BENEFIT PLAN

Summary Plan Description

Prepared Exclusively for
State of Florida

HMO Standard Medical Plan
(Aetna Select)
Effective January 1, 2014

What Your Plan Covers and How Benefits are Paid

SERVICE AREAS AND

WHO TO CALL FOR INFORMATION

HMO CORPORATE OFFICE

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

HMO MEMBER SERVICES - ALL AREAS
1-877-858-6507

www.aetnastateflorida.com

HMO SERVICE AREA

Brevard County

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*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface

The medical benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** or any of its affiliates, but will be paid from the Employer's funds. **Aetna** and its HMO affiliates will provide certain administrative services under the **Aetna** medical benefits plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** medical benefits plan.

The *Booklet* describes your rights and obligations, what the **Aetna** medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments. This *Booklet* is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this *Booklet* and the contents of the Plan, your rights shall be determined under the Plan and not this *Booklet*.

This *Booklet* replaces and supersedes all **Aetna** *Booklets* describing coverage for the medical benefits plan described in this *Booklet* that you may previously have received.

Employer:	State of Florida
Contract Number:	326415
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Booklet Number:	1

Coverage for You and Your Dependents

Health Expense Coverage

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., Health Investor Health 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.)

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

Eligibility and Enrollment

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Eligibility

All State of Florida employees defined in Sectoin 110.123(2)(c), 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 Aetna 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 a 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 must 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 (60 days 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 the event to result in a gain or loss of eligibility for group coverage, 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 must 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.) within 60 days of making the change.

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. You must include their 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. Employed spouse become ineligible for the Spouse Program if:
    - One or both of end employment with the state, including retirement, or
    - They divorce, or
    - A 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 60 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 31 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 the Plan. You will receive this certificate when coverage ends and again when any COBRA coverage ends. In addition, you may request a certificate in writing at any time during the 24-month period following your initial loss of coverage and/or the loss of COBRA coverage. You will need this certificate as proof of creditable coverage if you enroll in a new health plan that has a pre-existing Condition limitation.

Coverage Continuation Family and Medical Leave and Job-Protected Leave

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

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

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

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

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

If you cancel this Plan while on any of these leave types and subsequently return to work before or at the end of the leave, you and your eligible dependents may enroll under the Plan without regard to pre-existing Conditions that arise while on job-protected leave, provided you cancelled your coverage within 60 days of going out on leave. If you do not cancel coverage within 31 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 within 60 days of their leave date to cancel. This ensures they can enroll in coverage if they return 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 of dependent eligibility or because of voluntary or involuntary termination for reasons other than gross misconduct. You may also continue healthcare coverage that would otherwise end because you did not return to work after an unpaid leave under the Family and Medical Leave Act. 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.

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 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 Aetna and pay the first month's premium within 63 days of the date your group coverage ended. 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.

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Continuation of Benefits if You are Disabled

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

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

For this continuation of benefits, total disability means:

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

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

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

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

Extension of Benefits if the Plan is Terminated

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

1. If you are in the Hospital when the Plan is terminated, your covered services will be eligible for payment for 90 days following Plan termination.
2. If you are pregnant when the Plan is terminated, covered maternity benefits will continue to be paid for the rest of your pregnancy.

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

How Your Medical Plan Works

Common Terms

Accessing Providers

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet in a safe place for future reference.

Common Terms

Many terms throughout this Booklet are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your HMO Standard Medical Plan

This HMO Standard medical plan provides coverage of medical expenses for the treatment of **illness** or **injury**. The plan also provides coverage for certain preventive and wellness benefits.

With your HMO Standard medical plan, you can directly access any **network physician**, **hospital** or other health care provider for covered services and supplies under the plan. As a participant in this Plan, you have the freedom to choose the **network physician** or health care professional you prefer each time you need to receive covered health services. Except as specially described within this summary benefits are not available for services provided by a non-network physician.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet. Coverage is subject to all the terms, policies, and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions*, *Limitations*, and *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This HMO Standard medical plan provides access to covered benefits through a network of health care providers and facilities. These network **physicians**, **hospitals** and **other health care** professionals have contracted with **Aetna** or an affiliate to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**.

Participants should remember that services that are provided or received without advance authorization from Aetna, 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 and urgent care services, benefits will only be paid when you utilize **network providers** and facilities.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **network provider** may terminate the provider contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between **Aetna** and your selected **PCP** is terminated, **Aetna** will notify you of the termination and request you to select another **PCP**.

Ongoing Reviews:

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet. If **Aetna** determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Claim Procedures/Complaints and Appeals* section of this Booklet.

How Your HMO Standard Medical Plan Works

The Primary Care Physician:

To access network benefits, you are encouraged to select a **Primary Care Physician (PCP**) from **Aetna**'s network of providers at the time of enrollment. Each covered family member may select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of participating providers in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory through your employer or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, or pediatrician. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on **Aetna**'s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna**'s receipt and approval of the request.

Specialists and Other Network Providers

You may directly access **specialists** and other health care professionals in the network for covered services and supplies under this Booklet. Refer to the **Aetna provider directory** to locate network **specialists**, **providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Network Providers and Benefits

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians** and **other health care** providers and facilities. You can change your **PCP** at any time.
- If a service you need is covered under the plan but not available from a **network provider** or **hospital** in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **copayments**.

You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **copayments** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- For certain types of services and supplies, you will be responsible for any **copayments** shown in the *Schedule of Benefits*.
- You will be responsible for any applicable **copayments** for **covered expenses** that you incur. You will not have to pay any balance bills above the **copayment** for that covered service or supply. You will be responsible for your **copayment** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* section for information on what expenses do not apply. Refer to your *Schedule of Benefits* for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **copayment** or any non-covered expenses that you incur.

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. We 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.

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.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent condition**.

In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **primary care physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **PCP** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan.

Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

Important Reminder

With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

In Case of an Urgent Condition

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **PCP**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna**'s online provider directory at www.aetna.com.

Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-**urgent condition**, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder
If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **PCP**.

Important Notice
Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Requirements for Coverage

When Services are Covered

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:
   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

HMO Standard Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply. Services and supplies not described here but mandated by state or federal law and applicable to the Health Plan will be covered by the HMO. Refer to the *Schedule of Benefits* for the frequency limits that apply to these services, if not shown below

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 covered provider;
- 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 force.

Types of Care	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 o When the pick-up point is inaccessible by ground transportation o 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 o When speed in excess of ground vehicle speed is critical
Anesthesia Services • Both inpatient and outpatient	
Autism Spectrum Disorder • Diagnosis and treatment through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services for 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 Florida Statutes 627.6886 and 641.31098, 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 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 specified by statute.
Clinical Trials	• Includes routine patient care costs that are incurred by an insured individual who participates in a clinical cancer trial if those services, including drugs, items and devices, 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.
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 otherwise 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 our HMO 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 such treatment or surgery is the result of an accident • For 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 dermatologist who is under contract with the HMO
Diabetes and Pre-diabetes Treatment • Diabetes self-management and training	• 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) 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 • 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: • PCP must request the consultation • Consulting physician shall prepare a written report • Child health supervision services and Adult preventive medical services will be as defined by the Patient Protection and Affordable Care Act, which includes: • 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; • Immunizations that have in effect a recommendation from the Advisory committee on Immunization Practices of the Centers for Diseases 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
Durable Medical Equipment • At the Health Plan's option, the rental or purchase of medical equipment and medical supplies for the care and treatment of a condition covered under this Health Plan, which includes: • 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 • Ambulatory home uterine activity monitoring devices (AHUM) • Wheelchairs, hospital beds, lumbar-sacral-orthotic (LSO) and thoracic-lumbar-sacral-orthotic (TLSO) braces, and traction equipment • Other medical equipment and supplies as determined to be	• Durable Medical Equipment: o Shall not serve as a comfort, hygiene, or convenience item o Shall not be used for the sole purpose of exercise o Shall not be used by any other party o Shall have been manufactured specifically for medical use o Shall not include shoe buildups, shoe orthotics, shoe braces or shoe supports unless the shoe is attached to a brace o Shall not include water therapy devices, modification to motor vehicles and/or homes or similar items

medically necessary	
Emergency Care	• Coverage, without prior authorization, for screening and stabilization based on determination by either a participating or non-participating 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: o Limited to the first pair following an accident to the eye or cataract surgery o Includes the examination for the prescribing or fitting thereof o For treatment of a covered condition: o Aphakic patients and soft lenses or sclera shells o Following an injury, disease or accident
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 healthcare agency for a covered person confined and convalescing at home for a covered condition • Home health care services include: o Part-time, intermittent or continuous nursing care by registered nurses or licensed practical nurses, nurse registries or home health agencies; o Physical, speech, occupational and respiratory therapy; and infusion therapy o 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 bad been confined in a hospital	• For approval of home health care services by your PCP or the Health Plan: o The treating physician must submit a home health care plan of treatment to your PCP o 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 o 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: o Any service that would not have been covered had the covered person been confined to a hospital o Services which are solely for the convenience of the covered person o Physical therapy is subject to outpatient limitations described under rehabilitative services
Hospice Care • In-home care o Physician services o Physical, respiratory, massage, speech and occupational therapy if approved by the Health Plan o Medical supplies, drugs and appliances o Home health aide services o Part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) or private duty nursing service o Oxygen o Infusion Therapy • Hospice Inpatient Care o Room and board and general nursing care	• Hospice treatment program shall: o Meet the standards outlined by the National Hospice Association; o Be recognized as an approved hospice program by the Health Plan; o Be licensed, certified, and registered as required by Florida law; and o 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: o Treatment for and counseling of terminally ill

○ 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	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, regular plan benefits are not payable for expenses related to the terminal illness ○ Limited to 210 calendar days per lifetime • These following services are not covered under this Health Plan: ○ Social work services ○ Bereavement and pastoral ○ Financial ○ Legal ○ Dietary counseling ○ Day care ○ Homemaker and chore services ○ Funeral services
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, for example: ○ Use of operating room, labor room, delivery room and recovery room ○ Use of covered 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 two years – ages 40 through 49 • One mammogram every year – age 50 and over • At any age if deemed medically necessary
Maternity Care • Pre-natal and post-natal care and monitoring of the mother	• Covered hospital stays for the mother and newborn child will be no less than:

• Delivery in a hospital or birth center • Postpartum care • Newborn care and assessment, including initial exam from pediatrician • Medically necessary clinical tests and immunizations • Routine well-baby nursery services • Midwife services • Breastfeeding support, supplies and counseling	○ 48 hours for a normal delivery ○ 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: ○ Limited to one breast pump per 36 months or 1 manual standard breast pump per birth.
Mental health, alcoholism and substance abuse care • Inpatient – hospital or specialty institution • Outpatient – alcoholism and substance abuse	• 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: ○ Alcoholism and substance abuse care includes detoxification • For outpatient care: ○ Mental health and nervous disorders treatment includes diagnostic evaluation, and psychiatric treatment, and individual and group therapy ○ For learning and behavioral disabilities or intellectual disabilities, coverage is limited to evaluation and diagnosis ○ No coverage is provided for marriage counseling, court ordered care or testing or required as a condition of parole or probation, testing for aptitude, ability, intelligence or interest
Newborn Care • Coverage includes, but is not limited to: ○ Coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities or prematurity. ○ 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.	• 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 Coverage for the unenrolled newborn child of a covered.
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	• Does not include care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes

Organ Transplants • Services, care and treatment received for or in connection with the approved transplantation of the following human tissue and organs: o Heart o Heart/lung o Lung o Liver o Kidney o Kidney/pancreas o Bone marrow o Cornea • Covered services include: o Hospital and medical expenses in accordance with the same terms and conditions as the Health Plan shall pay benefits for care and treatment of any other covered condition; and o 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 • To have a transplant covered: o 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 o 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 o 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 • For bone marrow transplants: o Includes the harvesting, transplantation and chemotherapy components o Donor costs are covered in the same way as costs for the covered person, including limitations and non-covered services • 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; o The expense relates to the transplantation of any non-human organ or tissue; o The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ; o The organ is sold rather than donated to the person; o The expense relates to the donation or acquisition of an organ for recipient who is not covered by the Health Plan except in the case of the donor costs for bone marrow transplants; or o 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: o Artificial heart devices used as a bridge to transplant; o Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; and o Any service or supply in connection with identification of a donor from a local, state, or national listing
Outpatient Care • Treatment as an outpatient in a hospital, a health care	• Includes medically necessary supplies provided or used by the facility during the surgery or treatment, such as:

provider's office, an ambulatory surgical center or other licensed outpatient healthcare facility • Clinical laboratory services • Services for outpatient surgery and outpatient treatment of an injury	○ 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.
Preventive Services	• Preventive medical services will be as defined by the Patient Protection and Affordable Care Act, which includes: ○ 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 o 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 1 electric breast pump per 36 months or 1 manual pump per birth) • Annual well woman visits expanded to include prenatal care, contraceptive counseling and methods (see *Contraceptive Services* within this table of services)
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 • Agreement 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	
Second Medical Opinions • May be requested by the covered person or the Health Plan for: o Elective surgery o When the appropriateness or necessity of a covered surgical procedure is questioned o Serious injury or illness	• The covered person: Must provide prior notice to the Health Plan o May obtain the opinion from any licensed physician within the Health Plan's service area. The use of second medical opinions in connection with a particular diagnosis or treatment may be restricted to maximum of three per calendar year. • All necessary tests for the second medical opinion must be conducted by participating providers. • 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: o If a participating physician is selected, the only cost to the covered person will be the applicable copayment. o If a non-participating physician is selected, the member may be required 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	• PCP or Health Plan 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.

Newborn Care. Coverage for the newborn child of an eligible dependent will be terminated 18 months after the birth of the newborn. This coverage shall include:

- Coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity; and
- 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

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 OUR MEMBER SERVICES AND IS INTENDED TO ACCOMPANY THIS SUMMRY PLAN DESCRIPTION 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	$250 per admission; 100% coverage thereafter

	• Radiation and inhalation therapies	
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) • 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.	$100 copayment
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 Maternity Care • Outpatient	 $20 per visit $40 per visit $40 copay/first visit only for prenatal

	• Inpatient	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

Additional Coverage Details

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment copayment** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Pregnancy Related Expenses

In regards to the employee or spouse, **covered expenses** include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;

- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- any item listed in the *Exclusions* section.

Short-Term Rehabilitation Therapy Services

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy (limited) and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy is excluded unless as a home health or hospice service or to treat Autism Spectrum Disorder.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period. **Covered expenses** also include expenses incurred by a covered person under the age of 18 for services for the diagnosis and treatment of Autism. Benefits are payable on the same basis as any other neurological disorder.
Services for Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavioral Analysis in association to Autism are covered up to a calendar year maximum of $36,000 and a l**ifetime maximum** of $200,000.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - the defect results in severe facial disfigurement, or
  - the defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits*.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition (except as required by law);
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **copayment** and maximum benefit limits.

Treatment of Infertility

Basic Infertility Expenses

Covered expenses include charges made by a **network physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Spinal Manipulation Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; ***or*** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders
Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities

Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Treatment of Mental Disorders and Substance Abuse

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of **mental disorders** by **behavioral health providers**.

Important Note
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a **physician** or licensed provider; and
- The Plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder

- Please refer to the *Schedule of Benefits* for any **copayments**, maximums and **Maximum Out-of-Pocket Limit** that may apply to your **mental disorders** benefits.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers**.

Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a **physician** or licensed provider; and
- The plan is for a condition that can be favorably changed.

Please refer to the *Schedule of Benefits* for any **substance abuse copayments**, maximums and **Maximum Out-of-Pocket Limit** that may apply to your **substance abuse** benefits.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Important Reminder

- Please refer to the *Schedule of Benefits* for any **copayments**, maximums and **Maximum Out-of-Pocket Limit** that may apply to your **substance abuse** benefits.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Limitations and Exclusions

Service Limitations

Excluded Services

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. Elective abortions performed at any time during a Pregnancy; or services in connection with the Pregnancy of eligible Children; however, medically necessary services due to the following complications of Pregnancy are covered by the Plan:

- Conditions whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy;
- Conditions that are caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
- A non-elective cesarean section;
- an ectopic Pregnancy which is terminated; and
- a spontaneous termination of Pregnancy, which occurs before the twenty-second (22^{nd}) week of gestation.

NOTE: Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning Sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult Pregnancy which do not constitute a nosologically distinct complication of 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.

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 (e.g., services or supplies to treat a complication of cosmetic surgery shall not be covered under this Health Plan)**.**

Cosmetic surgery (plastic and reconstructive surgery), and any other service and supply to improve the covered person's appearance or self-perception, such as electrolysis, procedures or supplies to correct baldness, or the appearance of skin (wrinkling).

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 completion of 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; implant, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic, rapid palatial expanders; continuous passive motion (CPM) devices, except 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 due to a significant amount of undue medical risk.

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

Experimental/Investigational or not Medically Necessary Treatment, as defined in the glossary, 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, hyperiopa, 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.

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

Hearing aids, (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers; however, hearing tests shall be a covered service when associated with covered ear surgery.

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 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. This includes artificial insemination, 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.

Marital therapy.

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, unless determined to be medically necessary by the Health Plan, 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.

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 accommodations and/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.

Services or supplies that are:

- Determined not to be medically necessary
- Not specifically listed in the covered benefits section unless such services are specifically required to be covered by state or federal law. This Health Plan shall provide coverage on a primary or secondary basis as required by state or federal law;
- Court ordered care or treatment, unless otherwise covered in this Health Plan;
- For the 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;
- 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;
- Provided by a physician or other health care provider who normally resides in the covered person's home;

- Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust or similar person or group;
- Non-medical conditions related to hyperkinetic syndromes, learning disabilities, intellectual disabilities or inpatient confinement for environmental change;
- Supplied at no charge, or;
- Determined by the Health Plan not to be the most cost-effective setting, procedure or treatment.

Sexual reassignment, reproduction or modification services, including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prostheses, genetic tests to determine paternity or sex of a child, or the insertion of penile prosthesis except when necessary in the treatment of organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post prostatectomy, post priapism, and epispadias and exstrophy.

Sleep therapy.

Smoking cessation programs, Including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and 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.

Transfusion, autologous.

Transportation service that Is non-emergency transportation between institutional care facilities, or to and from the covered person's residence.

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 disabilities, 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

Prescription Drug Program

Covered Drugs

Excluded Drugs

Fills at Retail and Mail

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 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.

Coordination of Benefits - What Happens When There is More Than One Health Plan

Coordination with Other Group Insurance Plans

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

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

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

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

In order to ensure claims processing accuracy and appropriate coordination of benefits, DSGI requires that Aetna 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. Aetna will automatically process or reprocess any claims that may have been denied or held once you have provided the requested OCL information.

How Coordination Works

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

- If this Plan is primary, it will pay benefits first. Benefits will be paid as they normally would under this Plan, regardless of your other insurance coverage.

- If this Plan is secondary, it will pay benefits second. In this case, benefits from this Plan and from the primary plan will not be more than 100% 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.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible, if applicable, any amounts that would have been credited in the absence of other coverage.

Under the Coordination of Benefits provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans coordination generally does not occur with respect to the use of panel providers. However, coordination may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, 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 covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

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 Aetna 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 provides a Special Enrollment Period to allow you to enroll in Medicare Part B without incurring an additional Medicare premium in this situation. However, the Medicare Special Enrollment Period rules have no bearing on the provisions of this Plan. If you are Medicare eligible and Medicare Part A and 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.

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 Aetna after Medicare pays what is covered. Call Aetna Customer service and request to be set up for automatic crossover from Medicare. No separate filing to Aetna 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 we continue as the primary plan with the corresponding higher monthly insurance premium. If you delay, we will pay claims secondary as if you had Medicare, which will require you to pay significantly more out-of-pocket.

How Coordination With Medicare Works

When the Plan is Primary
The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary
Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information
Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

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's 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).

General Provisions

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the **Aetna** medical benefits plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The **Aetna** medical benefits plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this **Aetna** medical benefits plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this **Aetna** medical benefits plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this **Aetna** medical benefits plan.

Subrogation and Right of Recovery Provision

Definitions
As used throughout this provision, the term **Responsible Party** means any party actually, possibly, or potentially responsible for making any payment to a **Covered Person** due to a **Covered Person's** injury, illness or condition. The term **Responsible Party** includes the liability insurer of such party or any **Insurance Coverage**.

For purposes of this provision, the term **Insurance Coverage** refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile **Insurance Coverage**, or any first party **Insurance Coverage**.

For purposes of this provision, a **Covered Person** includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation
Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a **Covered Person** has against any **Responsible Party** with respect to any payment made by the **Responsible Party** to a **Covered Person** due to a **Covered Person's** injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement
In addition, if a **Covered Person** receives any payment from any **Responsible Party** or **Insurance Coverage** as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the **Covered Person** for all amounts the plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the **Covered Person** receives from any **Responsible Party**.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** agrees that if he/she receives any payment from any **Responsible Party** as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the **Covered Person's** fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which **Responsible Party** is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any **Insurance Coverage**, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the **Covered Person**, the **Covered Person's** representative or agent; **Responsible Party**; **Responsible Party's** insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim
By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** acknowledges that the plan's recovery rights are a first priority claim against all **Responsible Parties** and are to be paid to the plan before any other claim for the **Covered Person's** damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any **Responsible Party's** payments, even if such payment to the plan will result in a recovery to the **Covered Person** which is insufficient to make the **Covered Person** whole or to compensate the **Covered Person** in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the **Covered Person** to pursue the **Covered Person's** damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any **Responsible Party** and regardless of whether the settlement or judgment received by the **Covered Person** identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation
The **Covered Person** shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the **Covered Person** to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the **Covered Person's** intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the **Covered Person**. The **Covered Person** and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery obtained by the **Covered Person**, may result in the termination of health benefits for the **Covered Person** or the institution of court proceedings against the **Covered Person**.

The **Covered Person** shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The **Covered Person** acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any **Responsible Party**. The plan reserves the right to notify **Responsible Party** and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the **Covered Person** hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Workers' Compensation

If benefits are paid under the **Aetna** medical benefits plan and **Aetna** determines you received Workers' Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna**, on behalf of the Plan, **w**ill exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this **Aetna** medical benefits plan, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna**, on behalf of the Plan, as described above.

If benefits are paid under this **Aetna** medical benefits plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna**, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

When a **PCP** provides care for you or a covered dependent, or care is provided by a **network provider** (**network services or supplies**), the **network provider** will take care of filing claims.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Claims and Appeals

Filing Health Claims under the Plan
Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your benefit claim is totally or partially denied, Aetna Life Insurance Company (Aetna) 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 Aetna or Express Scripts.

Appealing to the HMO – A Level I Appeal

You, or your authorized representative on your behalf, have the right to appeal a full or partial denial of benefits or payment of a claim for medical services, supplies and/or prescription drugs you have received (post-service) or are planning to receive (pre-service). Your appeal must be received by Aetna 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 (Aetna 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:

Aetna
Attn: National Account CRT
P.O. Box 26411
Tampa, FL 33623

Or fax to: (859) 425-3379

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's 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's denial of your Level I Appeal. Your Level II Appeal must include:

1. A copy of the denial notice (EOB, MHS, or other notice of denial);
2. A copy of your letter to the HMO or Express Scripts requesting a Level I Appeal;
3. A copy of the HMO or Express Scripts's 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.

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

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 (Aetna 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, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit (including a denial, reduction, or termination of, or a failure to provide or make payment for a benefit resulting from the application of any utilization review); or

    b. denial to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

    c. 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, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit (including a denial, reduction, or termination of, or a failure to provide or make payment for a benefit resulting from the application of any utilization review); or

    b. denial to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

    c. 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.

The appeal process described in this Section of 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*.

Glossary

Defined Terms

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

Accident
This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Contract. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

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.

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.

B

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center
A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.

- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

C

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage

A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

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.

Directory
A listing of all **network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have a **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

E-visit
An **E-visit** is an online internet consultation between a network **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet E-visit service vendor.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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.

Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

G

H

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.
- **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.
-

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to furnish services or supplies to an **IOE** patient in connection with specific transplants at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants for which it has signed a contract.

J

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L

Late Enrollee
This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet.

Lifetime Maximum
This is the most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime.

L.P.N.
A licensed practical or vocational nurse.

M

Mail Order Pharmacy
An establishment where **prescription drugs** are legally dispensed by mail or other carrier.

Maintenance Care

Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit

Your plan has a **maximum out-of-pocket limit**. Your **copays** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the calendar year.

Medically Necessary or Medical Necessity

Health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not primarily for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (excluded when in association to Autism Spectrum Disorder).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

Morbid Obesity
This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge
The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Network Advanced Reproductive Technology (ART) Specialist
A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology** (**ART**) services.

Network Provider
A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Night Care Treatment
A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Provider
A health care provider who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

Payment Percentage

Payment percentage is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "plan **payment percentage**," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)
This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician
This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R

Recognized Charge
The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the 80th percentile of the Prevailing Charge Rate;

  for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)
This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

R.N.
A registered nurse.

Room and Board
Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Semi-Private Room Rate
The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for those with intellectual disabilities, for custodial or educational care, or for care of **mental disorder**s.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Substance Abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.

- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

U

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in a **illness**; or
- The diagnosis of a **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.

  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden **illness**; **injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

W

Walk-in Clinic

Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of unscheduled, non-emergency **illnesses** and **injuries** and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/HealthInsReformforConsume/, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information.

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

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

The plans' duties with respect to health information about you

The plans are required by law to maintain the privacy of your health information and to provide you with a notice of the plans' legal duties and privacy practices with respect to your health information. Participants in the self-insured plan will receive notices directly from BlueCross and BlueShield of Florida (BCBSF) and Express Scripts (which provides third-party medical and pharmacy support to the self-insured plan); the notices describe how BCBSF 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 U.S. 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 cannot revoke your authorization for a plan that has taken action relying on it. In other words, you cannot 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, P.O. Box 5450, Tallahassee, Florida 32314-5450 to obtain any necessary forms for exercising your rights. The notices you receive from BCBSF, 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 plans' right to refuse

You have the right to ask the plans to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the plans to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the plans to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request must be in writing.

The plans are not required to agree to a requested restriction. 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 information 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 (1) request in any 12-month period at no cost to you, but the plans may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the plans upon request

You have the right to obtain a paper copy of this Privacy Notice upon request.

Changes to the information in this notice

The plans must abide by the terms of the Privacy Notice currently in effect. This notice 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 dms.myflorida.com/dsgi 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 will not be retaliated against for filing a complaint. Complaints about activities by your insurer or HMO, or by BCBSF 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, Florida 32314-5450.

Contact

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