1-800-447-3725.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Preauthorization of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not Preauthorized, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was Preauthorized before incurring charges.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-Service Requests for benefits (requests for benefits that require Preauthorization and are for services that have not yet been provided).

To make a pre-service request for benefits that will be provided by an Out-of-Network Provider, the Plan Participant or the Out-of-Network Provider on the Plan Participant's behalf should contact the Claims Administrator at the number provided on the member ID card for Preauthorization and provide the following information:

The name of the patient and relationship to the Covered Employee,

The name, member ID number and address of the Covered Employee,

The name of the Employer,

The name and telephone number of the attending Physician,

The name of the Medical Care Facility, proposed date of admission, and proposed length of stay,

The diagnosis and/or type of surgery, and

The proposed rendering of listed medical services.

After the Claims Administrator receives the request, it will notify the Provider of any additional information needed in order make a coverage determination. The Plan Administrator or its designee will make its decision and notify the Provider within 15 days after it receives the request for benefits.

Urgent Care Requests for benefits (requests for benefits related to services that the health care Provider believes places the Plan Participant's life, health or ability to regain maximum function in immediate jeopardy, or for care that the treating Physician determines is urgent, or determines that a delay would subject the Plan Participant to severe pain that could not be adequately managed without the treatment requested).

Expedited notification for Urgent Care determinations. The Claims Administrator will make notification for a Claim involving Urgent Care not later than seventy-two (72) hours after receipt of the Claim, and will notify a Plan Participant of a benefit determination (whether adverse or not) for a Claim involving Urgent Care as soon as possible, but not later than twenty-four (24) hours after receipt of the Claim, unless the Plan Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered. In some cases, the Plan Participant or the Provider may not have provided the Claims Administrator with sufficient information to make a decision. If this is the case, the Claims Administrator, within 24 hours after it has received the request, will notify the Plan Participant of the additional information that it needs to make a determination. The Claims Administrator will give the Plan Participant or Provider a reasonable amount of time, at least 48 hours, to provide the information. The Claims Administrator will make its decision within the earlier of: 48 hours after it receives the information, or within 48 hours of the time it gave the Plan Participant or Provider to provide the additional information.

Concurrent Care Benefit Determinations

If a Plan Participant is undergoing an approved course of treatment, and the Plan Administrator or its designee determines that the number or course of the treatment should be reduced or terminated and the Plan Participant will be held financially responsible, the Claims Administrator on behalf of the Plan will inform the Plan Participant of its decision before the end of the approved course of treatment, so that the Plan Participant has sufficient time to Appeal the decision to reduce or limit the treatment.

Notifications of Benefit Determinations

If the Plan Administrator or its designee denies a request for services in whole or in part, it will provide the Plan Participant with a written explanation of the decision, including the specific reason that the request was denied, the Plan provision on which the denial was based, a description of any additional information that may be submitted and why the information is necessary, and a description of the Appeal procedures.

Admission/Continued Stay Review

In the event of an emergency Hospitalization or Outpatient surgery or procedure, the Claims Administrator must be contacted at the number provided on the member ID card must be contacted within 24 hours after the Medical Emergency or as soon as reasonably possible following the receipt of the services.

If the Plan Participant is being treated by an In-Network Provider, it is the responsibility of the attending In-Network Provider to contact the Claims Administrator.

If the Plan Participant is being treated by a Non-Network Provider, it is the Plan Participant's responsibility to contact the Claims Administrator. A friend or relative, the attending Physician, the Hospital, or anyone a Plan Participant designates may contact the Claims Administrator.

If the Claims Administrator was contacted by the Plan Participant or the In-Network Provider and the emergency admission was not Medically Necessary, the services will be denied.

- In the event that a Plan Participant wants to stay in the Hospital longer than is Preauthorized by the Plan Administrator or its designee, no further benefits will be provided.Coventry Health Care of Florida uses numerous Transplant and Specialty Hospitals throughout the Country. Pre-approval is required

for all services and must be submitted to Coventry's Medical Management Department for approval, by the ordering physician.

Case Management

• Multiple Admission Program (MAR) – Quarterly identification of adult members with 3 or more admissions in a rolling twelve month period. Exclusions: pediatrics, OB, scheduled admissions

• Readmissions – Adult members readmitted within 60 days of a prior admission

• Any member discharged from the hospital requiring ongoing care including medical supplies, treatment/therapy and medications

• Pediatric Case Management – Any member under the age of 19 may be referred to the Pediatric Case Management program. Pediatric members may be referred for CM enrollment for the following reasons: discharged with needs; abnormal blood lead results; beginning implementation of intravenous infusions (e.g. IVIG); diagnosed with hemophilia/Factor deficiency; chronic conditions or diagnosed with autism. NICU – the pediatric case manager also provides 2 week post discharge follow up to assist with discharge needs. CM may coordinate services for up to 30 days.

• Obstetrical Case Management (OB) – The UM department requires all obstetricians fax an OB notification form to the health plan, which serves to identify high risk pregnancies and at-risk conditions as defined by ACOG. The OB CM also identifies and manages member with the following conditions: 17P, HTN, Diabetes, Preterm labor, Tocolytic therapy and infertility treatments.

• Transplant- Any member requiring any of the four phases: Pre-Transplant Evaluation- Phase I, Approval/Listing- Phase II, Admission for Transplant- Phase III and Post Transplant Follow up- Phase IV at the transplant Phase III and Post Transplant Follow up- Phase IV at the transplant facility. The CM can expect to follow member through all phases and follow up which lasts minimum of one year post transplant.

• End of Life Program – The End of Life program is a collaborative effort with the organization's vendor, Vital Decisions, in order to identify members who may benefit from counseling regarding execution of Advance Directives, Living Will, Hospice, etc.

Disease Management

• Chronic Condition Management – Asthma, Congestive Heart Failure, Diabetes and pre-diabetes, Hypertension, Renal Disease, and Wound care.

• Members identified and assessed with high risk for Asthma, Congestive Heart Failure and Diabetes qualify for Tele-monitoring in collaboration with the organization's vendor, Cardiocom. This is an opt-in program.

• Preventive Care Reminders – Reminder mailings of Preventive Care educational materials are sent on a monthly basis during the birthday month of all active members.

• Health information tools and services: Members can go to www.chcflorida.com to access an online library of health information, as well as offer members access to a larger library in the wellness portal of My Online Services. Further our members receive a bi-annual commercial newsletter "Living Well", which contains multiple articles related to health and wellness

• Member website: Coventry's member website, specifically our authenticated member portal, My Online Services offers our members information on the status of their claims, the ability to view their EOBs, track the status of their deductible dollars, view their schedule of benefits and many more features.

Wellness Programs: Members can go to https://member.cvty.com and access the My Online Services area where they have access to the WellBeing Program. This program is comprised of an online Health Risk Assessment and nine digital coaching sessions. These include: weight management, tobacco cessation, nutrition improvement, physical activity, stress management, cholesterol management, blood pressure management, sleep improvement, and depression management.

IX. PRESCRIPTION DRUG PROGRAM

How the Program Works

You automatically participate in the State Employees' Prescription Drug Plan. The Plan features a select network of participating retail pharmacies and a mail order program. Below is an overview describing when and which feature to use.

Retail pharmacies
Use retail pharmacies for short-term medications or drugs 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 drugs, up to a 90-day supply at one time provided 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 fill the prescription at any participating pharmacy. Call (877) 531-4793 or log in (registration required) at www.Express-Scripts.com to locate a participating pharmacy.

Take your prescription and present your prescription drug program identification card to the pharmacist. You pay a Copayment (Coinsurance for Health Investor Health Plan option) for up to a 30-day supply of each covered prescription. There is no paperwork when you use your prescription drug card at a participating pharmacy; claims are submitted electronically.

- Standard HMO Option
  - $7 for a generic drug
  - $30 for a preferred brand name drug
  - $50 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 HMO Option
  - 30% for a generic drug (subject to Calendar Year Deductible)
  - 30% for a preferred brand name drug (subject to Calendar Year Deductible)
  - 50% for a non-preferred brand name drug (subject to Calendar Year Deductible)
  - 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.

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 equivalent is not 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 equivalent, you will pay the lesser of:

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

Using a Participating Pharmacy (an example):
At participating 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 drug that costs the Plan $25. In this case, you pay:

The Plan's cost difference between preferred brand name and generic		Brand $50
	minus	Generic $25
		Total Difference $25
Preferred Brand Name Copayment	plus	$30
Your Cost	Your total out-of-pocket	**$55**

In addition to the higher brand name copayment, if a generic is available, you pay the pharmacist 100 percent of the difference between the generic and the brand name prescription drug when it is dispensed at the request of the covered person. If the prescribing physician or other participating provider authorized to prescribe drugs within the scope of his or her license indicates on the prescription "brand name medically necessary" or "dispense as written" for a drug for which there is a generic equivalent, the brand name drug shall be dispensed for the brand name copayment only.

Using the Mail Order Program

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

- Complete a mail order form available from Express Scripts at (877) 531-4793 or www.express-scripts.com
- Be sure to have at least a 14-day supply on hand when ordering; generally, refills are mailed within 5 days of a request and new prescriptions mailed within 8 days of receipt of all necessary information.
- Enclose your prescription written for up to a 90-day supply, and the appropriate Copayment or Coinsurance
- The Copayment or Coinsurance will be based on the date the prescription is filled, not on the date the prescription is received by Express Scripts
- Order online by logging in at www.express-scripts.com or call Express Scripts at (877) 531-4793 and Express Scripts will contact your physician to get a mail order prescription for you.
- Ask your doctor to call Express Scripts at (888) 327-9791 to call in your prescription or to obtain instructions on how to fax your prescription directly to Express Scripts.

- Standard HMO Option
  - $14 for a generic drug
  - $60 for a preferred brand name drug
  - $100 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 HMO Option
  - 30% for a generic drug (subject to Calendar Year Deductible)
  - 30% for a preferred brand name drug (subject to Calendar Year Deductible)
  - 50% for a non-preferred brand name drug (subject to Calendar Year Deductible)

- 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.

Automatic Refill and Renewal Options at Mail Order
If you are taking long-term or maintenance medications, Worry Free Fills® provides easy and convenient refill and/or renew options through mail order for many but not all medications. If you sign up for this program (and have refills remaining), Express Scripts will automatically fill and mail your medications at the appropriate refill date saving you time from ordering online or by phone.

Also, Express Scripts will contact your Physician and request a new prescription automatically after your last available refill. Express Scripts will alert you in advance by email or phone. For additional information on this program or to sign up log in at www.Express-Scripts.com or call (877) 531-4793.

How You Will Save With Mail Order
If you use a drug regularly, you will save on Copayments (Coinsurance for Health Investor Health Plan) through mail order. For instance, if your drug is a preferred brand name, under the HMO Standard plan:

Mail Order	**Participating Retail Pharmacy**
...up to a 90-day maximum supply	…up to a 30-day maximum supply
$60 Copayment applies	$30 Copayment applies
You pay $60 for 90 days and order once (you save $30)	You pay $90 for 90 days and make three trips to the pharmacy (you save nothing)
IMPORTANT: Ask your Physician to prescribe a 90-day supply to send to the mail order pharmacy. Otherwise, if your prescription is only for up to a 30-day supply, you will get the 30-day supply and still have to pay $60 for mail order, which is more than had you gone to a retail pharmacy.	

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

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

Drugs That Are Covered by the Prescription Drug Plan

Covered drugs include, but are not limited to:

1. Federal legend drugs
2. State restricted drugs
3. Compound medications
4. Smoking cessation drugs requiring a prescription
5. Insulin and other covered injectable medication;

6. Needles and syringes for insulin and other covered injectable drugs;
7. FDA-approved glucose strips, tablets and lancets;
8. Zostavax (however, the charge to administer this vaccine is not covered under the Prescription Drug Program).

Drugs That Are Covered by the HMO

Covered drugs shall include, but are not limited to:

1. Any drug, medicine, medication or immunization that is consumed, administered or provided at the place where the prescription is given (medical provider's office or health care facility);
2. Any drug, medicine or medication that is dispensed or administered by a physician or other participating provider (other than a pharmacy) including, but not limited to, outpatient facilities;
3. Any prescriptions to be taken by or administered to the covered person, in whole or in part, while a patient in a hospital, skilled nursing facility, convalescent hospital, inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis.

Drugs <u>NOT</u> Covered by the Prescription Drug Plan

The prescription drug program does not cover:

1. Retin-A for cosmetic purposes;
2. Anti-obesity drugs and amphetamines and/or anorexiants for weight loss;
3. Infertility and fertility drugs
4. Devices or appliances
5. Non-federal legend or over-the-counter drugs;
6. Drugs labeled "Caution-Limited by Federal Law to Investigational Use" or experimental drugs.
7. Non-prescription drugs, aids and supplies to deter smoking (i.e., gums, patches, lozenges)
8. Immunizing agents such as flu vaccine, except Zostavax;
9. Medication that is covered by Worker's Compensation or Occupational Disease Laws or by any state or governmental agency;
10. Medication furnished by any drug or medical service for which no charge is made;
11. Viagra and similar drugs for psychosexual disorders for females, and males under age 18;
12. Enteral formulas exceeding $2500 per calendar year, or for individuals 25 years of age or older;
13. Growth hormones for the diagnosis of idiopathic short statute syndrome;
14. Overlapping therapies within the same drug classifications, even if used for different conditions. For example, an erectile dysfunction drug for the treatment of benign prostate hyperplasia (BPH) and an erectile dysfunction drug for treatment of erectile dysfunction, as both are in the same drug classification of erectile dysfunction drugs;
15. Prescriptions filled at a non-participating pharmacy, except for prescriptions required during emergency care which visit is subject to approval by the HMO;

Important Information about the Prescription Drug Program

1. The Preferred Drug List (PDL) is updated and subject to change on a semi-annual basis. Contractually, Express Scripts has full authority over the development of the PDL; therefore, DSGI cannot require that

specific drugs be included.

2. Generic substitution: Prescriptions written for brand name drugs that have a generic equivalent will be automatically substituted unless the prescribing Physician writes “dispense as written” or “DAW” on the prescription. Generally, even if the prescription includes “DAW,” Express Scripts 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 to or provide clarifications to a prescription. Authorizations may be obtained verbally or in writing. If Express Scripts is unable to contact the Physician or an authorized agent of the Physician, the prescription may be returned unfilled to the member.
4. Medco mail order facilities will only substitute with generic drugs that have received an “A” or “AB” rating by the Federal Drug Administration (FDA). Other retail pharmacies may choose to dispense drugs with a different FDA rating.
5. Certain medications, including most biotech and/or Specialty Drugs, are only available through Accredo. Generally, these drugs are for chronic or genetic disorders including, but not limited to, multiple sclerosis, growth hormone deficiency and rheumatoid arthritis and may require special delivery options, such as temperature control. Your prescribing physician may contact Accredo at (800) 803-2523.
6. Express Scripts 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, Express Scripts will dispense the alternative drug and provide written notification of the change to the member.
7. Express Scripts 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, Express Scripts 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 interactions and manufacturer’s guidelines to determine if there are any interactions, side effects, and/or contraindications. Express Scripts will contact the prescribing Physician if any questions, conflicts or issues are identified. Express Scripts 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, Express Scripts will change the prescription accordingly, dispense the drug accordingly, and provide written notification of the change to the member.
9. Express Scripts 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 Express Scripts 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 75% of the previous prescription must be utilized, if used as prescribed, before a request for a refill will be processed.
12. Requests for mail order refills that are received within 90 days of the "too soon to fill" date (based on the previous paragraph) will be held and filled when eligible to be filled. You may check your medication label for the next available refill date, or if the prescription was filled through mail order, you may log onto www.express-scripts.com for the next available mail order refill date.
13. As part of the Accredo specialty services, Express Scripts will administer the Specialty Management Program for this Plan. This program is intended to optimize outcomes and promote the safe, clinically appropriate and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for this program during the coverage review will result in denial of medication coverage for the Plan participant and discontinuation of medication coverage for the Plan participant.

The Specialty Management Program is a process by which authorization for a specialty medication is obtained based on the application of currently acceptable medical guidelines and consensus statements for the appropriate use of the medication in a specific disease state. Therapies reviewed under this Program include, but are not limited to: multiple sclerosis, oncology, allergic asthma, human growth hormone deficiency, hepatitis C, psoriasis, rheumatoid arthritis, and respiratory syncytial virus. Additional therapies may be added at any time. For additional information on specialty medications or to see if your medication is in this category call Member Services toll-free at (877) 531-4793.

Some medications require coverage review and/or prior authorization before your prescription can be filled and some medications may be subject to quantity limits. Your pharmacist will let you know if your prescription requires coverage review, prior authorization and/or is subject to quantity limits. If your prescription requires coverage review, prior authorization and/or is subject to quantity limits, Express Scripts will work with your Physician to determine medical necessity. Approval or denial of coverage will be determined within 72 hours after contacting your Physician and receiving all required information and/or documentation. Various drug classifications require coverage review, prior authorization and/or are subject to quantity limits; for example, drugs for the diagnosis of erectile dysfunction require coverage review, prior authorization and are limited to eight doses per month. Most prior authorizations are valid for one year and must be renewed after expiration; however, prior authorizations may be as brief as one month.

X. HOW TO FILE A CLAIM

Medical Claims

A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving notification of the Adverse Benefit Determination. This HMO shall notify the Claimant, in accordance with the Grievance section within this document, of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination. An appeal may be submitted to:

Coventry Health Care of Florida
Attention: Appeals Department
1340 Concord Terrace
Sunrise, Florida 33323

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 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 Express Scripts by calling (877) 531-4793 or at *www.express-scripts.com*.

To submit the claim:

1. Complete all the 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:

Express Scripts Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

XI. COORDINATION OF BENEFITS

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

In order to ensure claims processing accuracy and appropriate coordination of benefits, DSGI requires this HMO 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 [HMO name], in writing, that you should contact its office to verify OCL information. The HMO will automatically process or reprocess any claims that may have been denied or held once you have provided the requested OCL information. For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of the Plan, this HMO may, without the consent of or notice to any person, release to or obtain from any other insurance company, organizations or person, any information, with respect to any Participant, or applicant for participation, which this HMO deems to be necessary for such purposes.

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 were the primary plan.

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

For All Covered Individuals

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

For Eligible Dependent Children

1. The plan of the parent whose birthday comes first in the calendar year pays first for covered dependent children, unless the parents are divorced or separated. If both parents have the same birthday, the plan that has covered the parent for the longest time pays first.
2. In the case of divorce of separation, the plan of the parent with custody pays first, except where a court decrees otherwise.
3. If the parent with legal custody has remarried:
    a. The plan of the parent with legal custody pays first
    b. The plan of the spouse of the parent with custody pays second; and
    c. The plan of the parent without custody pays last; unless a court decrees otherwise.

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

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

Coordination with Medicare

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

Active Employees

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

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

For active employees with a dependent who is disabled for reasons other than end-stage renal disease, this Plan will pay benefits first for the disabled dependent until he or she reaches age 65. At age 65, Medicare becomes the primary plan and will pay benefits first for any disabled dependent other than the spouse. If the disabled dependent is your spouse, your spouse's coverage under this Plan will continue to be primary, paying benefits first, as long as you are an active employee.

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

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

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

Benefits from this Plan and from Medicare will never be more than 100% 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:

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

All treatments must be Medically Necessary and comply with all terms, conditions, Limitations, and Exclusions of this Plan even if this Plan is secondary to other coverage and the treatment is covered under the other coverage.

If the amount of the payments made by the Plan is more than it should have paid under the provisions of this Coordination of Benefits section, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Participant. The 'amount of the payments made' includes the reasonable cash value of any benefits provided in the form of services.

In the event the State of Florida offers Health Reimbursement Arrangements (HRA) in connection with this Plan, the HRA is intended to pay solely for otherwise un-reimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

An Important Note for Retirees

Once you or your spouse become eligible for Medicare, any claims filed with Medicare for you or your spouse may automatically be filed with this HMO after Medicare pays what is covered. Call your HMO's Customer Services and request to be set up for automatic crossover from Medicare. No separate filing to this HMO will be required.

Not Eligible for Medicare

If you are not eligible for Medicare, send a copy of your Medicare ineligibility letter to People First immediately. People First will reverse your enrollment so that this HMO continues as the primary plan with the corresponding higher monthly insurance premium. If you delay, this HMO will pay claims secondary as if you had Medicare, which will require you to pay significantly more out-of-pocket.

Coordination of Prescription Drug Benefits with Medicare Part B

Express Scripts 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 Billing/Medical Release Authorization form. This form is required in order to bill Medicare on your behalf. Since some drugs are only eligible under Medicare Part B for specific diagnoses, Medicare Part B requires that each prescription include a written diagnosis. There may be other situations when Medicare Part B requires additional specific documentation before accepting a prescription drug claim for payment. In most cases, Medicare Part B will only accept claims for a prescription fill for up to a 30-day supply. Generally, Medicare eligible items are covered under Medicare Part B and are subject to the Medicare calendar year deductible.

Using the Mail Order Pharmacy for Part B Drugs

1. All appropriate documentation must be on file or presented with the prescription.
2. You must mail the prescription with the appropriate diagnosis to Express Scripts. If the prescription drug is determined to be eligible under Medicare Part B, Express Scripts will forward your prescription request to one of Express Scripts' Medicare Part B suppliers: Liberty Medical Supply Inc. for Medicare Part B prescription drugs, Arriva Medical for Medicare Part B eligible diabetic supplies, and Accredo for Medicare Part B specialty drugs.
3. Arriva Medical may contact you for any information necessary to fill the prescription, within all appropriate prescription guidelines, and file a claim to Medicare Part B on your behalf.
4. You will receive an Explanation of Medicare Benefits (EOMB) after Medicare Part B processes the claim indicating Medicare's payment, amount applied to the deductible, and your responsibility.
5. After the prescription claim is paid by Medicare, Liberty, Arriva or Accredo will submit a claim to Express Scripts for your secondary benefits under this Plan and bill you for any remaining balance. 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.
2. You must present the prescription with the appropriate diagnosis to the participating Medicare Part B retail pharmacy.
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 processed the claim indicating Medicare Part B's payment, amount applied to the deductible, and your responsibility.
5. 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.

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

IMPORTANT NOTE: Medicare automatically notifies the State of Florida of any of its Plan members that are enrolled in a Medicare Part D Prescription Drug Plan. Upon such notification from Medicare, this Plan will automatically become the secondary coverage. This Plan will not be changed to the primary coverage until you provide Express Scripts 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.

Special Notice about the Medicare Part D Drug Program

Jan. 1, 2014

Please read this notice carefully. It explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll in Medicare Part D.

Medicare prescription drug coverage (Medicare Part D) became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage.

All approved Medicare prescription drug plans must offer a minimum standard level of coverage set by Medicare. Some plans may offer more coverage than required. As such, premiums for Medicare Part D plans vary, so you should research all plans carefully.

The State of Florida Department of Management Services has determined that the prescription drug coverage offered by the State Employees' Health Insurance Program (State Health Program) is, on average, expected to pay out as much as or more than the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you enroll in a Medicare prescription drug plan and do not drop your State Health Program coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Health Program. However, if you are enrolled in a state-sponsored HMO offering a Medicare Advantage Prescription Drug Plan, you may have to change to the State Employees' PPO Plan to get all of your current health and prescription drug benefits.

If you drop or lose your coverage with the State Health Program and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. Additionally, if you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage, and you may have to wait until the following Nov. to enroll.

Additional information about Medicare prescription drug plans is available from:

- www.medicare.gov
- Your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- (800) MEDICARE or (800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, payment assistance for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). Contact

your local SSA office, call (800) 772-1213, or www.socialsecurity.gov for more information. TTY users call (800) 325-0778.

For more information about this notice or your current prescription drug plan, call the People First Service Center at (866) 663-4735.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium amount (a penalty).

XII. SUBROGATION AND RIGHT OF RECOVERY

If the Plan provides health care benefits to a Participant for injuries or illness for which another party is or may be responsible, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on behalf of the Participant that are associated with the injury or illness for which another party is or may be responsible. The Plan's rights of recovery apply to any recoveries made by or on behalf of the Participant from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Participant for injuries resulting from an accident or alleged negligence. For purposes of this SPD, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

Participant specifically acknowledges the Plan's right of subrogation. When the Plan provides health care benefits for injuries or illnesses for which a third party is or may be responsible, the Plan shall be subrogated to the Participant's rights of recovery against any party to the extent of the full cost of all benefits provided by the Plan, to the fullest extent permitted by law. The Plan may proceed against any party with or without the Participant's consent.

Participant also specifically acknowledges the Plan's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the Plan has provided health care benefits for injuries or illness for which another party is or may be responsible and the Participant and/or the Participant's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this SPD, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Participant to the extent of the full cost of all benefits provided by the Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

Participant and the Participant's representatives further agree to:

- notify the Plan promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Participant that may be the legal responsibility of a third party; and
- cooperate with the Plan and do whatever is necessary to secure the Plan's rights of subrogation and/or reimbursement under this SPD; and
- give the Plan a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and
- pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due the Plan as reimbursement for the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by the Plan in writing; and

- do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by the Plan.

The Plan may recover the full cost of all benefits provided by the Plan under this SPD without regard to any claim of fault on the part of the Participant, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. In the event the Participant or the Participant's representative fails to cooperate with the Plan, the Participant shall be responsible for all benefits paid by the Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

XIII. DISCLAIMER OF LIABILITY

Neither this HMO nor the Plan directly employs any practicing physicians nor any Hospital personnel or physicians. These health care providers are independent contractors and are not the agents or employees of the HMO. The HMO shall be deemed not to be a health care provider with respect to any services performed or rendered by any such independent contractors. Participating Providers maintain the physician/patient relationship with Participants and are solely responsible for all Medical Services which Participating Providers render to Participants. Therefore, this HMO nor the Plan shall be liable for any negligent act or omission committed by any independent practicing physicians, nurses or medical personnel, nor any Hospital or health care facility, its personnel, other health care professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Participant. Furthermore, neither this HMO nor the Plan shall be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat a Participant of the Plan.

Certain Participants may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians. Participating Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the physician/patient relationship and as obstructing the provision of proper medical care. If a Participant refuses to accept the medical treatment or procedure recommended by the Participating Physician and if, in the judgment of the Participating Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Participating Physician, the Participant shall be so advised. If the Participant continues to refuse the recommended treatment or procedure, the State of Florida may terminate the Participant's coverage under this Plan.

XIV. GRIEVANCE PROCEDURE

Complaints. Participants have the right to a review of any complaint regarding the services or benefits covered under the Plan. If a Participant has a complaint regarding Plan services, including quality of service, office wait time, physician behavior and other concerns, the Participant or someone he names to act on his behalf (an authorized representative) may call the Member Services Department at the number listed in the contact section within this document. This HMO encourages the informal resolution of complaints relating to Plan services, and Member Services Representatives will work with complainants to resolve any such issues over the telephone. If a complainant asks for a written response, or if a complaint is related to quality of care, the HMO will respond in writing. The Member Services Department can also advise how to name an authorized representative.

Grievances. A grievance is any complaint other than one that involves a request (Claim) for benefits, or a request for review of an Adverse Benefit Determination. If a complaint cannot be resolved informally over the telephone, the Participant or his authorized representative may submit the complaint to the HMO, in writing. This is referred to as 'filing a grievance'. The written grievance will be processed through the HMO's formal grievance procedures.

Grievances must be filed within one year from the date of the event or action that led to the grievance. The HMO will acknowledge and investigate the grievance, and provide a written response advising of the disposition within 60 days after receipt of the grievance. A grievance may be submitted in writing to:

Coventry Health Care of Florida
Attention: Appeals Department
1340 Concord Terrace
Sunrise, Florida 33323

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

Appealing to the HMO – A Level I Appeal

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

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

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

Service toll-free telephone number on your member ID card (the HMO or Express Scripts, as appropriate) and stating that you are requesting an urgent Level I Appeal.

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

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

Coventry Health Care of Florida
Attention: Appeals Department
1340 Concord Terrace
Sunrise, Florida 33323

For pharmacy claims, mail your Level I Appeal to Express Scripts:

Express Scripts
Attention: Appeals
P.O. Box 30252
Tampa, FL 33630-3252

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

The HMO or Express Scripts will review your Level I Appeal and provide a written notice of the review decision. If the appeal is for a pre-service denial, the HMO or Express Scripts will respond within 15 days from receipt of your appeal; if the appeal is for a post-service denial, the HMO or Express Scripts will respond within 30 days from receipt of your appeal; and, if your appeal is urgent, the HMO or Express Scripts will respond within 72 hours from receipt of your appeal. If the HMO or Express Scripts' review is unfavorable (Level I Appeal is denied), the notice from the HMO or Express Scripts will include information about appealing the decision to DSGI.

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

If you are not satisfied with the Level I Appeal decision, you may file a Level II Appeal to DSGI. You may request a Level II urgent appeal if the timeframe to complete the pre-service Level II Appeal would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent appeal. If your Level II Appeal is for the denial of a pre-service or concurrent care decision, you may verbally request an urgent Level II Appeal by calling DSGI at 850-921-4600 and stating that you are requesting an urgent Level II Appeal.

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

Your Level II Appeal must be in writing or filed verbally (for urgent appeals) and must be postmarked within 60 days of the written notice of the HMO or Express Scripts' denial of your Level I Appeal. Your Level II Appeal must include:

1. A copy of the denial notice (EOB, MHS, or other notice of denial);
2. A copy of your letter to the HMO or Express Scripts requesting a Level I Appeal;
3. A copy of the HMO or Express Scripts' Level I Appeal denial;
4. A Level II Appeal letter to DSGI appealing the Level I Appeal decision; and
5. Any other information or documentation that could assist in the review of your appeal.

Mail your written Level II Appeal to DSGI at:

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

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

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

Two review options are available if you want to contest the Level II Appeal denial; an Administrative Hearing and an external review from an Independent Review Organization. You may request a review through either or both of these options. However, please note that each option has a specific timeframe for requesting a review as described below.

Requesting an Administrative Hearing

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

Requesting an External Review from an Independent Review Organization (IRO)

You have the right to request an external review from an Independent Review Organization (IRO) after the finalization of both the Level I and Level II Appeal processes. You may call the Customer Service toll-free telephone number on your member ID card (the HMO or Express Scripts, as appropriate) for additional information about requesting or to request an external review. External review is not available for claim denials based on an individual's eligibility under a plan. You may request an external review in writing within four months after receipt of the Level II Appeal decision.

Standard External Review

You may request a standard external review of your Level II Appeal denial if:

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

    b. rescission (cancellation) of coverage; and

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

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

Expedited or Urgent External Review

You may request an expedited or urgent external review if the timeframe to complete a standard external review would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent external review and if:

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

    b. rescission (cancellation) of coverage; and

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

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

Important Notes:

1. Throughout the appeal and review process, you have the right to present evidence and testimony as well as request and receive, free of charge, copies of all documents and other information relevant to your claim and/or appeal, including, but not limited to, the following information about the processing of your claim:

    - the specific rule, guideline, protocol or other similar criterion used, if any, in making the benefit or payment decision, and/or

    - an explanation of the scientific or clinical factors relied upon if the claim was denied in whole or in part based on the lack of medical necessity or the experimental or investigational nature of a service or medication.

2. A favorable decision by the IRO is binding on the Plan and is cause to interrupt and stop any administrative hearing proceedings. An unfavorable decision by the IRO is binding on the Plan if you did not previously timely pursue action through the administrative hearing process.

3. If, after commencement of any administrative proceeding, you decide to request an external review by the IRO, the administrative proceeding will be held in abeyance pending the IRO decision.

The appeal process described in this Benefit Document implements the internal claims, appeals, and external independent review organization review processes and guidelines as required under the Patient Protection and Affordable Care Act (PPACA), Florida law, and *Florida Administrative Code*. This appeal process is subject to change if or as required by finalization of current interim federal regulations applicable to the PPACA, change to Florida law, and/or to *Florida Administrative Code*.

XV. MISCELLANEOUS

1. **Clerical errors**. Clerical errors shall neither deprive any individual Participant of any benefits or coverage provided under the Plan nor shall such error(s) act as authorization of benefits or coverage for the Participant that is not otherwise validly in force. Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a 60 day period from the date of notification. Refunds of administrative service fees are done for up to a 60 day period from the date of notification. Refunds of administrative service fees are limited to a total of 60 days from the date of notification of the event, provided there are no claims incurred subsequent to the effective date of such event.

2. **Gender**. Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.

3. **Identification cards**. Cards issued by this HMO to Participants pursuant to the Plan are for purposes of identification only. Possession of an identification card confers no right to health services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable charges under the Plan have actually been paid and accepted by the Plan.

4. **Individual information**. Participants or other individuals shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. If the Participant or other individual fails to provide accurate information that the Plan deems material to providing coverage for such individual, upon ten days written notice, the Plan may deny coverage and/or participation in the Plan to such individual

5. **Non-waiver**. The failure of the Plan to enforce any of the provisions of the Plan or to exercise any options herein provided or to require timely performance by any Participant or the State of Florida of any of the provisions herein, shall not be construed to be a waiver of such provisions nor shall it affect the validity of the Plan or any part thereof or the right of the Plan to thereafter enforce each and every such provision.

6. **Plan administration**. The State of Florida may from time to time adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan.

7. **Waiver**. A Claim that has not been timely filed with the Plan within one year of date of service shall be considered waived.

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 this HMO and Express Scripts (which provides third-party medical and pharmacy support to the self-insured plan); the notices describe how this HMO and Express Scripts 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 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:

- Disclosures to Workers' Compensation or similar legal programs, as authorized by and necessary to comply with such laws
- Disclosures related to situations involving threats to personal or public health or safety
- Disclosures related to situations involving judicial proceedings or law enforcement activity
- 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
- Disclosures related to organ, eye or tissue donation and transplantation after death
- Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances by researchers regarding the necessity of using your health information and treatment of the information during a research project. Certain disclosures may be made 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 the 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 this HMO, Express Scripts, 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 your providing an alternative address or other method of contact and, when appropriate, on your providing information on how payment, if any, will be handled.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the plans use to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the plans may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the plans will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request.

The plans may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The plans also may charge reasonable fees for copies or postage. If the plans do not maintain the health information but know where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the plans amend your health information in a Designated Record Set. The plans may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the plans (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the plans will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the plans have made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law in connection with public health activities 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 formation going back for six 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:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request must be in writing. Within 60 days of the request, the plans will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request. You may make one request in any 12-month period at no cost to you, but the plans may charge a fee for subsequent requests. You'll be notified of the fee in advance and 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 took effect on April 14, 2003. However, the plans reserve the right to change the terms of their privacy policies as described in this notice at any time and to make new provisions effective for all health information that the plans maintain. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If 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 Web site 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 U.S. 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 Express Scripts can be filed by following the procedures in the notices they provide. To file other complaints with the plans, contact the DSGI for a complaint form. It should be completed, including a description of the nature of the particular complaint, and mailed to the Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL 32314-5450.

Contact

For more information on the privacy practices addressed in this Privacy Notice and your rights under HIPAA, contact the Division of State Group Insurance at PO Box 5450, Tallahassee, FL 32314-5450.

SUMMARY PLAN DESCRIPTION INFORMATION

Official Plan Name:	State Employees' HMO Plan
Plan Administrator:	Division of State Group Insurance P.O. Box 5450 Tallahassee, FL 32314-5450 (850) 921-4600
Claims Administrator:	Coventry Health Care of Florida, Inc.
Plan Year:	January 1 – December 31
Effective Date of the Plan:	January 1, 2014
Employer Identification No.:	59-3458983
Plan Type:	Self-insured welfare benefit plan
Source of Funding for the Plan:	The State of Florida has elected to create a self-insured group health plan.
Sources of Contribution:	State of Florida and its Employees
Organization that Provides the Benefit:	Benefits under the plan are provided through an Administrative Services Agreement with this HMO.

Prior Authorization EXHIBIT Quick Guide
Access to Services

Contact Numbers - Prior Authorization Requests: 800-447-3725		
Service	Details	Comments
Inpatient Admissions	-Acute Care Hospitals, -Acute Rehabilitation Hospitals -Long Term Acute Care Hospital,-Skilled Nursing Facilities	Please contact health services via phone at number above
Observation	-Acute Care Hospitals	Please contact health services via phone number above
Hospital Outpatient Services	-All services provided in outpatient hospital setting	Effective 8-1-2011 excludes mammography; colonscopy; endoscopy; bone density; ileoscopy; sigmoidoscopy; proctosigmoidoscopy; heart catheterization; transvaginal ultrasound Effective 3-1-2013 All ultrasounds in POS 22 no longer require authorization for participating providers Effective 4-1-2012 excludes Temporary Transcutaneous Pacing,Cardioversion, elective of arrhythmia, Internal cardioversion, Cardioassist-method of internal circulatory assist, External cardioassist, Thrombolysis coronary incl. angiography, Thrombolysis by intravenous infusion,Intravascular u/s during diagnostic eval or therapeutic intervention,Intravascular u/s each additional vessel,Transcatheter placement of intracoronary stents,Stents-each additional vessel,PTCA balloon angioplasty,Balloon angioplasty each additional vessel,Percutaneous balloon valvuloplasty-aorta,Valvuloplasty mitral valve,Valvuloplasty pulmonary valve,Atrial septectomy or septostomy,PTCA w/ or w/o balloon angioplasty,PTCA each additional vessel,PTCA pulmonary artery balloon angioplasty; single vessel & PTCA each additional vessel
Ambulance	-Transport (Non Emergent), -Air (Non Emergent)	
Durable Medical Equipment (DME)	-Power Mobility Devices, -Custom Wheelchairs -Clinitron beds, -Liquid Oxygen -Bone Growth Stimulator -Prosethics & Orthotics	**Purchases over $500 and all rental equipment require authorization. DME purchases less than $500 in a physician office does not require authorization, Effective 3-1-2013 Prosthetics and Orthotics included.** South Florida Members contact Florida Home Medical Equipment 888-914-2201 or fax 888-914-2202
High Tech Imaging	-CT/CTA/CTTA, -MRI/MRA, -PET, -Nuclear Cardiology -ECHO Stress	National Imaging Associates, Inc: 800-642-7821 www.radmd.com
Home Health Services	-All Home Health Services, Including Therapy Services -Home vents -Home Infusion	Statewide contact **Univita:** 888-914-2201 & Specialty Infusion Services: 954-217-6055 Please visit directprovider.com for service area details.
Hospice Care		
Drugs	-Replacement -Home/Office	Statewide except Central Florida Market Contact Icore 866-522-2469 or fax: 866-522-2478
Mental Health/Substance Abuse Services	-Inpatient -Outpatient	Please refer to the back of the member ID card for the preferred mental health vendor
Pain Management		All Pain Management services require authorization including evaluations
Rehabilitation Therapy	-Physical Therapy,-Occupational Therapy, -Speech Therapy	Effective 3-1-2013 Commercial member no longer require authorizations for participating providers
Sleep Studies		
Transplants	-Evaluations and Transplant	
Wound Care Centers	-Wound Care (Non Emergent), -Wound Care Vacs, -Hyberbaric Treatments	
Other Services	-Oral Surgery, -Reproductive Endocrinology -Automatic Implantable Cardioverter Defibrillator -Enhanced External Counter Pulsation -Orthotripsy, -Laparoscopic Hysterectomy -Manipulation under Anesthesia, -Neuropsychology -Spinal Fusion, -Uvulopalatopharygoplasty	Effective 2-23-12 a maximum of 3 OB ultrasounds, including transvaginal, per pregnancy can be performed without prior authorization in POS 11 and 24. Effective 3-1-2013 all ultrasounds in POS 22 and 24 no longer require authorizations for participating providers Effective 12/29/10 prior authorization is not required for maternal fetal medicine office visits
Other Procedures	-Genetic Testing, -Cosmetic Surgery -Experimental/Investigational Services, Devices, and Drugs -Blepharoplasty,-Sclerotherapy for **Varicose** Veins -Removal of Keloid/Lipomas, -Gastric Bypass/Banding	Benefit limitations may still apply; please contact customer service to confirm coverage details

	-Panniculectomy/Abdominoplasty,-Rhinoplasty/Septopasty	
Non-Participating Providers		Please send request for authorization to the appropriate number above
COMMERCIAL MEMBERS: If members do not obtain a prior authorization, the amount covered by Coventry Health Care of Florida may be reduced depending on the member's specific health benefit plan		
IMPORTANT: Members should refer to their Summary of Benefits or Evidence/Certificate of Coverage for information regarding their covered health care services.		

You may also go to the following links for the most updated information:

- **http://chcflorida.coventryhealthcare.com/web/groups/public/@cvty_regional_chcfl/documents/webcontent/c080174.pdf**
- **http://chcflorida.coventryhealthcare.com/web/groups/public/@cvty_regional_chcfl/documents/webcontent/c083803.pdf**