FLORIDA DEPARTMENT OF MANAGEMENT SERVICES
state group insurance
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State Employees' HMO Plan

Group Health Insurance Plan Booklet and Benefits Document

Effective January 1, 2015

My Health My Benefits My Decisions
www.MyFlorida.com/MyBenefits

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

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CONTACT INFO and SERVICE AREA	
Florida Health Care Plans	1340 Ridgewood Avenue Holly Hill, FL 32117
Member Services – All Areas	(877) 615-4022
HMO Service Area	
Flagler County	Volusia County

If you need information about…	Contact…	
Medical benefits or Claims under FHCP or finding a medical Network Provider within the State of Florida	(877) 615-4022 Email: www.fhcp.com, select "Contact Us" **For medical Claims:** Florida Health Care Plans – Claims P.O. Box 9910 Daytona Beach, FL 32120 (800) 352-9824 **For Level I Appeals:** Florida Health Care Plans – Member Services Grievance Supervisor 1340 Ridgewood Ave Holly Hill, FL 32117	
Pre-Admission Hospital Certification and Prior Authorization	(800) 352-9824 Or fax request to (386) 238-3253	
Prescription drug program information	CVS/caremark (888) 766-5490 *caremark.com/sofrxplan* (plan information) *caremark.com* (user account information)	
	For paper Claims only: CVS/caremark P.O. Box 52010 MC003 Phoenix, AZ 85072-2010	**Level I Appeals:** CVS/caremark Attention: Appeals P.O. Box 52071 Phoenix, AZ 85072-2071
	Or fax your Level I Appeal to CVS/caremark toll-free at (866) 443-1172.	
Enrollment, eligibility, or changing coverage	People First Service Center P.O. Box 6830 Tallahassee, FL 32314	(866) 663-4735 *https://PeopleFirst.myFlorida.com* Fax: (800) 422-3128 (Include your People First ID number on the top right of each page)
Medicare eligibility and enrollment	The Social Security Administration office in your area	

I. INTRODUCTION

The descriptions contained in this document are intended to provide a summary explanation of your benefits. Easy-to-read language has been used as much as possible to help you understand the terms of the Plan. Your insurance coverage is limited to the express written terms of this Summary Plan Description (SPD). Your coverage cannot be changed based upon statements or representations made to you by anyone, including employees of the Division of State Group Insurance (DSGI), Florida Health Care Plans (FHCP), CVS/caremark, People First or your employer. This SPD of the medical benefits provided to you by the State of Florida under the State Employees' HMO Plan (or Plan). This SPD is made available for your reference and is subject to various legal requirements, including the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The State Employees' HMO Plan is further subject to federal and State of Florida laws and rules promulgated pursuant to law including, but not limited to, as authorized by Title 60 of the Florida Administrative Code. In any instance of conflict, the provisions of this SPD shall take precedence over provisions of law, so far as legally permitted. Any clause, section or part of this SPD that is held or declared invalid for any reason shall be eliminated, and the remaining portion or portions shall remain in full force and be valid, as if such invalid clause or section had not been incorporated herein. Unless otherwise noted in this document, if the terms of this document and the terms of the Plan conflict, the SPD shall control.

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

Florida Health Care Plans, in arranging for the delivery of Medical Services or benefits, does not directly provide these Medical Services. Florida Health Care Plans arranges for the provision of said services in accordance with the covenants and conditions contained in this SPD.

This benefit plan is designed to cover most major medical expenses for a covered illness or injury, including Hospital, physician services and prescription drugs. However, you will be responsible for any:

1. Deductibles (HIHP Option only);
2. Coinsurance (HIHP Option only);
3. Copayments;
4. Hospital admission fees;
5. Non-covered services;
6. Amounts above or beyond the Plan's Limitations;
7. Non-emergency services in a non-Network Hospital, facility or office (i.e., anesthesiology, nurse anesthetists, radiology, pathology, laboratory, emergency room physician services and so forth) unless authorized in advance by FHCP, not the Primary Care Physician; and
8. Any other services identified in this SPD as excluded.

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

The State of Florida contracts with FHCP to arrange for the provision of Medical Services which are Medically Necessary for the diagnosis and treatment of Health Plan Members through a Network of contracted independent physicians and Hospitals and other health care providers.

You Must Enroll to Receive Benefits

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

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

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

Medical Claims

The Plan is not intended to and does not cover or provide any Medical Services or benefits that are not Medically Necessary for the diagnosis and treatment of the Health Plan Member. Florida Health Care Plans determines whether the services are Medically Necessary, subject to the terms and conditions of the Plan.

Claims for benefits are to be sent to FHCP. Sometimes medical providers make a mistake and over charge for the service. Please report any suspected billing errors to FHCP.

Prescription Drug Claims

When you use a participating pharmacy, you do not need to file a Claim. The Claim will be submitted electronically to CVS/caremark. You will be responsible for your Copayment or Coinsurance, subject to the calendar year Deductible, if applicable to your Prescription Drug Plan.

Important: Timely Filing of Claims

All Claim forms must be submitted within six months after the date of service in accordance with section 641.3155, Florida Statutes. 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 six month requirement does not apply if you are legally incapacitated.

Rights to Employment

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

Rights to Amend or Terminate the Plan

The State has arranged to sponsor this Plan indefinitely, but reserves the right to amend, suspend, or terminate it for any reason. Plan fee schedules, allowed amounts, allowances, physician and pharmacy Network participation status, medical policy guidelines, prescription preferred drug list, prescription specialty drug program guidelines and premium rates are subject to change at any time without the consent of Health Plan Members. You will be given notice of any changes that affect your benefit levels as soon as administratively possible. The Plan Administrator fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Primary Care Physician

The first and most important decision you must make is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of Specialists, are coordinated.

You are free to choose any Primary Care Physician listed in FHCP's Provider Directory whose practice is open to new patients. This choice should be made when you enroll. You are responsible for choosing a Primary Care Physician for all minor Dependents including a newborn child or an adopted newborn child. If you fail to choose a Primary Care Physician when enrolling, FHCP will assign one to you and notify you of that assignment.

The following includes important information concerning your Primary Care Physician relationship:

- Primary Care Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs.
- Developing and continuing a relationship with a Primary Care Physician allows the physician to become knowledgeable about your health history.
- A Primary Care Physician can help you determine the need to visit a Specialist and also help you find one based on their knowledge of you and your specific healthcare needs.
- The Primary Care Physician selected by you will be responsible for helping to coordinate medical Services on your behalf.

You should also ask whether the Primary Care Physician has a referral relationship with any Specialist you are currently seeing or may wish to see. Your choice of Primary Care Physician may affect your access to certain Network Specialists.

II. DEFINITIONS

As used in this SPD, each of the following terms shall be capitalized throughout this document and shall have the meaning indicated:

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

Applied Behavior Analysis - 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 - Any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

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

Claim - A request for benefits under the Plan made by a Health Plan Member in accordance with FHCP's procedures for filing benefit Claims, including Pre-Service Claims and Post-Service Claims.

Coinsurance - The amount a Health Plan Member must pay once the Deductible has been met, if applicable, and is expressed as a percentage of the fee for the covered benefit.

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

Deductible - The first payments up to a specified dollar amount which a Health Plan Member must make in the applicable calendar year for covered benefits. The Deductible applies to each Health Plan Member, subject to any family Deductible listed on the Schedule of Benefits. For purposes of the Deductible, "family" means the Enrollee and Health Plan Members. The Deductible must be satisfied once each calendar year.

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

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

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

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

With respect to a pregnant woman:

- That there is inadequate time to effect safe transfer to another Hospital prior to delivery;
- That a transfer may pose a threat to the health and safety of the patient or fetus; or
- That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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

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

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

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

Enrollee - All state officers and employees, retired state officers and employees, Surviving Spouses of deceased state officers and employees, and terminated employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program. "Enrollee" includes all state university officers and employees, retired state university officers and employees, Surviving Spouses of deceased state university officers and employees, and terminated state university employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program.

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

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

- The FDA has not granted the approval for general use; or
- There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- There is no consensus among practicing physicians that the medication, treatment, therapy, procedure or device is safe or effective for the treatment in question or such medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or a similar condition; or
- Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or Experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard for treatment or diagnosis of the condition in question.

Group Health Insurance - That form of health insurance covering groups of persons under a master Group Health Insurance policy issued to any one of the groups listed in Sections 627.552 (employee groups), 627.553 (debtor groups), 627.554 (labor union and association groups), and 627.5565 (additional groups), Florida Statutes. Under this SPD, FHCP is your State of Florida contracted, independent, licensed, group Health Insurer. Florida Health Care Plans is:

- a state certified, federally qualified Health Maintenance Organization accredited by the National Committee for Quality Assurance. Providing fully insured health care benefits in accordance with Florida Statutes 627 & 641.
- an affiliate of Florida Blue otherwise known as Blue Cross and Blue Shield of Florida, and an Independent Licensee of the Blue Cross and Blue Shield Association.

Health Maintenance Organization or "HMO" - An entity certified under part I of chapter 641.

Health Plan Member - Any person participating in a State Group Health Insurance Plan or a Health Maintenance Organization plan under the state group insurance program, including Enrollees and covered dependents thereof.

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

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

Hospice - A public agency or private organization that is duly licensed by the State to provide Hospice services. Such licensed entity must be principally engaged in providing pain relief, symptom management and supportive services to terminally ill Health Plan Members.

Hospital - Any general acute care facility which is licensed by the State.

Hospital Services - Except as expressly limited or excluded by the Plan, means those services for registered bed patients that are:

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

Limitation - Any provision, other than an Exclusion, which restricts coverage under the Plan.

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

- Consistent with the symptom, diagnosis, and treatment of the Health Plan Member's condition;
- The most appropriate level of supply and/or service for the diagnosis and treatment of the Health Plan Member's condition;
- In accordance with standards of acceptable community practice;
- Not primarily intended for the personal comfort or convenience of the Health Plan Member, the Health Plan Member's family, the physician or other health care providers;
- Approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Health Plan Member's condition; and
- Not Experimental or investigational.

Medical Office - Any outpatient facility or physician's office.

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

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

Network - The providers and facilities that have contracted with FHCP to provide covered services to Health Plan Members. The Health Plan Members' Copayment, Deductible and/or Coinsurance responsibilities are outlined in the Medical Benefits section within this document. Sometimes referred to as "Participating Provider."

Non-participating Provider - Any Health Professional or group of Health Professionals, Hospital, Medical Office or Other Health Care Facility with whom FHCP has neither made arrangements nor contracted to render the professional health services set forth herein as a Participating Provider. Sometimes referred to as "Non-Network."

Other Health Care Facility - Any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services such as skilled nursing care and rehabilitative services.

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

Participating Provider - Any Health Professional (or group of), Hospital, Medical Office or Other Health Care Facility with whom FHCP has made arrangements or contracted to render the professional health services set forth herein.

Plan Administrator - State of Florida, Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL 32314-5450.

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

Pre-Service Claim - Any Claim for benefits under the Plan for which (in whole or in part), a Health Plan Member must obtain authorization from FHCP in advance of such services being provided to or received by the Health Plan Member.

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

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

Retired State Officer or Employee or "Retiree" - Any state or state university officer or employee who retires under a state retirement system or a state optional annuity or retirement program or is placed on disability retirement, and who was insured under the state group insurance program at the time of retirement, and who begins receiving retirement benefits immediately after retirement from state or state university office or employment. The term also includes any state officer or state employee who retires under the Florida Retirement System Investment Plan established under part II of chapter 121 if he or she:

1. Meets the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29); or
2. Has attained the age specified by s. 72(t)(2)(A)(i) of the Internal Revenue Code and has 6 years of creditable service.

Service Area - Those counties in the State of Florida where FHCP has been approved to conduct business by the State of Florida Agency for Health Care Administration.

Specialist - Any Participating Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), Florida Statutes, other than the Health Plan Member's Primary Care Physician.

State Group Health Insurance Plan or Plans or "state plan or plans" - The state self-insured and/or fully insured health insurance plan or plans offered to state officers and employees, retired state officers and employees, and Surviving Spouses of deceased state officers and employees pursuant to this section.

State Group Insurance Program or "programs" means the package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan or plans, health maintenance organization plans and other plans required or authorized by law

Summary Plan Description - This document which describes the Plan benefits, Exclusions, cost-share amounts, and other Plan features. Also called "Plan Booklet and Benefits Document."

Surviving Spouse - The widow or widower of a deceased state officer, full-time state employee, part-time state employee, or Retiree if such widow or widower was covered as a dependent under the State Group Health Insurance Plan or a Health Maintenance Organization plan established pursuant to this section at the time of the death of the deceased officer, employee, or Retiree. "Surviving spouse" also means any widow or widower who is receiving or eligible to receive a monthly state warrant from a state retirement system as the beneficiary of a state officer, full-time state employee, or Retiree who died prior to July 1, 1979. For the purposes of this section, any such widow or widower shall cease to be a Surviving Spouse upon his or her remarriage.

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

Urgent Care - Medical screening, examination and evaluation in an ambulatory setting outside of a Hospital emergency department, including an urgent care center, retail clinic or PCP office after-hours, on a walk-in basis and usually without a scheduled appointment and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

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

- Concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate;
- Case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a skilled nursing facility) and for outpatients when deemed appropriate; and
- The benefit coordination program which is designed to conduct prospective reviews for select Medical Services to ensure that services are covered and Medically Necessary. The benefit coordination program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.
- Concurrent review or care means an ongoing course of treatment to be provided over a period of time or number of treatments that was previously approved by FHCP.

III. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

Active Employees

All State of Florida employees as defined in Section 110.123(2)(c) and (f), Florida Statutes, qualify for coverage under the active employee benefit plans described in this guide.

Retirees

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

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

2. Retired before January 1, 1976, under any state retirement system and you are not eligible to receive any Social Security benefits.

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

Employees thinking of retirement should review the State Group Insurance Benefits Package for New Retirees, available at *www.MyFlorida.com/myBenefits* under *Forms and Resources*. Employees who do not continue health and life insurance coverage at the time of retirement may not enroll or re-enroll later as a Retiree.

When you become Medicare eligible, please visit *www.medicare.gov* or contact your local Social Security office to learn about your eligibility, coverage options, enrollment periods and necessary steps to follow to ensure that you have adequate coverage. Carefully review the Coordination of Benefits section of this document for more information about how this Plan works with Medicare.

Important Reasons to Call People First, the State of Florida's vendor for insurance administration. Call (866) 663-4735 when:

- You go off the payroll for any reason;
- You or your dependent becomes eligible for Medicare;
- You have a change of mailing address;
- Your dependent becomes ineligible for coverage; or
- Your spouse becomes employed by or ends employment with the state.

To cover your eligible dependents, you must:

1. Register your dependents online in People First;
2. Select the correct family coverage tier for each plan selected to cover dependents;
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	• As defined in section 741.212, Florida Statutes
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 Enrollee is still married to the children's parent • Foster children • Children for whom the Enrollee has established legal guardianship under chapter 744, Florida Statutes, or court-ordered temporary custody • Children with a qualified medical support order requiring the Enrollee 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 Enrollee 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. You may cover your over-age dependent, defined as a child age 26-30, under an individual health policy for an additional monthly premium. You and your eligible over-age dependent must be enrolled in the same health plan. The amount of financial support you provide determines whether the monthly premium for coverage comes out of your paycheck pretax as an active employee 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 FHCP prior to their 26th birthday; and • They are incapable of self-sustaining employment because of intellectual or physical disability, and • They are dependent on you for care and financial support, and • The treating physician provides documentation supporting the intellectual or physical disability while the dependent is still covered under the Plan. You must submit documentation to the health plan upon request for review and confirmation. Disability status is verified at least every five years. If you fail to provide the required documentation or your dependent no longer meets eligibility requirements, you may be liable for medical and prescription drug Claims or premiums back to the date you enrolled your dependent. Enrollees who have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria may enroll that child in the Plan the **first** time they enroll in a State-sponsored Plan.
Dependent of a dependent – you may cover your dependent's newborn from birth up to age 18 months if:	• The baby is born while the your dependent is covered under the Plan, and • The dependent remains covered under the Plan, and • You add the newborn within 60 days of the birth. You may be asked to provide documentation for your eligible dependents. Failing to provide the required documentation may make you liable for medical and prescription Claims or premiums back to the date of enrollment. You must fax required documentation to (800) 422-3128 or mail to People First Service Center, P.O. Box 6830, Tallahassee, Florida 32314. Please include your People First ID number on the top right corner of each page of your fax or other documentation. Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.

When Coverage Ends

Your coverage in the Plan ends:

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

If your spouse is enrolled, their coverage ends on the last day of the month:

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

Coverage for dependent children (as defined above) ends:

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

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

Enrolling and Making Changes

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

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.

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 *People First*.

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 you are 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 of employment. For example, employees hired in March will begin coverage in May.

Option 2 – Qualifying Status Change (QSC) Event

To make an enrollment change based on a Qualifying Status Change (QSC) event, federal law requires that the event result in a gain or loss of eligibility for 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 may be asked to submit all required documentation to People First within 60 days of the change. The complete list of QSC events, required documentation and important time frames is available on the myBenefits web site in the *Forms and Resources* section, QSC Matrix.

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

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

Changes made during the year because of a QSC event are effective on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and continues for the rest of the calendar year, as long as you pay premiums on time and you and your 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 on the myBenefits web site in the *Forms and Resources* section and list all eligible dependents, and
- Attach a copy of your marriage license to the Spouse Program Election Form when you submit it to the People First Service Center. Include both you and your spouse's People First ID numbers on each page, and
- Enroll in the same health plan, and
- Agree to notify the People First Service Center within 60 days of becoming ineligible for the Spouse Program. The employed spouse becomes ineligible for the Spouse Program if:
    - One or both end employment with the state, including retirement, or
    - You divorce, or
    - Your spouse dies.

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

Option 5 – Surviving Spouse

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

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 Enrollee'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 Enrollee's death. To enroll, the Surviving Spouse has 60 days to notify the People First Service Center of the death and 31 days to enroll after receipt of the enrollment package. Coverage is effective retroactively once the enrollment form and premiums have been received. Coverage begins the first of the month following the last month of coverage for the deceased; in other words, coverage must be continuous.

Coverage Continuation Family and Medical Leave and Job-Protected Leave

This provision is administered by each employing agency just like any other leave whether 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 an Enrollee 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 you taking such leave. The State of Florida will continue to pay its share of the premium throughout your FMLA leave. You will still be responsible for your portion of the premium. Premium payments will be collected by People First. You and your eligible dependents shall remain covered under this Plan while you are on FMLA leave as if you were still at work as long as premiums are paid.

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

If you cancel this Plan while on any of these leave types and subsequently return to work before or at the end of the leave, you and your eligible dependents may enroll under the Plan without regard to pre-existing conditions that arise while on job-protected leave, provided you cancelled your coverage within 60 days of going out on leave. If you do not cancel coverage within 60 days of going out on leave and your coverage is subsequently canceled for non-payment, you will only be able to enroll during the next Open Enrollment period.

Coverage Continuation When You Are Off Payroll

If you are an active employee and go off the payroll, you must pay your share of the health insurance premium by personal check, cashier's check or money order to continue coverage. You may be required to pay the full premium cost (your share plus the state's share) depending on the reason you are not working. Call People First for more information at (866) 663-4735.

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

COBRA

The Consolidated Omnibus Budget Reconciliation Act is referred to as COBRA. Under COBRA, you can continue healthcare coverage that would otherwise end because dependent eligibility and because of voluntary or involuntary termination for reasons other than gross misconduct. You may also continue healthcare coverage that would otherwise end because you did not return to work after an unpaid leave under the Family and Medical Leave Act. You may keep this continuation coverage for up to 18 months, provided you pay the required cost of the continued coverage. The monthly premium is 102 percent of the cost of coverage (you pay the full premium plus 2% administrative fee).

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

Non-disabled family members who receive COBRA coverage because of the same termination of employment or change in employment status as the disabled person are also eligible for the disability extension. The monthly premium for the additional 11 months of coverage is 150% of the cost of coverage.

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

1. Death of the Enrollee, whether active or on an approved leave of absence;
2. Divorce or legal separation from the employee; or
3. Enrollee 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 the date:

1. Coverage is lost because of one of the events described above; or
2. The form is received from People First.

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 dependents who are Health Plan Members 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 FHCP and pay the first month's premium within 63 days of the date your group coverage ended. When you convert, you will have the standard HMO conversion policy. The benefits provided by the conversion policy may be different from the benefits provided under the State Employees' HMO Plan. If you choose COBRA continuation coverage when your Plan coverage ends, you can convert to a private policy when COBRA coverage ends. In this case, you must still apply in writing and pay the first month's premium within 63 days of the date your COBRA coverage ends. Call FHCP at number listed in the contact section within this document for information.

Continuation of Benefits if you are Disabled

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

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

For this continuation of benefits, total disability means:

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

This extension of benefits is provided at no cost to you and can continue if you do not have any other insurance to cover this loss:

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

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

Extension of Benefits if the Plan is Terminated

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

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

IV. SCHEDULE OF BENEFITS

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

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

Any and all decisions that pertain to the medical need for, or desirability of, the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Health Plan Member and his physician in accordance with the normal patient/physician relationship for purposes of determining what is in the best interest of the Health Plan Member. Florida Health Care Plans does not have the right of control over the medical decisions made by the Health Plan Member's physician or health care providers. The ordering of a service by a physician, whether participating or Non-participating, does not in itself make such service Medically Necessary or a covered benefit under the Plan.

The State of Florida and you as the Health Plan Member acknowledge the possibility that a Health Plan Member and his physician may determine that such services or supplies are appropriate even though such services or supplies are not covered and will not be arranged or paid for by the Plan. Any covered service for which the Health Plan Member is seeking reimbursement must be submitted to FHCP within one year from the date of service to be considered.

Understanding Your Share of Health Care Expenses

Deductibles and Copayments are paid by Health Plan Members

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

A Deductible (applies only to Health Investor Option) is an amount of money you pay one time each benefit year before this Plan pays anything. Typically, there is one Deductible amount per Health Plan Member and it must be paid before any money is paid by the Plan for any Claim. Each January 1, a new Deductible amount is required to be met.

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

- **If you have family coverage,** the family aggregate amount must be met by one or a combination of your covered family members before this Plan begins paying a percentage of your eligible expenses. Once your family satisfies the family aggregate Deductible, this Plan begins paying a percentage of covered expenses from Network Providers for you and all your dependents covered as Health Plan Members for the rest of the calendar year.

Preventive services are paid at 100% and not subject to the Deductible.

Global Network Out-of-Pocket Maximum

There is a limit on the amount you pay out of your pocket toward covered expenses in any one calendar year for in-Network covered services and supplies and prescription drugs. Once your share of Network out-of-pocket expenses reaches the annual limit, this Plan begins paying 100 percent of the Claims for Network allowed amount for Network covered services and supplies and prescription drugs for the remainder of the calendar year for you. You meet the family global out-of-pocket maximum when two covered family members or a combination of family members meet the family Network out-of-pocket maximum.

- **If you have individual coverage,** this Plan begins paying all of your eligible expenses after you meet your individual out-of-pocket limit.

- **If you have family coverage,** the family aggregate amount must be met by one or a combination of your covered family members before this Plan begins paying a percentage of your eligible expenses. Once your family satisfies the family aggregate out-of-pocket, this Plan begins paying all of the covered expenses from Network Participating Providers for you and all your dependents covered as Health Plan Members for the rest of the calendar year.

Only expenses from Network covered services and supplies and prescription drugs count toward the Network out-of-pocket maximum. Expenses that apply to this maximum include applicable cost share until the aggregate out-of-pocket limit is met. Preventive services are paid at 100%.

Expenses that do not apply to the global Network out-of-pocket limit:

1. Premiums;
2. Prescription drug brand name additional charges;
3. Charges for services, supplies and prescription drugs that are not covered by this Plan;
4. Charges for covered services, supplies and prescription drugs that are greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment;
5. Specialty drugs that are denied by the Specialty Drug Management Program;
6. Specialty drugs that would have been denied or would have been outside clinical treatment guidelines by the Specialty Management Program if you had tried to get the drug approved but did not go through the proper approval process; and,
7. The difference between the cost of the generic drug and brand name drug when the prescribing physician does not indicate "dispense as written" or "brand name Medically Necessary" and you request the brand name drug.

Services that require prior authorization from FHCP include, but are not limited to:	• All inpatient admissions (including but not limited to Hospital and observation stays, skilled nursing facilities, ventilator dependent care and/or acute rehabilitation); • Complex diagnostic testing, therapeutic, and sub-specialty procedures (including but not limited to CT, CTA, MRI, MRA, PET Scans, Nuclear Cardiac Studies and Nuclear Medicine); • Surgical procedures or services performed in an outpatient Hospital, Hospital-affiliated ambulatory surgery center or free-standing ambulatory surgery center; • All medications administered in an outpatient Hospital or infusion therapy setting • Select medications administered in a physician's office; • Non-emergency transportation; • Care rendered by Non-participating Providers (except for Emergency Medical Services and Care); • Transplant services; • Second Medical and Surgical Opinions; • Certain durable medical equipment; and • Dialysis services. For more information about which services require prior authorization, contact FHCP at the number listed in the contact section within this document.

Remember to confirm with your Participating Provider before services are rendered that an authorization for services outside of his purview has been obtained from FHCP. Also, services performed beyond the scope of practice authorized for that provider under State law will be denied unless otherwise expressly authorized under the terms of the Plan or when required to treat an Emergency Medical Condition. Except for Emergency Medical Services and Care, all services must be received from Participating Providers. Any Health Plan Member requiring medical, Hospital or ambulance services for emergencies as described in the Definitions section, either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive emergency benefits.

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

Health Plan Members are free to choose any Primary Care Physician listed in FHCP's Provider Directory list of Primary Care Physicians. This choice should be made when the Health Plan Member enrolls. The Health Plan Member is responsible for choosing a Primary Care Physician for all minor Dependents including a newborn child or an adopted newborn child. If a Health Plan Member fails to choose a Primary Care Physician, FHCP will assign one to the Health Plan Member and notify the Health Plan Member of that assignment. The Primary Care Physician selected by the Health Plan Member maintains a physician-patient relationship with the Health Plan Member, and will be responsible for helping to coordinate all medical Services. Health Plan Members should also ask whether the Primary Care Physician has a referral relationship with any Specialist you are currently seeing or may wish to see. Your choice of Primary Care Physician may affect your access to certain Network Specialists.

Health Professionals may from time to time cease their affiliation with FHCP. In such cases, you must receive services from another participating Health Professional. If the provider is a Primary Care Physician, FHCP may assist the Health Plan Member in selecting, or FHCP may assign, another Primary Care Physician to the Health Plan Member. If the provider is a Specialist, FHCP will authorize a Health Plan Member who, at the time of the contracting provider's termination, is actively receiving treatment for a Condition, to continue to be covered *(for treatment of that Condition)* after the date of the contracting provider's termination. Coverage for that Condition shall continue only until the completion of current course of treatment for the Condition or the Health Plan Member selects another contracting provider.

If you do not follow the access to care rules, you risk having the services and supplies received not covered under the Plan.

You Pay The Cost Share Listed Below To The Health Care Provider At The Time Services Are Rendered

	SCHEDULE OF MEMBER COST SHARE		
	Benefit Description	**Cost to Member**	
		Standard Option	**Health Investor Option**
Deductible (Per Calendar Year)		None	$1,300 Single $2,600 Family
Medical Out-of-Pocket Maximum – (Per Calendar Year)	Includes covered medical expenses only.	$1,500 Single $3,000 Family	See below Global Out-of-Pocket Max
Global Out-of-Pocket Maximum – including Rx (Per Calendar Year)	Includes covered expenses for both medical and prescription drugs.	$6,600 Single $13,200 Family	$3,000 Single $6,000 Family
Preventive Care **Not Subject to Deductible**	Preventive care services include, but are not limited to: • Well-woman examinations, including Pap smears and prenatal care • Annual physical examinations • Immunizations • Well-child care and 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	No Charge
Primary Care Physician	Services at participating doctor's offices include, but are not limited to: • Routine office visits • Minor surgical procedures • Medical hearing examinations	$20 per visit	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Specialty Care Physician Services	Your Primary Care Physician and, in certain situations, FHCP must authorize services in advance for: • Office visits, consultation, diagnosis and treatment	$40 per visit	20% of the contracted rate after you pay Deductible
Hospital	Pre-authorization is required for inpatient care. Inpatient Care at participating Hospitals includes: • Room and board – unlimited days (semi-private) • Physician's, specialist's and surgeon's services • Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication • Intensive care unit and other special units, general and special duty nursing • Laboratory and diagnostic imaging • Required special diets • Radiation and inhalation therapies	$250 per admission; 100% coverage thereafter	20% of the contracted rate after you pay Deductible
Surgery	• Outpatient • Inpatient Except for emergency, your Primary Care Physician or Specialist must obtain prior authorization from FHCP prior to surgery including preparation services and treatment.	No Charge $250 per admission; 100% coverage thereafter	20% of the contracted rate after you pay Deductible
Vision Benefits	Annual eye exam • Primary Care Physician • Specialist Services (office visits, refractions) ○ Participating Optometrist and ophthalmologist	$20 Copayment $40 Copayment	20% of the contracted rate after you pay Deductible
Outpatient Laboratory and X-ray	• Diagnostic Tests • CAT scan, PET scan, MRI • Outpatient Laboratory Tests • Mammograms	No Charge	20% of the contracted rate after you pay Deductible. No Charge for mammograms or preventive diagnostic tests and services

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Emergency Services	Copayment waived if admitted. • Emergency room at participating Hospitals, facilities and/or physicians Hospital and/or referring or admitting physician must call FHCP as soon as possible and within 24 hours of emergency admission or as soon as reasonably possible.	$100 Copayment	20% of the contracted rate after you pay Deductible
Urgent/Immediate Care	• When in FHCP's Service Area, Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office. • When outside FHCP's Service Area, Medical services at a Non-participating Urgent/ Immediate Care facility or Non-participating retail clinic outside FHCP's Service Area.	$25 Copayment	20% of the contracted rate after you pay Deductible
Mental Health	• Inpatient • Outpatient	$250 per admission, 100% coverage thereafter $20 per visit	20% of the contracted rate after you pay Deductible
Alcohol/Drug Treatment	• Inpatient • Outpatient	$250 per admission, 100% coverage thereafter $20 per visit	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Family Planning	Family planning services • Primary Care Physician Services • Specialist Services • Contraceptives, supplies and related services • Sterilization Except for contraceptives and sterilization where no Copayment applies, Copayment amount depends on type of service as noted within this chart for Preventive Adult Care, physician office visits, other physician services, durable medical equipment and prescription drugs. Maternity Care • Outpatient • Inpatient	$20 per visit $40 per visit $40 first visit only $250 per admission, 100% coverage thereafter	20% of the contracted rate after you pay Deductible
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	20% of the contracted rate after you pay Deductible
Ambulance	When pre-authorized or in the case of an emergency	No Charge	20% of the contracted rate after you pay Deductible
Autism Spectrum Disorder, Diagnosis and Treatment of	• Applied Behavior Analysis Services • Physical, speech or occupational therapy	$40 per visit	20% of the contracted rate after you pay Deductible
Home Health Care	Per Occurrence	No Charge	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Durable Medical Equipment	Per Device	No Charge	20% of the contracted rate after you pay Deductible
Rehabilitative Services	Outpatient Services limited to 60 visits per injury	$40 per visit	20% of the contracted rate after you pay Deductible
Skilled Nursing Facilities	• Pre-authorization required • Up to 60 days maximum per calendar year	No Charge	20% of the contracted rate after you pay Deductible
Prosthetic or Orthotic Devices	Per Device	No Charge	20% of the contracted rate after you pay Deductible
Prescription Drugs **CVS/caremark**	Participating Retail Pharmacy (up to a 30-day supply) • Generic • Brand Name, Preferred • Brand Name, Non-Preferred Participating Retail Pharmacy (up to a 90-day supply) • Generic • Brand Name, Preferred • Brand Name, Non-Preferred Mail Order Pharmacy (up to a 90-day supply) • Generic • Brand Name, Preferred • Brand Name, Non-Preferred	$7 $30 $50 $14 $60 $100 $14 $60 $100	After you pay Deductible: 30% 30% 50%
	• If a generic is available and you, rather than your physician, request the brand name drug, your cost is the brand Copayment (or Coinsurance if HIHP) *plus* the difference in the Plan's cost between brand name and the generic. • For oral cancer treatment medications, your cost is the lesser of the appropriate Copay (or Coinsurance if HIHP) or $50.		

V. MEDICAL BENEFITS

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

Coverage Access Rules

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

Also, Health Plan Members shall understand that the ordering of a service by a physician does not in itself make such service a Medically Necessary covered service. Final decisions concerning the existence of coverage or benefits under FHCP cannot be delegated or deemed to have been delegated by the state. However, the health plans hired by the state are responsible for processing Claims in accordance with the terms of this document.

Decisions concerning the benefits or Medical Necessity under the Plan will be made by FHCP. FHCP is responsible for processing Claims in accordance with the terms of its contract with the employer (the State of Florida) and applicable State and/or Federal Laws.

Network providers shall not bill Health Plan Members for covered, authorized services and non-network providers shall not balance bill above negotiated or allowed amounts paid, if any, by the Plan based on usual and customary charges for similar covered services in the community, less the member's cost share, as follows.

Florida Health Care Plans pays the cost of covered care and medical supplies, less the member's cost share, as long as the care or supplies are:

- Ordered by a Network provider (a provider who is in FHCP's Network or otherwise pre-approved by FHCP);
- Considered Medically Necessary for the covered person's treatment because of a covered accident, illness, condition or mental health or nervous disorder;
- Not specifically limited or excluded under this Plan; and
- Rendered while this Plan is in effect.

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

Covered Services	Special Limits/Circumstances
Autism Spectrum Disorder • Diagnosis and treatment through speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis services for an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger. • Coverage includes well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder, speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis. Applied Behavior Analysis is covered when provided by Applied Behavioral Analysts, psychologists, clinical social workers, and others within the scope of their license.	• Coverage limited to services prescribed by the Enrollee's treating physician in accordance with a treatment plan. The required treatment plan includes, but is not limited to, a diagnosis; proposed treatment by type, frequency and duration of treatment; anticipated outcomes stated as goals; frequency with which treatment plan will be updated; and a signature from the treating physician. • Covered as required by sections 627.6686 and 641.31098, Florida Statutes, and as further amended by state and federal law. • Developmental Disability means a disorder or syndrome that is: 1) attributable to intellectual disability, 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.
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 Florida Agency for Health Care Administration. • Includes costs associated with the donor-patient.
Cancer Services • Diagnosis and Treatment	• Includes both inpatient and outpatient diagnostic tests and treatment (including anti-cancer medications administered by Network providers), including cancer clinical trials as set forth in the Florida Clinical Trial Compact. Does not include Experimental or Investigational Treatment.
Cleft Lip and Cleft Palate	• Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology and nutrition services only as required by sections 627.64193 and 641.31(35), Florida Statutes.
Clinical Trials	• Includes routine patient care costs incurred by an insured individual who participates in approved Phase I, II, III or IV clinical trials relating to cancer and other life threatening diseases if those services, including drugs, items and devices, would otherwise be covered under the plan or contract for an insured person not enrolled in a clinical trial program. Experimental treatment is excluded.

Covered Services	Special Limits/Circumstances
Child Health Supervision Services	• Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. • Services as defined by the Patient Protection and Affordable Care Act.
Contraceptive Supplies • Insertion and removal of IUD • Diaphragm • Insertion and removal of contraceptive implants • Contraceptive injections • Oral contraceptives	• With respect to Women's Preventive Services (see also *Preventive Services)*, coverage is limited to: ○ Contraceptive methods – Medical ▪ Barrier: Diaphragm ▪ Implanted: IUD ▪ Sterilization: Tubal ligations ○ Contraceptive methods – Pharmacy ▪ Hormonal: All generic oral contraceptives • Other contraceptives may be covered based on medical necessity. • For additional information on medical coverage, please call FHCP's Member Services Department listed in the contact section within this document. For additional information on prescription coverage, please call CVS/caremark at 1-877-531-4793.
Cosmetic Surgery • Plastic and reconstructive • Reduction mammoplasty	• Repair or alleviation of damage if the result of an accident. • Correction of a congenital anomaly for an eligible dependent. • Correction of an abnormal bodily function. • For an area of the body which was altered by the treatment of a disease. • All stages of reconstruction of a breast on which a mastectomy was performed in accordance with federal law. However, if there is no evidence of malignancy, such reconstruction and initial prosthetic device shall only be covered if received within two years after the date of the mastectomy.

Covered Services	Special Limits/Circumstances
Dental Care and Accidental Dental Injury Accidental Dental Injury - 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. Sound Natural Tooth - A tooth that is whole or properly restored (restoration with amalgams only) and is not in need of the treatment provided for any reason other than an Accidental Dental Injury. For purposes of this Plan, a tooth previously restored with a crown inlay, inlay or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	• 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. • Accidental dental injury coverage is limited as stated herein. General Dental Care is not covered as stated in the Exclusion section of this document. • Benefits for accidental dental injury are limited to care and treatment rendered within 120 days of an accidental dental injury.
Dermatology Services	• Direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a Network dermatologist, as required by sections 627.6472(16) and 641.31(33) Florida Statutes.
Diabetes and pre-diabetes Treatment	• All medically appropriate and necessary equipment, supplies and outpatient self-management training and educational services used to treat pre-diabetes and diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary. • Certain diabetic equipment and supplies are covered through FHCP. Those not covered by FHCP may be covered by the Prescription Drug Plan. See Prescription Drug Plan section within this document for additional information.

Covered Services	Special Limits/Circumstances
Doctor's Care • Office visits • Medical treatment in Hospital or outpatient facility or surgery (other than office visit), which includes anesthesia services, concurrent physician care (surgical assistance provided by another physician) and consultations • Child health supervision services • Adult preventive Medical Services • Allergy treatment – including testing, desensitization therapy and allergy immunotherapy, which includes hyposensitization serum when administered by a health care provider • Diagnostic procedures, lab tests or x-rays, including their interpretation, for the treatment of a covered condition	• For concurrent physician care and surgical assistance: ○ The additional physician must actively participate in the treatment; and ○ The condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; and ○ The physicians have different specialties or have the same specialty with different sub-specialties; and ○ Must be authorized by the covered person's PCP or the Health Plan • For consultations: ○ The ordering physician must request the consultation; and • Consulting physician shall prepare a written report

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

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

Covered Services	Special Limits/Circumstances

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

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

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

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

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

Covered Services	Special Limits/Circumstances

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

Pathologist Services • Both inpatient and outpatient	

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

Covered Services	Special Limits/Circumstances
Radiologist Services • Both inpatient and outpatient	
Rehabilitative Services • Spine and back disorder treatment • Manipulative services • Physical therapy • Speech therapy	• All services shall be provided by licensed therapists, chiropractors and physicians for the purpose of aiding in the restoration of normal physical function. • Requires Health Plan approval or a written plan of treatment, including documentation that the covered person's condition should improve significantly within 60 days of the date therapy begins. • Outpatient rehabilitative services limited to 60 visits per injury; inpatient rehabilitative services limited to the duration of Hospital confinement. • Rehabilitative services shall not be covered when: ○ The covered person was admitted to a Hospital or other facility primarily for the purpose of providing rehabilitative services; or ○ The services or supplies maintain rather than improve a level of physical function, or where it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60-day period.
Respiratory Therapy • Both inpatient and outpatient • Services of respiratory or inhalation therapists • Oxygen	

Covered Services	Special Limits/Circumstances

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

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

VI. LIMITATIONS AND EXCLUSIONS

Services Not Covered by the Health Plan The following services and supplies are excluded from coverage under this Health Plan unless a specific exception is noted. Exceptions may be subject to certain coverage Limitations.	
Abortion	Which is elective, performed at any time during a pregnancy.
Acupuncture	Services, supplies, care or treatment in connection with acupuncture (except when used in lieu of an anesthetic agent for covered surgery).
Arch Supports	Orthopedic shoes, sneakers, or support hose, or similar type devices/appliances, regardless of intended use.
Autologous transfusion	In which blood is removed from a donor and stored before it is returned to the donor's circulation.
Autopsy	
Biofeedback services	And other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, mind expansion, elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard seminar training (EST)**.**
Complications of non-covered services	Including the diagnosis or treatment of any condition which arises as a complication of a non-covered service**.**
Cosmetic surgery/services	Including plastic and reconstructive surgery (except as noted as a covered service), and any other service and supply to improve the covered person's appearance or self-perception.
Costs incurred by the Health Plan related to…	Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy, telephone consultations, failure to keep a scheduled appointment or complete any form and/or medical information.
Custodial care	Including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services and respite care. Custodial Care includes services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking and taking oral medications. "Custodial Care" also means services and supplies that can be safely and adequately provided by persons other than licensed Health Professionals, such as dressing changes and catheter care, or that ambulatory patients customarily provide for themselves, such as ostomy care, administering insulin and measuring and recording urine and blood sugar levels.

Dental care	Or any treatment relating to the teeth, jaws, or adjacent structures (e.g. periodontium), including but not limited to extraction or cleaning of the teeth; implants, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic treatment; rapid palatial expanders; continuous passive motion (CPM) devices.
Dietary regimens	Treatments, food, food substitutes, vitamins or exercise programs for reducing or controlling weight.
Experimental/Investigational or Not Medically Necessary Treatment	With the exception of routine care in connection with a clinical trial in cancer, pursuant to the Florida Clinical Trial Compact and the Patient Protection and Affordable Care Act.
Eye care	• Including the purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the covered benefits section; • Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or astigmatic error; and • Training or orthoptics, including eye exercises.
Foot care (routine)	Including any service or supply in connection with foot care in the absence of disease, injury or accident. This Exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Health Plan to be Medically Necessary.
Gender reassignment or modification services and supplies	
Genetic tests	To determine paternity or sex of a child.
Hearing aids	External or implantable or the examination, including hearing tests, for the prescription or fitting of hearing aids, including tinnitus maskers.
Human Growth Hormone	For diagnosis and/or treatment of idiopathic short stature.
Hypnotism	Medical hypnotherapy or hypnotic anesthesia.
Immunizations and physical examinations	When required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such immunizations and examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements and/or the protective care requirements of the Patient Protection and Affordable Care Act.
Infertility treatment and supplies	Including infertility testing; treatment of infertility, diagnostic procedures and artificial insemination to determine or correct the cause or reason for infertility or inability to achieve conception, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer or cryogenic or other preservation techniques used in such or similar procedures.

Marriage counseling	
Massage therapy	
Non-prescription drugs and supplies	Including any non-prescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods or blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.
Obesity and weight reduction treatment	Including surgical operations and medical procedures for the treatment of morbid obesity, such as intestinal or stomach by-pass surgery and a weight loss program required by the covered person's Primary Care Physician prior to surgery, unless determined to be Medically Necessary by the Health Plan.
Occupational therapy	Unless provided as a home health service or hospice service or as treatment for Autism Spectrum Disorder.
Orthomolecular therapy	Including nutrients, vitamins, and food supplements.
Personal comfort, hygiene or convenience items	Including but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel or other housing accommodations (even if recommended or approved by a physician), air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment. Also excluded are services not directly used to render treatment.
Recreational therapy	
Reversal of voluntary, surgically-induced sterility	Including the reversal of tubal ligations and vasectomies.
Sexual deviations, disorders or psychosexual dysfunctions services and supplies	
Sleep therapy	
Smoking cessation products	Including but not limited to Nicorette gum, patches, lozenges, inhalers or vapor and e-cigarettes.
Training and educational programs	Including programs primarily for pain management or vocational rehabilitation unless specifically provided by law.
Volunteer services	Or services which would normally be provided free of charge to a covered person.
Weight control/weight loss programs	

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 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 not Medically Necessary as determined by the Health Plan and/or the Prescription Drug Plan clinical staff and the state.
	• Services or supplies that are not specifically listed in the covered benefits section unless such services are specifically required by state or federal law.
	• 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 Plan, unless coverage is extended in accordance with extension of benefit provisions;
	• Services provided by a physician or other health care provider who normally resides in the covered person's home;
	• Services rendered from a medical or dental department maintained by or on behalf of a public health entity;
	• Non-medical conditions related to hyperkinetic syndromes, learning disabilities, intellectual disability, or inpatient confinement for environmental change;
	• Services or supplies supplied at no charge, or determined by the Health Plan not to be the most cost-effective setting, procedure or treatment.
	• The following services:
	  ○ Social work
	  ○ Bereavement and pastoral
	  ○ Financial
	  ○ Legal
	  ○ Dietary counseling
	  ○ Day care
	  ○ Homemaker and chore
	  ○ Funeral

VII. SPECIAL HMO PLAN FEATURES

Specialist Care

If a Health Plan Member requires an office visit to a Specialist, in most cases Health Plan Member and/or the Health Plan Member's Primary Care Physician may choose a Network Specialist from the Specialists listed in the Provider Directory.

The Health Plan Member's Primary Care Physician may consult with FHCP regarding coverage or benefits and with the Specialist in order to coordinate the Health Plan Member's care. This procedure provides the Health Plan Member with continuity of treatment by the physician who is most familiar with the Health Plan Member's medical history and who understands the Health Plan Member's total health profile.

Health Plan Members must obtain referrals from their Primary Care Physician to see a Network Specialist; unless the Specialist is designated as a "Direct Access Provider" in the Provider Directory. Direct Access providers include dermatologists, obstetrician/gynecologists, optometrists, or podiatrists. Also, some services require an authorization for coverage. For these certain services, FHCP's contracting provider is responsible for obtaining prior authorization from the Plan.

When going to a Specialist's office the Health Plan Member is responsible for the applicable Specialist Copayment, co-insurance and/or Deductible even if the Health Plan Member was seen by an ARNP, PA or other certified licensed professional acting under the guidance of the Specialist.

Health information tools and services

FHCP provides every Health Plan Member in our plans the following additional services:

- Nurse Advise Line available 24 hours a day , 7 days a week to assist you with understanding a condition or symptom and where to do for care.
- Translation Services Florida Health Care Plans' Member Services Department and staff has immediate access to over 200 languages and can offer Health Plan Members assistance and information, including written materials, in the language of your choice. Our Member Services Department can also assist your health care provider should you and your provider require access to a Translation Service to aide in the delivery of your care.
- Member Newsletters. The Member newsletters contain information about using your FHCP services, information on diet, health, wellness and safety tips, along with recipes and community activities. Member Newsletters are sent to all FHCP Health Plan Members and are also available on-line at www.fhcp.com.

Health Programs

The programs listed below are available to Health Plan Members in FHCP. You can participate by contacting FHCP or by calling the Member Services Department as (877) 615-4022 or (386) 615-4022. The Acute Low Back and Neck Pain program is conducted by Network providers and your applicable Copayment, co-insurance and/or Deductible will apply. You are not limited in the number of programs you can participate in:

- Balance Improvement Class
- Acute Low Back and Neck Pain
- Nutrition Programs including Healthy Heart Eating Course and Nutrition Game Plan for Diabetics
- Osteoporosis
- Smoking Cessation *(a $20 fee for supplies will apply)*
- Weight Management

FHCP Member Portal, Website, Mobile App

FHCP's web site and the FHCP free mobile app, "myFHCP", have all of the following features and more:

- Provider Search allowing you to search for a specific health care provider, facility or specialty based on the most current Provider Directory information
- Information about using your Florida Health Care Plan services, information on diet, health, wellness and safety tips, along with recipes and community activities.
- Contact information
- Forms such as Advance Directives
- Member Newsletters online
- Community Activities

In addition to the information above, Health Plan Members in Florida Health Care Plans can access their medical information online any time by signing up for "FollowMyHealth". Just contact Florida Health Care Plans and you will receive a link via email from noreply@followmyhealth.com. When you click on the link will be able to create your member portal login. Use the invitation code provided by Florida Health Care Plans, click agree and you will have access to all of the following features:

- View test and lab results
- Send and receive secure online messages
- Request appointments
- Receive email care reminders
- Set up proxy accounts for children and dependent adults

Wellness Program

Health Plan Members must complete an online Health Risk Assessment and digital coaching sessions about:

- weight management
- tobacco cessation
- nutrition improvement
- physical activity
- stress management
- cholesterol management
- blood pressure management
- sleep improvement
- depression management

Best of all, once you have completed your Health Risk Assessment any Health Plan Member 18 years of age or older will have unlimited access to over 50 gyms throughout our Service Area.

Utilization Review Programs

Prior Authorization

Some services require an authorization for coverage. For these certain services, the FHCP contracting provider is responsible for obtaining coverage authorization from the Plan.

Services that require Prior-Authorization by Florida Health Care Plans include, but are not limited to, the following non-emergency services. Note: The following listing is subject to change:

- Autism Services
- Balance and Vestibular Therapy
- Cardiac Catherization;
- Certain Diagnostic studies / procedures:
    - Breast MRI's;
    - Stereotactic Breast Biopsies;
    - Sestamibi Scans;
    - CT Colonography (*aka Virtual Colonoscopy);*
    - ill Cams;
    - Genetic Testing;
    - Pet Scans when ordered by a Primary Care Physician;
- Certain Injections and Infusion Therapy;
- Certain Provider Administered Drugs;
- Certain Durable Medical Equipment:
    - Mattress Gel Overlays;
    - Wheelchair Cushions;
    - Alternating Pressure Relieving Mattresses;
    - Pumps and Pads; and
    - Mattress Replacement Systems;
- Home Health Care Services;
- Litholink Services;
- Lymphedema Clinic;
- Oral Surgery *(see Limitations and Exclusions section)*
- Participation in a Clinical Trial;
- Physical Medicine and Rehabilitation Services;
- Plastic Surgeon *(see Section VI Limitations and Exclusions)*
- Prosthesis & Orthotic Devices;
- Pulmonary Rehabilitation;
- Second Medical Opinions and Second Surgical Opinions:
- Services provided by a Birthing Center, a Mid-wife in the Home or at a Birthing Center;
- Services provided at Non-Network Hospitals;
- Services provided by Non-Network Providers;
- Services provided for, and related to, Organ and Bone Marrow Transplants;
- Skilled Nursing Facilities;
- Surgeries: All surgeries, elective and non-elective *(including emergency, whenever possible)*, in-patient or out-patient;
- Varicose Vein Treatment.

If non-emergency services from a non-Network provider are required, payment for such services will only be made if the services were Pre-Authorized by FHCP. The Health Plan Member's Primary Care Physician or Network Specialist who is treating the Health Plan Member is responsible for obtaining authorization.

Note: Pre-Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Expedited Review for Urgent Care determinations (prior to receiving)

For a Pre-Service Claim Involving Urgent Care, FHCP will use its best efforts to provide notice of the determination (whether adverse or not) as soon as possible, but not later than 24 hours after receipt of the Pre-Service Claim unless additional medical information is required for a coverage decision. If additional medical information is necessary to make a determination, FHCP will provide notice within 24 hours of:

- The need for additional medical information;
- The specific information that the Health Plan Member or the provider may need to provide; and
- The date that FHCP expects to provide notice of the decision.

If FHCP requests additional medical information, FHCP must receive it within 48 hours of the request. FHCP must provide notice of the decision on the Pre-Service Claim for Urgent Care within 24 hours of receipt of the request. If additional medical information was requested, FHCP's total processing timeframe shall not exceed 72 hours from receipt of the request.

Concurrent Care Benefit Determinations

Reduction or Termination of Coverage or Benefits for Services:

A reduction or termination of coverage or benefits for services will be considered an Adverse Benefit Determination when:

- FHCP has approved in writing coverage or benefits for an ongoing course of services to be provided over a period of time or a number of Services to be rendered (concurrent care); and
- The reduction or termination occurs before the end of such previously approved time or number of service(s); and
- The reduction or termination of coverage or benefits by FHCP was NOT due to an amendment to the Plans benefits or termination of the Health Plan Member's coverage as noted in Section III *Eligibility, Enrollment and Effective Date.*

FHCP will use its best efforts to notify the Health Plan Member of such reduction or termination in advance so that he or she will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the appeal process outlined in Section XIII *Grievance Procedure*. In no event will FHCP be required to provide more than a reasonable period of time within which the Health Plan Member may develop and files his or her appeal before FHCP actually terminates or reduces coverage for the services.

Requests for Extension of Services:

The Health Plan Member's provider may request an extension of coverage or benefits for a service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, FHCP will use its best efforts to notify the Health Plan Member of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such services. Florida Health Care Plans will use its best efforts to notify the Health Plan Member within 24 hours if:

- FHCP needs additional information; or
- The Health Plan Member or the Health Plan Member's representative failed to follow proper procedures in the request for an extension.

If FHCP requests additional information, the Health Plan Member will have 48 hours to provide the requested information. FHCP may notify the Health Plan Member orally, unless the Health Plan Member or the Health Plan Members's representative specifically request that it be in writing. A denial of a request for an extension of services is considered an Adverse Benefit Determination and is subject to the "Complaint, Grievance and Appeal Process" described in this Certificate of Coverage.

Notifications of Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination:

FHCP will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will:

- List the specific reason or reasons for the Adverse Benefit Determination;
- Refer to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- Describe any additional information that might change the determination and why that information is necessary;
- Describe the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational Limitations and Exclusions, the notice will include a statement telling the Health Plan Member how to obtain the specific explanation of the scientific or clinical judgment for the determination.
- If the Claim is a Claim Involving Urgent Care, FHCP may notify the Health Plan Member orally within the proper timeframes, and will follow up with a written or electronic notification no later than three days after the oral notification.

All documentation and materials utilized in making the "Adverse Benefit Determination" will by made available to the Health Plan Member, upon request, at no charge.

Admission/Continued Stay Review

Upon notification by the provider, facility, or the Health Plan Member, FHCP's Case Management Department will review all Hospital Admissions. This review will include medical necessity, benefit coverage, and appropriate level of care. Once notified, the Case Management Department will remain in contact with the hospital or facility during your stay and will coordinate any post discharge care you may require such as admission to a skilled nursing facility, home health care and/or any special equipment or services your physician may have ordered.

Disease Management /Chronic Condition:

These programs provide support to Health Plan Members with the following health issues and include education to through health coaching ,self-management education, contact with a nurse advisor, and when available participation in prevention programs aimed at controlling, such health issues as cholesterol and blood sugar levels and decreasing emergency events such as emergency department utilization and hospital admissions. The FHCP Disease Management Programs include:

- Asthma
- Depression *(for Health Plan Members 18 years of age and older recently prescribed anti-depressant medications)*
- Chronic Obstructive Pulmonary Disease *(COPD)*
- Congestive Heart Failure *(CHF)*
- Diabetes and pre-diabetes
- Heart Disease
- Hypertension

Case Management

Available to all FHCP Health Plan Members, this program offers telephonic management and care coordination. Health Plan Members must meet screening criteria; such as multiple health problems, medically needy, polypharmacy, or service utilization issues. Any Network provider or staff may refer Health Plan Members to this free program. Physician's offices or Health Plan Members may call the FHCP's Member Services Department at: (877) 615-4022 or (386) 615-4022 to request a form.

Readmissions within 60 days

Part of FHCP's Utilization Management processes includes a review of all emergency room usage and inpatient hospital admissions. When a Health Plan Member is identified as having one or more emergency room and/or inpatient hospital admissions within a 60 day period, the Health Plan Member will be contracted and offered the services of our Disease Management / Chronic Condition Program. In the event the Health Plan Member is already enrolled in this program, both the Health Plan Member and the Health Plan Member's attending physician(s) will be contracted to re-evaluate the Health Plan Member's current condition to better meet the Health Plan Member's additional needs, reduce the Health Plan Member's emergency room and/or hospital admissions, and to improve the Health Plan Member's overall outcome(s).

Transplant

When a request for prior authorization of a transplant service is received by Florida Health Care Plans, once approved, the authorization is forwarded to a team of nurses in our Case Management Department who specialize in transplant patients. The Health Plan Member will be contacted by one of these nurses who will be available to the Health Plan Member and the Health Plan Member's providers during the entire process, pre and post-transplant.

End of Life

Making plans for end of life care is important to do long before you need it. Health Care Advance Directives and power of attorney agreements can designate someone such as a family member or close friend act on your behalf whenever you are unable to make health care decisions for yourself. Types of advance health care directives include:

- **Living Will** – a statement that declared the type of medical care you want or don't want should you become unable to communicate your wishes.
- **Designation of Health Care Surrogate** – This document allows you to name a person to act as your health care representative at any time you become unable to make health care decisions for yourself
- **Organ Donor** – Sometimes called Anatomical donation. This document allows you determination your specific wishes for donating organs or all or part of your body. (*In the State of Florida organ donation can also be designated when you apply for or renew your driver's license*)

Although there is not legal requirement in the State of Florida for you to complete an Advance Directive, if you do not have one, your family and friends may not be aware of your wishes. You do not need an attorney to complete these documents. However, you may certainly wish to consult an attorney especially if you are completing a Durable or General Power of Attorney.

FHCP can provide you with a Living Will, Designation of Health Care Surrogate and/or Organ Donor form you can simply contact our Member Services Department at: (877) 615-4022 or (386) 615-4022. In addition, you can also obtain these documents directly from the State of Florida's website at www.myflorida.com and enter Living Will or Health Care Surrogate in the search box in the upper left hand corner. Additional information regarding Advance Directives can be found on FHCP's website at www.fhcp.com

VIII. PRESCRIPTION DRUG PROGRAM

How the Program Works

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

Participating Retail pharmacies: 30-Day Supply

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

Mail order program and Participating Retail Pharmacies: 90-Day Supply

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

Purchasing Prescriptions at 30-day Retail Pharmacies

When your doctor prescribes a medication, you may fill the prescription at any participating pharmacy. Call (888) 766-5490 or log in (required) at caremark.com/sofrxplan 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 Option) for up to a 30-day supply of each covered prescription (90-days maintenance at participating retailers). There is no paperwork when you use your prescription drug card at a participating pharmacy; the Claims are submitted electronically.

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

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.

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

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:

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 cost	**$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.

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 U.S. Food and Drug Administration's doctors and pharmacists review generic products regularly to make sure they are safe and effective.

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

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

If you are taking maintenance medication, you may use either the prescription drug mail order pharmacy or a participating 90-day retail pharmacy.

To order up to a 90-day supply, you:	• Take your prescription written for up to a 90-day supply to a participating 90-day maintenance at retail pharmacy, or • Complete a mail order form available from CVS/caremark at (888) 766-5490 or *www.caremark.com*. • Be sure to have at least a 14-day supply on hand when ordering. • Your medication will arrive usually within ten days after receipt. • The Copayment or Coinsurance will be based on the date the prescription is filled, not on the date the prescription is received by CVS/caremark. • Order online at *www.caremark.com* or call (888) 766-5490. • Ask your doctor to call CVS/caremark at (888) 766-5490 to call in your prescription or to obtain instructions on how to fax your prescription directly to CVS/caremark.

Automatic Refill and Renewal Options at Automatic Refill and Renewal Options at Mail Order

If you are taking long-term or maintenance medications, ReadyFill at Mail™ 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) CVS/caremark will automatically fill and mail your medications at the appropriate refill time saving you time from ordering online or by phone. Also, CVS/caremark will contact your physician and request a new prescription automatically after your last available refill and alert you in advance.

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

Standard HMO Option

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

The Copayments are:

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

Using mail order or a 90-day retail pharmacy allows you to obtain up to a 90-day supply, as longs the prescription is written to allow a 90-day supply to be dispensed.

The Coinsurance amounts are:

Health Investor Health Plan 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.

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

If you use a drug regularly, you will save on Copayments (Coinsurance for Health Investor Option) through mail order and at participating 90-day retail pharmacies. For instance, if your drug is a preferred brand name, here is the resulting impact to you on the Standard HMO Option:

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

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

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 U.S. Food and Drug Administration's doctors and pharmacists review generic products regularly to make sure they are safe and effective.

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

Covered by the Prescription Drug Program

Covered drugs include:

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 (administration of this vaccine is not covered under the Prescription Drug Program).

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. CVS/caremark will work with your physician to determine medical necessity. Approval or denial of coverage will be determined within 72 hours after contacting your physician and receiving all required information and/or documentation. Various drug classifications require coverage review, 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 a one-year period and must be renewed after expiration; however, prior authorization may be as brief as one month.

Covered by FHCP

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.

Not Covered by the Prescription Drug Program

The prescription drug program does not cover:

1. Retin-A for cosmetic purposes
2. Anti-obesity drugs and amphetamines and/or 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 for individuals 25 years of age or older
13. Growth hormones for the diagnosis of idiopathic short stature syndrome
14. Overlapping therapies, even if used for different conditions, within the same drug classifications, e.g., 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 FHCP

The Plan’s general Limitation and Exclusions apply to the prescription drug program. See “Limitations and Exclusions” section within this document.

Important Information about the Prescription Drug Program

1. The Preferred Drug List (PDL) is updated and subject to change on a quarterly basis. Contractually, CVS/caremark has full authority over the development of the PDL; therefore, DSGI cannot require that specific drugs be included.
2. Generic substitution: Prescriptions written for brand name drugs that have a generic equivalent will be automatically substituted unless the prescribing physician writes "dispense as written" or "DAW" on the prescription. Generally, even if the prescription includes "DAW," CVS/caremark will still contact the physician to ask if the generic equivalent may be substituted.
3. Only the prescribing physician or an authorized agent of the physician can authorize changes to or provide clarifications to a prescription. Authorizations may be obtained verbally or in writing. If CVS/caremark is unable to contact the physician or an authorized agent of the physician, the prescription may be returned unfilled to the member.
4. CVS/caremark mail order facilities will only substitute with generic drugs that have received an "A" or "AB" rating by the Federal Drug Administration (FDA). Retail pharmacies may choose to dispense drugs with a different FDA rating.
5. Certain medications, including most biotech and/or specialty drugs, are only available through CVS/caremark Specialty Pharmacy. Generally, these drugs are for chronic or genetic disorders including, but not limited to, multiple sclerosis, growth hormone deficiency and rheumatoid arthritis, and may require special delivery options, such as temperature control. Your prescribing physician may contact CVS/caremark Specialty Pharmacy at (800) 237-2767.
6. CVS/caremark may contact the prescribing physician when a prescription for a non-preferred brand name drug is submitted and a therapeutically equivalent preferred drug is available. If the physician or an authorized agent of the physician authorizes a change to the preferred drug, CVS/caremark will dispense the alternative drug and provide written notification of the change to the member.
7. CVS/caremark will contact the prescribing physician if the prescribed dosage differs from the dosage recommended by the FDA or the manufacturer's guidelines. Dosage is the number of units, the strength of such units, and the length of time to take the medicine. If the physician or an authorized agent of the physician authorizes a change to the dosage, CVS/caremark will change the dosage amount, dispense the new dosage, and provide written notification of the change to the member.
8. During the prescription review process, your mail order and retail pharmacy prescription history, age, self-reported allergies, and self-reported disease states are reviewed along with the FDA drug interactions and manufacturer's guidelines to determine if there are any interactions, side effects, and/or contraindications. CVS/caremark will contact the prescribing physician if any questions, conflicts or issues are identified. CVS/caremark may contact the prescribing physician if any indication of fraud or excessive usage is identified. If the physician or an authorized agent of the physician authorizes any changes, CVS/caremark will change the prescription accordingly, dispense the drug accordingly, and provide written notification of the change to the member.
9. For mail order, CVS/caremark will contact the prescribing physician to verify the prescription if the prescription is illegible, written in different pen and/or penmanship, or altered in any way. If CVS/caremark cannot reach the physician or an authorized agent of the physician, the prescription will be returned to the member unfilled.
10. Prescriptions for treatment of Conditions for unapproved indications or "off-label" use will not be filled if not proven safe and effective for the treatment of the Condition based on the most recently published medical literature of the United States, Canada or Great Britain, using generally accepted scientific, medical or public health methodologies or statistical practices.
11. Seventy-five percent of the previous prescription or fill must be utilized, if used as prescribed, before a request for a refill will be processed.
12. Requests for mail order refills that are received within 90 days of the "too soon to fill" date (based on the previous paragraph) will be held and filled when eligible to be filled. You may check your medication label for the next available refill date, or if the prescription was filled through mail order, you may log

onto http://www.caremark.comfor the next available mail order refill date.

13. CVS/caremark Specialty Pharmacy administers the Specialty Management Program for this Plan. This program is intended to optimize outcomes and promote the safe, clinically appropriate and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for this program during the coverage review will result in denial of medication coverage for the Health Plan Member and discontinuation of medication coverage for the Health Plan Member.

The Specialty Management Program is a process by which authorization for a specialty medication is obtained based on the application of currently acceptable medical guidelines and consensus statements for the appropriate use of the medication in a specific disease state. Therapies reviewed under this Program include, but are not limited to, the following: multiple sclerosis, oncology, allergic asthma, human growth hormone deficiency, hepatitis C, psoriasis, rheumatoid arthritis, and respiratory syncytial virus. Additional therapies may be added at any time. For additional information on specialty medications or to see if your medication is in this category call CVS/caremark Customer Care toll-free at (888) 466-5490.

IX. HOW TO FILE A CLAIM

Medical Claims

In the event you, your spouse, or dependent as a Health Plan Member receive a bill, or are required to pay for services you believe should be covered under your medical benefits, you can submit the bill or paid receipt directly Florida Health Care Plans for consideration. There are no claim forms. When submitting any claim either for payment or reimbursement please make sure the statement includes the following information: Date of Service, Place of Service, Patient's Name, date of birth, and Florida Health Care Plans Member ID # that appears on the Patient's Membership Card, Name of the provider, type of service(s) rendered (CPT Code), reason for the service(s) (ICD 9 or 10 Code). Also include any supporting documentation, such as medical records, and a paid receipt if you are seeking reimbursement. If the services were rendered outside of the United States, please be sure to that all information is translated into English.

Claims must be submitted within one year of the occurrence. All claims will be processed in accordance with the benefit provisions contained in this SPD and will be subject to any applicable Copayment, Coinsurance, and calendar year Deductible.

Send appeal to:	Florida Health Care Plans – Claims P.O. Box 9910 Daytona Beach, FL 32120

Prescription Drug Claims

Participating Pharmacies

When you use a participating pharmacy, you do not need to file a Claim. The Claim will be submitted electronically. You will be responsible for your Copayment or Coinsurance, subject to the calendar year Deductible (Health Investor Option)

Non-Participating Pharmacies

If you use a Non-participating pharmacy, you will be responsible for filing your own Claim. You must file the Claim within 16 months of the day you fill your prescription. Benefits will be paid directly to you. You can get prescription Claim forms from *www.caremark.com* or call (888) 766-5490.

To submit the Claim:

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

Send drug Claim to:	CVS/caremark P.O.Box 52010 MC003 Phoenix, AZ 85072-2010

Denial of Claims

If a Claim is denied, in whole or in part, CVS/caremark will send you a written notice indicating the specific reason(s) for the denial within 30 days of receiving your clean Claim. A clean Claim is a Claim that provides all information requested regarding the services provided. The notice will include any additional information needed to appeal the denial.

A claimant may appeal an Adverse Benefit Determination within 180 days of receiving notification of the Adverse Benefit Determination in accordance with Section XIII, Grievances and Appeals Procedures.

X. COORDINATION OF BENEFITS

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

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

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

In accordance with section 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 FHCP to 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, FHCP will notify you, in writing, that you should contact its office to verify OCL information. Florida Health Care Plans will automatically process or reprocess any Claims that may have been denied or held once you have provided the requested OCL information. For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of the Plan, FHCP may, without the consent of or notice to any person, release to or obtain from any other insurance company, organizations or person, any information, with respect to any Health Plan Member, or applicant for participation, which FHCP deems to be necessary for such purposes.

How Coordination Works

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

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

- If this Plan is secondary, it will pay benefits second. In this case, benefits from this Plan and from the primary plan will not be more than 100% of total reasonable expenses. Also, when this Plan is secondary, it will not pay benefits above what it would pay if it were the primary plan.

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

For All Covered Individuals

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

For Eligible Dependent Children

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

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

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

Coordination with Medicare

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

When you become Medicare eligible, please visit *www.medicare.gov* or contact your local Social Security office to learn about your eligibility, coverage options, enrollment periods and necessary steps to follow to that you have adequate coverage. Carefully review the Coordination of Benefits section of this document for more information about how this plan works with Medicare.

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 dependent covered as a Health Plan Member 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, Medicare continues to pay first as your primary carrier and this Plan pays 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 lessor of:
  - 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.

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

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

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

An Important Note for Retirees
Once you or your spouse become eligible for Medicare, any Claims filed with Medicare for you or your spouse may automatically be filed with FHCP after Medicare pays what is covered. Call FHCP's Customer Services and request to be set up for automatic crossover from Medicare. No separate filing to FHCP 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 FHCP continues as the primary plan with the corresponding higher monthly insurance premium. If you delay, FHCP will pay Claims secondary as if you had Medicare, which will require you to pay significantly more out-of-pocket.

Coordination of Prescription Drug Benefits with Medicare Part B

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

Medicare Part B requires that the retail or mail order pharmacy obtain a signed Assignment of 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 CVS Caremark Mail Service Pharmacy or CVS Caremark Specialty Pharmacy, as appropriate. **Important Note:** The CVS Caremark Mail Service Pharmacy is not a Medicare approved diabetic supplies mail order pharmacy. Prescriptions for diabetic supplies should filled by an in-Network 30-day retail pharmacy or a participating 90-day retail pharmacy that is also approved or participating Medicare retail pharmacy. Diabetic supplies are considered maintenance and are subject to the maintenance prescription drug provisions. If the prescription drug is determined to be eligible under Medicare Part B, CVS/carmark will forward your prescription request to the CVS Caremark Mail Service Pharmacy for Medicare Part B covered drugs or the CVS Specialty Pharmacy for Medicare Part B covered specialty drugs.
3. CVS/caremark will 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, CVS Mail Service Pharmacy or CVS Specialty Pharmacy, as appropriate, will submit a Claim to CVS/caremark for your secondary benefits under this Plan. CVS Mail Service Pharmacy or CVS Specialty Pharmacy may bill you for any remaining balance up to the Medicare allowed amount. In most cases, after this Plan has paid secondary carrier benefits and Medicare Part B has paid primary benefits, you will have zero out-of-pocket expense.

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

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

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

If you submit a prescription to a retail pharmacy that does not participate with Medicare Part B you will pay the retail pharmacy for 100 percent of the cost of the medication. To receive primary benefits under Medicare Part B, you or the Non-participating Medicare Part B retail pharmacy must submit a Claim directly to Medicare Part B. If the Claim is not submitted to Medicare Part B and you do not receive an EOMB, you will not be allowed to submit a Claim to CVS/caremark for secondary benefits.

Coordination of Prescription Drug Benefits with Medicare Part D

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

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

If you are receiving state or federal assistance, you might 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) 633-4227.

IMPORTANT NOTE:

Medicare automatically notifies the State of Florida of any of its Health Plan Members who 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 change to become primary coverage until you provide CVS/caremark a letter of creditable coverage or disenrollment from the Medicare Part D Plan. Such letter of creditable coverage must include your name and the effective and termination dates of your Medicare Part D coverage. Due to the confidential nature of your prescription drug information, Medicare will not discuss your Medicare Part D coverage with the State of Florida.

Special Notice about the Medicare Part D Drug Program

January 1, 2015

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).

XI. SUBROGATION AND RIGHT OF RECOVERY

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

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

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

Health Plan Member and the Health Plan Member's representatives further agree to:

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

- Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by the Plan.
- The Plan may recover the full cost of all benefits provided by the Plan under this SPD without regard to any Claim of fault on the part of the Health Plan Member, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. In the event the Health Plan Member or the Health Plan Member's representative fails to cooperate with the Plan, the Health Plan Member shall be responsible for all benefits paid by the Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

XII. DISCLAIMER OF LIABILITY

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

Furthermore, neither FHCP nor the Plan Administrator shall be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat a Health Plan Member of the Plan.

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

XIII. APPEALS AND GRIEVANCE PROCEDURE

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

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

Grievances must be filed within one year from the date of the event or action that led to the grievance. Florida Health Care Plans will acknowledge and investigate the grievance, and provide a written response advising of the disposition within 60 days after receipt of the grievance.

A grievance may be submitted in writing to:	Florida Health Care Plans – Member Services Attn: Grievance Supervisor 1340 Ridgewood Avenue Holly Hill, FL 32117

Appealing Denials of Claims for Benefits

If your benefit Claim is totally or partially denied, FHCP or CVS/caremark 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 FHCP or CVS/caremark.

Appealing to FHCP (medical) or CVS/caremark (prescription) – A Level I Appeal

NOTICE OF WAIVER

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

You or your authorized representative on your behalf have the right to appeal a full or partial denial of benefits or payment of a Claim for Medical Services, supplies and/or prescription drugs you have received (post-service) or are planning to receive (pre-service). Your appeal must be received by FHCP or CVS/caremark, 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 (FHCP or CVS/caremark, 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.

Level I Appeal (Medical)	Florida Health Care Plans – Member Services Attn: Grievance Supervisor 1340 Ridgewood Avenue Holly Hill, FL 32117
Level I Appeal (Prescription)	CVS/caremark Appeals Department MC 109 P.O. Box 52071 Phoenix, AZ 85072-2071 Or fax toll free to (866) 443-1172

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

Florida Health Care Plans or CVS/caremark will review your Level I Appeal and provide a written notice of the review decision. If the appeal is for a pre-service denial, FHCP or CVS/caremark will respond within 15 days from receipt of your appeal; if the appeal is for a post-service denial, FHCP or CVS/caremark will respond within 30 days from receipt of your appeal; and, if your appeal is Urgent, FHCP or CVS/caremark will respond within 72 hours from receipt of your appeal. If FHCP or CVS/caremark's review is unfavorable (Level I Appeal is denied), the notice from FHCP or CVS/caremark will include information about appealing the decision to DSGI.

Appealing to Division of State Group Insurance - A Level II Appeal (Prescription Drug Appeals Only)

If you are not satisfied with the Level I Appeal decision from CVS/caremark, 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 CVS/caremark'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 CVS/caremark requesting a Level I Appeal;
3. A copy of CVS/caremark'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.

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

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

DSGI will review the Level II Appeal and provide a written notice of the review decision. If the Level II Appeal is for a pre-service (non-Urgent) denial, DSGI will respond within 15 days from receipt of your appeal; if the Level II Appeal is for a post-service denial, DSGI will respond within 30 days from receipt of your appeal; and, if your appeal is Urgent, DSGI will respond within 72 hours from receipt of your appeal.

If DSGI's review is unfavorable (Level II Appeal is denied), the notice from DSGI will include information of any additional appeal or review rights available to you.

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

Requesting an Administrative Hearing (Prescription Drug Appeals Only)

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

Requesting an External Review from an Independent Review Organization (IRO), Level II Appeal – Medical Benefits Only

You have the right to request an external review from an independent review organization (IRO) after the finalization of the Level I Appeal processes. FHCP's denial letter will include instructions and the required form for you to request a Level II appeal from the IRO. You may call the Customer Service toll-free telephone number on your FHCP member ID card for additional information or assistance. 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 I Appeal denial if:

1. the decision involved a:

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

    b. rescission (cancellation) of coverage; and

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

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

Expedited or Urgent External Review

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

1. the decision involved a:

    a. denial of service you have not received and that decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is Experimental or investigational; or

    b. rescission (cancellation) of a covered service that you are currently receiving, such as current hospital stay, skilled nursing services, home health care services, and certain outpatient services (i.e., physical and certain other types of therapies); and

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

As long as your request for an external review meets expedited or urgent criteria, you may request the IRO to conduct their external review of your appeal at the same time FHCP reviews your Level I Appeal. 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.

<u>Important Notes Regarding Appeal Processes:</u>

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

    - the specific rule, guideline, protocol or other similar criterion used, if any, in making the benefit or payment decision, and/or
    - an explanation of the scientific or clinical factors relied upon if the Claim was denied in whole or in part based on the lack of medical necessity or the Experimental or investigational nature of a service or medication.

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

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

The appeal process described in this Plan Booklet 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. The 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.

XIV. MISCELLANEOUS

Clerical errors	Clerical errors shall neither deprive any individual Health Plan Member of any benefits or coverage provided under the Plan nor shall such error(s) act as authorization of benefits or coverage for the Health Plan Member that is not otherwise validly in force. Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a 60 day period from the date of notification. Refunds of administrative service fees are done for up to a 60 day period from the date of notification. Refunds of administrative service fees are limited to a total of 60 days from the date of notification of the event, provided there are no Claims incurred subsequent to the effective date of such event.
Gender	Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.
Identification cards	Cards issued by FHCP to Health Plan Members pursuant to the Plan are for purposes of identification only. Possession of an identification card confers no right to health services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Health Plan Member on whose behalf all applicable charges under the Plan have actually been paid and accepted by the Plan.
Individual information	Health Plan Members or other individuals shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. If the Health Plan Member or other individual fails to provide accurate information that the Plan deems material to providing coverage for such individual, upon ten days written notice, the Plan may deny coverage and/or participation in the Plan to such individual.
Non-waiver	The failure of the Plan to enforce any of the provisions of the Plan or to exercise any options herein provided or to require timely performance by any Health Plan Member or the State of Florida of any of the provisions herein, shall not be construed to be a waiver of such provisions nor shall it affect the validity of the Plan or any part thereof or the right of the Plan to thereafter enforce each and every such provision.
Plan administration	The State of Florida may from time to time adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan.
Waiver	A Claim that has not been timely filed with the Plan within one year of date of service shall be considered waived.

Privacy Notice

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

Introduction

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 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. Health Plan Members in the insured plan will receive notices directly from FHCP and CVS/caremark (which provides third-party medical and pharmacy support); the notices describe how FHCP and CVS/caremark will satisfy the requirements.

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 Program 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 Health Plan Members' Claims information, but from which names and other identifying information have been removed.

In addition, the plans may disclose to the State information on whether an individual is participating in the plans or has enrolled or disenrolled in any available option offered by the plans.

The State cannot and will not use health information obtained from the plans for any employment-related actions. However, health information collected by the State from other sources is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

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

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

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization for a plan that has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the plan has already made.

Your individual rights

You have the following rights with respect to your health information the plans maintain. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right for the Flexible Spending Account and for the State activities relating to the self-insured plan. Contact the Division of State Group Insurance, PO Box 5450, Tallahassee, FL 32314-5450 to obtain any necessary forms for exercising your rights. The notices you receive from FHCP and CVS/caremark will describe how you exercise these rights for the activities they perform.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

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

The plans are not required to agree to a requested restriction. And if the plans do agree, a restriction may later be terminated by your written request, by agreement between you and the plans (including an oral agreement), or unilaterally by the plans for health information created or received after you're notified that the plans have removed the restrictions. The plans may also disclose health information about you if you need emergency treatment, even if the plans had agreed to a restriction.

Right to receive confidential communications of your health information

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

If you want to exercise this right, your request to FHCP 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 FHCP amend your health information in a Designated Record Set. FHCP 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 FHCP (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, FHCP will:

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

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the plans have made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law in connection with public health activities or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health formation going back for six years from the date of your request.

You do not have a right to receive an accounting of any disclosures made:

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

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

If you want to exercise this right, your request must be in writing. Within 60 days of the request, the plans will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request. You may make one request in any 12-month period at no cost to you, but the plans may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

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

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

Changes to the information in this notice

The plans must abide by the terms of their Notice of Privacy Practices currently in effect. However, the plans reserve the right to change the terms of their privacy policies 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 Notice of Privacy Practices through posting on the DSGI Web site, the FHCP Web site, or mailed to your last known home address.

Complaints

If you believe your privacy rights have been violated, you may complain to the plans and to the U.S. Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. Complaints about activities by your insurer or HMO or CVS/caremark can be filed by following the procedures in the notices they provide.

To file other complaints about 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:

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

Contact

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

SUMMARY PLAN DESCRIPTION INFORMATION

Official Plan Name:	State of Florida Employees' Group Insurance Program Health Maintenance Organization (HMO) Plan
Plan Administrator:	State of Florida Division of State Group Insurance P.O. Box 5450 Tallahassee, FL 32314-5450 (850) 921-4600
HMO Claims Administrator	Florida Health Care Plans 1340 Ridgewood Avenue Holly Hill, FL 32117 (877)615-4022
Plan Year:	January 1 – December 31
Effective Date of the Plan:	January 1, 2012
Employer Identification No.:	59-3458983
Plan Type:	Fully Insured Plan
Source(s) of Contribution:	State of Florida Employees
Organization that Provides the Benefit:	Benefits under the plan are provided through a contract with FHCP.