

State Employees' PPO Plan



DSGI
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Group Health Insurance

2004 Plan Booklet and Benefits Document



Department of Management Services
Division of State Group Insurance
Post Office Box 5450
Tallahassee, FL 32314-5450

Group Health Insurance

2004 Plan Booklet and
Benefits Document

State Of Florida Employees' PPO Plan

Who To Call For Information

If You Need Information About . . . Contact . . .

Benefits or claims (other than prescription drug claims) under the PPO plan, or finding a network provider within the State of Florida	Blue Cross and Blue Shield of Florida, Inc. P.O. Box 2896 Jacksonville, FL 32232-0079 1-800-825-2583
PPO Plan Pre-Admission Certification	1-800-955-5692
Finding a PPO network provider outside the State of Florida – BlueCard® PPO Program	1-800-810-2583 or www.bluecares.com
Healthy Addition® Pre-Natal Program	1-800-825-2583
Personal Health Advisor®	1-800-667-2546
Prescription drug program information	Caremark, Inc. www.caremark.com 1-800-378-4408
Enrollment, eligibility, or changing coverage	Division of State Group Insurance P.O. Box 5450 Tallahassee, FL 32314-5450 1-800-226-3734 or www.dsgi.state.fl.us 1-850-921-4600 SunCom 291-4600
Medicare eligibility and enrollment	The Social Security Administration office in your area

This benefit document replaces any other brochure or booklet printed prior to January 1, 2004, relative to the Plan and shall remain in effect until further notice. The State Employees' PPO Plan is further subject to federal and State of Florida laws and rules promulgated pursuant to law including, but not limited to, Title 60 of the Florida Administrative Code.

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

This health insurance plan contains a deductible provision. Details on deductible dollar amounts can be found on pages 4 and 5. The Summary of Plan Benefits starting on page 11 shows when deductibles may be applied.

Important Information About The Plan

Plan Administrator

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

The Division of State Group Insurance (DSGI), within the Department of Management Services, has been designated by the Florida Legislature as the entity responsible for administering state employee benefits, including this health insurance plan.

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

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

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

Medical Claim Administrator

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

Blue Cross and Blue Shield of Florida (BCBSF) provides claim payment services, customer service, provider network access, and utilization and benefit management services. Benefits are offered through a preferred provider organization (PPO), which is a network of providers managed by BCBSF.

Prescription Drug Program Claim Administrator

Caremark, Inc.
7034 Alamo Downs Parkway
San Antonio, Texas 78238
1-800-378-4408

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

Plan Documents and Contracts

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 plan provisions.

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

Rights to Employment

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

Continuity of Care

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

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

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

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

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

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

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Introduction

This booklet describes the benefits available to employees, retirees, COBRA participants, the surviving spouses of active State employees or retirees, and covered dependents through the State Employees' PPO Plan. The PPO plan is also called "this health insurance plan" or "the plan" in this booklet. If you have questions about your coverage after reading this booklet, you may call any of the telephone numbers listed on page i and talk with a member service representative.

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

- ◆ deductibles
- ◆ copayments
- ◆ admission fees
- ◆ non-covered services
- ◆ amounts above the plan's allowed amount for non-network services
- ◆ amounts above plan limitations
- ◆ penalties for not certifying hospital admissions or stays, and
- ◆ coinsurance (a percentage of the cost of the service provided).

This booklet describes enrollment and eligibility, covered services, what the plan pays, amounts that are your responsibility and services that are not covered in greater detail.

This health insurance plan contains a deductible provision. Details on deductible dollar amounts can be found on pages 4 and 5. The Summary of Plan Benefits starting on page 11 shows when deductibles may be applied.

Important enrollment and eligibility information can be found in Appendix 1 of this booklet including information on:

- ◆ who is eligible to participate in this plan
- ◆ how to enroll for coverage
- ◆ when coverage begins and ends
- ◆ when coverage may be continued – including COBRA continuation coverage.

An Overview

Here is a brief overview of how this health insurance plan pays benefits. More detail is provided later in this booklet.

	Network	Non-Network
Calendar year deductible	\$250/person \$500/family	\$750/person \$1500/family
Percentage of network allowed amount or non-network allowance paid by this health insurance plan for most covered services — after any copayments or deductibles	70% or 80%, depending on type of service or type of provider	60% or 70% or 80%, depending on type of service or type of provider
Office visit copayment	\$15 primary care physician \$25 specialty physician	no copayment applies*
Emergency room copayment	\$50, waived if admitted*	no copayment applies*
Hospital stay deductible	\$250	\$500
Prescription drug copayments	At network pharmacies ... \$10 generic, \$25 preferred-brand, \$40 non-preferred brand, up to a 30-day supply Mail order... \$20 generic, \$50 preferred-brand, \$80 non-preferred brand, up to a 90-day supply	
Calendar year out-of-pocket limit**	\$2,500/person; \$5,000/family network and non-network care combined	
Lifetime maximum	\$1,000,000 network and non-network care combined	

* Subject to coinsurance.

** Deductibles, copayments, charges for non-covered services, and amounts above the non-network allowance do not count toward the calendar year out-of-pocket limit.

Payment For Covered Services – Your Share And The Plan’s Share

How The Plan Pays Benefits

For Office Visits

For covered services in a physician’s office you pay:

- ◆ \$15 per visit for network primary care physicians
- ◆ \$25 per visit for network specialty physicians
- ◆ 40% of the non-network allowance for non-network physicians.

If you use non-network physicians, you will pay any amount above the non-network allowance. See page 5 for more information about the network allowed amount and the non-network allowance.

Copayments for office visits do not count toward meeting the plan’s calendar year deductible or the calendar year out-of-pocket limit. Also, charges for services received as part of an office visit do not count toward meeting the calendar year deductible if those services are provided on the same day as the office visit and by the same healthcare provider.

For Emergency Room Visits

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

At A Network Facility

You pay a set copayment of \$50 per visit. This copayment is waived if you are admitted to the hospital directly from the emergency room. The plan pays 80% of the network allowed amount, after you meet the calendar year deductible, for physician services provided in the network ER if the physician is a network provider. You pay the remaining 20%.

If the ER physician is not a network provider, benefits for physician services will be paid at the non-network level – 60% of the non-network allowance – after you meet the calendar year deductible. You are responsible for 40% coinsurance and any amount above the non-network allowance. It is not uncommon to receive non-network ER physician services within a network facility.

The \$50 per visit ER copayment does not count toward meeting the plan’s calendar year deductible or the calendar year out-of-pocket limit.

At A Non-Network Facility

This health insurance plan pays 60% of the non-network allowance for covered facility services. You pay the remaining 40% and any amounts above the non-network allowance.

Deductible For Most Other Covered Care

Before this health insurance plan pays benefits for covered expenses – except for services requiring copayments, such as health screening exams, well child care, hospice, pre-approved home health care or inpatient hospital services – you must meet a calendar year deductible. The calendar year deductible applies each January 1 to December 31.

Once the calendar year deductible is met, this health insurance plan pays a percentage of the network allowed amount for network providers and a percentage of the non-network allowance for non-network providers – you pay the rest. See page 7 for more information about the network.

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

Calendar Year Deductible	Network	Non-Network
Individual	\$250	\$750
Family	\$500	\$1500

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

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

- ◆ two family members can each meet the individual calendar year deductible, or
- ◆ all family members can combine their covered expenses to meet the family deductible.

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

How The Deductible Works

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

Joe	\$200
Wife	\$125
Daughter	\$100
Son	<u>\$ 75</u>
Total	\$500 = network family deductible

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

Deductible For Hospital Stays

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

	Network	Non-Network
Hospital stay deductible	\$250	\$500

Health Insurance Plan Pays a Major Share of Covered Expenses

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

After you meet the deductible ...

- ◆ network providers – the plan pays 80%, or in some cases 70%, of the network allowed amount
- ◆ non-network providers – the plan pays 60%, or in some cases 70% or 80%, of the non-network allowance.

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

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

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

- ◆ Use the PPO network ... when you go to PPO network providers, you will not be billed for charges above the network allowed amount. Network providers are sometimes called Preferred Patient Caresm (PPCsm) Providers.
- ◆ Go to a BCBSF participating provider ... BCBSF has agreements with providers throughout the state – including doctors, hospitals, and other healthcare specialists - who are not in the PPO network but have agreed to charge within a negotiated limit that is not higher than the non-network allowance. These providers are sometimes called Payment for Professional Services (PPS) or Payment for Hospital Services (PHS) providers. These providers can be identified by asking the provider or by calling BCBSF customer service. When you go to a participating (PPS or PHS) provider who is not in the network, this health insurance plan pays at the lower non-network level of benefit, but you are protected from being balance-billed for charges above the non-network allowance.

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

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

See page 7 for more information about the PPCsm network.

Calendar Year Limit On Your Share of Covered Expenses

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

	Individual	Family
Calendar year out-of-pocket limit	\$2,500	\$5,000

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

- ◆ calendar year and inpatient hospital deductibles
- ◆ copayments for office visits and network emergency room visits
- ◆ hospice care expenses
- ◆ charges for services and supplies that are not covered by this health insurance plan
- ◆ health screening benefit services
- ◆ charges greater than the non-network allowance for non-network providers
- ◆ charges greater than plan limits on dollar amounts, number of treatments, or number of days of treatment
- ◆ pre-admission certification or other penalties.

Maximum Plan Benefits

The total lifetime maximum amount this health insurance plan will pay is \$1,000,000 toward the covered expenses each enrolled person has for all years that the person is covered by this health insurance plan. Keep in mind, some services and treatments have specific limits as well. Any expenses paid toward these special limits count toward the overall lifetime maximum. This chart shows the plan maximums for network and non-network care combined.

Plan Maximums For Network and Non-Network Care Combined	
Total lifetime maximum	\$1,000,000/person
Inpatient care for mental or nervous disorders and/or alcoholism or drug addiction	31 days/calendar year
Manipulative therapy	26 visits/calendar year or a maximum of \$500/calendar year, whichever occurs first
Hospice care	210 days/lifetime
Physical therapy	4 treatments/day and 21 days/6-month period combined with massage therapy
Massage therapy	4 treatments/day and 21 days/6-month period combined with physical therapy

About the Preferred Patient Caresm Network

The Blue Cross and Blue Shield of Florida Preferred Patient Caresm (PPCsm) network is this health insurance plan's preferred provider organization (PPO) network. The PPCsm network is a large group of independent doctors, hospitals and other healthcare specialists and facilities who have agreements with BCBSF to provide health care services to plan participants. Network providers offer a broad range of services – such as, family practice, internal medicine, OB-GYN and pediatrics.

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

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

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

How To Use the PPCsm Network

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

- ◆ agency personnel office
- ◆ DSGI Client Services
- ◆ DSGI Website, www.dsgi.state.fl.us
- ◆ BCBSF Customer Service
- ◆ BCBSF Website, www.bcbsfl.com

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

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

An Important Note About Using Non-Network Providers

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

- ◆ In some situations, your network provider may use, or recommend, a non-network provider. For example, your network family doctor says you need to see another doctor and recommends a non-network doctor. It is your choice - you decide whether to go to the recommended non-network doctor or to ask your doctor for another recommendation to a network doctor. In this example, even though your family doctor is a network doctor, you will receive non-network benefits if you go to the recommended non-network doctor.
- ◆ Sometimes the healthcare professional you need to see is not in the network. You receive non-network benefits when you use non-network providers - even if no network provider is available.
- ◆ Not all healthcare professionals offering services at a network facility are network providers. For instance, an anesthesiologist, nurse anesthetist, pathologist, radiologist, or emergency room doctor working at a network hospital might be a non-network provider. In that case, the non-network provider's services will be paid at the non-network benefit level.

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

Pre-Admission Certification For Hospital Stays

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

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

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

See page 10 for information on penalties if you do not precertify your stay.

Precertifying Your Non-Network Hospital Admission

To precertify your stay in a non-network hospital, ask your doctor to complete a Request for Admission Certification form and send it to BCBSF within seven days before your scheduled date of admission. Or, instead of submitting the Request for Admission Certification form, your doctor can call BCBSF at 1-800-955-5692 before your hospital admission and provide the reason for hospitalization, the proposed treatment or surgery, testing, and the number of hospital days anticipated.

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

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

If You Have An Emergency Admission To A Non-Network Hospital

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

If You Do Not Precertify Your Stay

- ◆ If you are admitted to a participating BCBSF hospital (PHS) that is not part of the PPCsm network and you have not submitted a Request For Admission Certification or your request is denied, benefits for covered services will be reduced by 25% of the covered charges – not to exceed a maximum benefit reduction of \$500.
- ◆ If your hospital admission is denied, but you are admitted to a non-network hospital anyway, the plan will not pay room and board benefits for your first two days of hospitalization.
- ◆ If you are admitted to a non-network hospital without submitting a Request for Admission Certification or having your doctor call first, the plan will not pay room and board benefits for your hospital stay.
- ◆ If your hospital admission is certified but your stay is longer than the number of days for which the admission was certified, the plan will not pay room and board benefits for days that were not certified.

Summary Of Plan Benefits

Covered Services

This chart provides an overview of services and supplies covered by this health insurance plan. It shows how much the plan pays for these services and supplies *after* you meet any copayments or deductibles that apply. This health insurance plan pays a percentage of the cost of covered care and medical supplies as long as the care or supplies are ordered by a covered provider and are considered medically necessary for your treatment as a result of a covered accident, illness, condition or mental or nervous disorder.

<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<i>Acupuncture</i>	80%	60%	<i>For acupuncture:</i> <ul style="list-style-type: none"> ✓ May be provided by a medical doctor, a doctor of osteopathy, a chiropractor certified in acupuncture, or a certified acupuncturist
<i>Ambulance</i> <ul style="list-style-type: none"> ◆ Ambulance service to the nearest hospital 	100% with no deductible	100% with no deductible	<i>For ambulance service when medically necessary to:</i> <ul style="list-style-type: none"> ✓ Transport you from a hospital which is unable to provide proper care to the nearest hospital that can provide proper care; ✓ Transport you from a hospital to your home or a skilled nursing facility; or ✓ Transport you from the place a medical emergency occurs to the nearest hospital that can provide proper care.
<i>Cleft Lip and Cleft Palate Treatment and Services</i> <ul style="list-style-type: none"> ◆ for children under 18 years, including medical, dental, speech therapy, audiology and nutrition services 	80%	60%	
<i>Dental Services</i> <ul style="list-style-type: none"> ◆ Dental work, treatment or examinations needed because of accidental injury to teeth Non-physician services provided by a hospital, ambulatory surgical center, outpatient health care facility or skilled nursing facility related to dental work or exams 	80%	60%	<i>For dental services:</i> <ul style="list-style-type: none"> ✓ Must be performed within 120 days of accident unless extension is requested within 120 days of accident and approved by BCBSF ✓ In no instance will any services be covered unless provided within 120 days of the termination of the person's coverage

*Calendar year deductibles apply unless noted. Percentages indicate percentage of network allowed amount for network care or non-network allowances for non-network care.

<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<p><i>Doctor's Care</i></p> <ul style="list-style-type: none"> ◆ Office visits (including covered services received at the same time and by the same provider as the office visit) ◆ Medical treatment in hospital or outpatient facility or surgery (other than office visit) ◆ Well-child health supervision services <p>See page 22 regarding health screening benefit.</p>	<p>100% after you pay: \$15 primary care physician \$25 specialty physician</p> <p>80%</p> <p>80% with no deductible or copayment</p>	<p>60% with no deductible or copayment</p> <p>60%</p> <p>60% with no deductible or copayment</p>	<p>See page 21 for special limits applying to doctor visits and doctor fees for surgery.</p> <ul style="list-style-type: none"> ✓ For well-child health supervision services: The number of well-child visits considered as eligible expenses varies – <ul style="list-style-type: none"> ◆ Up to 6 visits from birth to 12 months ◆ Up to 2 visits from 1 year to 2 years ◆ 1 visit each year from 2 years through 8 years ◆ 1 visit from 9 years through 10 years ◆ 1 visit from 11 years through 12 years ◆ 1 visit from 13 years through 14 years ◆ 1 visit from 15 years through 16 years <p>Visits and age intervals shall be consistent with prevailing medical practice as established by the American Academy of Pediatrics and in accordance with s.627.6579, <i>Florida Statutes</i>.</p>
<p><i>Durable Medical Equipment</i></p> <ul style="list-style-type: none"> ◆ Rental or purchase of wheel chair, hospital type bed and other durable medical equipment 	80%	60%	<p>For rental or purchase of durable medical equipment:</p> <ul style="list-style-type: none"> ✓ Coverage for standard models of durable medical equipment only unless upgraded model determined to be medically necessary ✓ Purchase of equipment covered only if purchase price is less than rental cost ✓ If equipment is rented first and later purchased, the amount the plan would pay toward purchase will be reduced by the amount already paid toward rental
<p><i>Emergency Room Care</i></p> <ul style="list-style-type: none"> ◆ facility charges ◆ physician services 	<p>100% after you pay: \$50 copayment/visit; copayment waived if admitted directly from ER</p> <p>80%</p>	<p>60% with no deductible or copayment</p> <p>60%</p>	<p>See page 3 for special limits applying to emergency room care.</p>
<p><i>Eye Glasses or Contacts</i></p>	80%	60%	<p>For eye glasses or contacts:</p> <ul style="list-style-type: none"> ✓ Limited to the first pair following an accident to the eye or cataract surgery.

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<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<i>Fertility Testing and Treatment Services</i>	80%	60%	<p><i>For fertility testing and treatment services:</i></p> <ul style="list-style-type: none"> ✓ Some fertility tests and/or treatments are considered investigational or experimental and are not covered ✓ Artificial insemination, gamete intrafallopian transfer, ovum or embryo placement or transfer, in-vitro fertilization, cryogenic and/or other preservation techniques used in such and/or similar procedures are not covered
<i>Hearing Tests</i>	80%	60%	<p><i>For hearing tests:</i></p> <ul style="list-style-type: none"> ✓ Covered after a related covered ear surgery or when medically necessary for diagnosis of a covered condition other than hearing loss; no other hearing tests are covered even for supplying or fitting a hearing aid
<p><i>Home Health Care</i></p> <ul style="list-style-type: none"> ◆ Services by a home healthcare agency for nursing services, treatment, therapy, equipment, medication and supplies if you are confined and convalescing at home 	80% with no deductible if pre-approved; 80% after calendar year deductible if not pre-approved but determined medically necessary	80% with no deductible if pre-approved; 60% after calendar year deductible if not pre-approved but determined medically necessary	<p><i>For pre-approved home healthcare:</i></p> <ul style="list-style-type: none"> ✓ Your doctor must provide a detailed and priced home healthcare plan to BCBSF for prior approval of home healthcare ✓ To be approved and paid at the highest benefit level, home healthcare must be less costly than inpatient hospital or skilled nursing facility care ✓ Charges to the home healthcare plan must be approved in advance ✓ Home healthcare agency must provide weekly reports to the attending physician and an itemized bill to BCBSF ✓ Home healthcare agency employees must be fully licensed

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Types of Care	% Payable Network*	% Payable Non-Network*	Special Limits/Circumstances
<p><i>Hospice Care (continued)</i></p> <ul style="list-style-type: none"> ◆ Hospice outpatient care <ul style="list-style-type: none"> ◆ Physician services ◆ Laboratory, x-ray and diagnostic testing ◆ Same covered services as in-home hospice care 	80% with no deductible	80% with no deductible	See special limits/circumstances on page 14.
<p><i>Inpatient Hospital Care</i></p> <ul style="list-style-type: none"> ◆ Hospital room, board and general nursing care up to the charge for a semi-private room per day, unless a private room is medically necessary ◆ Room, board and treatment in an intensive or progressive care unit ◆ Other necessary services and supplies, for example... <ul style="list-style-type: none"> ◆ use of operating room, labor room, delivery room and recovery room ◆ all drugs and medicines if listed in “New and Non-Official Remedies” or the United States Pharmacopoeia Drug Information solutions, including glucose ◆ dressings ◆ anesthesia and related supplies ◆ oxygen therapy 	80%	60%; reduced if not precertified (see page 9)	<p><i>For care at non-network or non-participating hospitals:</i></p> <ul style="list-style-type: none"> ✓ Room and board benefits based on \$190/day allowance for semi-private room, unless private room is medically necessary ✓ Room and board benefits based on \$380/day allowance for intensive care unit, \$285/day allowance for progressive care unit ✓ Rehabilitative hospital stays not subject to pre-certification

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<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<ul style="list-style-type: none"> ◆ transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced ◆ laboratory services ◆ electrocardiograms ◆ basal metabolism examinations ◆ x-ray, including therapy ◆ electroencephalograms ◆ diathermy and physical therapy 			
<p><i>Mammograms</i></p> <ul style="list-style-type: none"> ◆ breast cancer screening ◆ diagnosis 	80%	60%	<p><i>For mammograms:</i></p> <ul style="list-style-type: none"> ✓ These services are considered eligible expenses: <ul style="list-style-type: none"> ◆ one baseline mammogram – age 35 through 39 ◆ one mammogram every two years – age 40 through 49 ◆ one mammogram every year – age 50 and over ◆ mammogram at any age if medically necessary ✓ Covered when referred by doctor or received at a health testing facility using equipment registered with the Department of Health
<p><i>Manipulative Services</i></p>	80%	60%	<p><i>For manipulative services:</i></p> <ul style="list-style-type: none"> ✓ Limited to 26 treatments/year or a maximum of \$500/year, whichever occurs first

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Types of Care	% Payable Network*	% Payable Non-Network*	Special Limits/Circumstances
<p><i>Mastectomy and Reconstructive Surgery</i></p> <ul style="list-style-type: none"> ◆ Removal of all or part of the breast for medically necessary reasons ◆ Reconstruction of the breast on which mastectomy was performed ◆ Surgery and reconstruction of the other breast for a symmetrical appearance ◆ Treatment of physical complications of all stages of mastectomy, including lymphedemas ◆ Prostheses and mastectomy bras 	80%	60%	
<p><i>Maternity Care</i></p> <ul style="list-style-type: none"> ◆ Pre-natal care and monitoring ◆ Delivery in a hospital or birth center ◆ Postpartum care ◆ Newborn care and one assessment, including initial exam from pediatrician ◆ Medically necessary clinical tests and immunizations ◆ Routine nursery charges ◆ Midwife services ◆ Birthing centers 	80%	60%	<p><i>For maternity care:</i></p> <ul style="list-style-type: none"> ✓ Covered for female employees, retirees or COBRA participants and spouses of male employees, retirees or COBRA participants; maternity care not covered for dependent children who become pregnant, except for certain pregnancy complications and care of the newborn (see page 49 for a definition of “complications of pregnancy”) ✓ Covered hospital stays for the mother and newborn child will be no less than <ul style="list-style-type: none"> ◆ 48 hours for a normal delivery ◆ 96 hours for a Cesarean-section delivery unless agreed to by the provider and patient. <p>See page 23 for more information on coverage for mothers and newborns.</p>

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<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<p><i>Mental Health and Substance Abuse Care</i></p> <ul style="list-style-type: none"> ◆ Hospital for acute care <ul style="list-style-type: none"> ◆ outpatient ◆ inpatient ◆ Specialty facility <ul style="list-style-type: none"> ◆ outpatient ◆ inpatient 	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>	<p>60%</p> <p>60%</p> <p>60% for substance abuse care only</p> <p>60% for substance abuse care only</p>	<p><i>For any inpatient care:</i></p> <ul style="list-style-type: none"> ✓ Up to 31-day inpatient stay maximum/year for mental health and substance abuse care combined <p><i>For hospital inpatient care:</i></p> <ul style="list-style-type: none"> ✓ Room and board benefits for non-network or non-participating hospitals based on \$190/day allowance for semi-private room, unless private room is medically necessary ✓ Detoxification limited to 6 days/year, which counts toward 31-day maximum for inpatient stays <p><i>For specialty facilities:</i></p> <ul style="list-style-type: none"> ✓ Non-network care covered for substance abuse treatment only – with inpatient care limited to active employees only, when requested by employing agency and approved by DSGI ✓ Room and board benefits for non-network or non-participating facilities based on \$190/day allowance for semi-private room, unless private room is medically necessary ✓ Detoxification limited to 6 days/year, which counts toward 31-day maximum for inpatient stays
<p><i>Nursing Services</i></p> <ul style="list-style-type: none"> ◆ Nursing care by a registered nurse (RN) or licensed practical nurse (LPN) 	<p>80%</p>	<p>60%</p>	<p><i>For nursing care:</i></p> <ul style="list-style-type: none"> ✓ Includes inpatient private duty nursing only when determined medically necessary
<p><i>Organ Transplants</i></p> <ul style="list-style-type: none"> ◆ heart ◆ heart/lung ◆ lung ◆ liver ◆ kidney ◆ kidney/pancreas ◆ bone marrow ◆ cornea 	<p>80%</p>	<p>60%</p>	<p><i>For organ transplants:</i></p> <ul style="list-style-type: none"> ✓ Prior approval from BCBSF required for all organ transplants other than kidney or cornea <p><i>For bone marrow transplants:</i></p> <ul style="list-style-type: none"> ✓ Donor costs are covered in the same way, including limitations and non-covered services, as costs for the covered person. Donor search costs are limited to immediate family and the National Bone Marrow Donor Program.

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<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<p><i>Outpatient Care</i></p> <ul style="list-style-type: none"> ◆ Treatment as an outpatient in a hospital, an ambulatory surgical center or an outpatient healthcare facility ◆ Clinical laboratory services ◆ Services for outpatient surgery and outpatient treatment of an injury 	80%	60%	<p><i>For outpatient surgery and treatment:</i></p> <ul style="list-style-type: none"> ✓ Includes supplies provided or used by the facility during the surgery or treatment
<p><i>Oxygen</i></p> <ul style="list-style-type: none"> ◆ Oxygen and rental of equipment for its administration 	80%	60%	
<p><i>Physical Therapy and Massage Therapy</i></p>	80%	60%	<ul style="list-style-type: none"> ✓ Combined limitation for physical and massage therapy limited to 4 treatments/treatment day, with no more than 21 treatment days during any six-month period ✓ Physical therapy may be provided by a physician, chiropractor, or a licensed physical therapist ✓ Massage therapy must be prescribed by your doctor as medically necessary for a specific number of treatments, not to exceed the 4/treatments/day 21 days/6 month limitation, and may be provided by a physician, a chiropractor, a licensed physical therapist or a licensed massage therapist
<p><i>Prostheses</i></p> <ul style="list-style-type: none"> ◆ Artificial limbs or eyes, except replacement of such prostheses 	80%	60%	<p><i>For artificial limbs or eyes:</i></p> <ul style="list-style-type: none"> ✓ Replacement covered if medically necessary based on medical review by BCBSF
<p><i>Reduction Mammoplasty</i></p>	80%	60%	<p><i>For reduction mammoplasty, see page 22 for special limits.</i></p>
<p><i>Rental of Trusses, Braces or Crutches</i></p>	80%	60%	<p><i>For rental of trusses, braces or crutches:</i></p> <ul style="list-style-type: none"> ✓ No shoe(s), shoe(s) build-up, orthotic, shoe brace or shoe support will be covered unless the shoe is attached to a brace

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<i>Types of Care</i>	<i>% Payable Network*</i>	<i>% Payable Non-Network*</i>	<i>Special Limits/Circumstances</i>
<p><i>Skilled Nursing Facility Care</i></p> <ul style="list-style-type: none"> ◆ Room, board and general nursing care ◆ Charges for services and supplies for necessary treatment 	70%	70%	<p><i>For skilled nursing facility care:</i></p> <ul style="list-style-type: none"> ✓ Up to 60 days/person a calendar year ✓ Convalescent facility care must come after hospital stay of at least 3 days, and patient must be transferred from the hospital to the facility ✓ Patient must require skilled care for a condition that was treated in the hospital, as certified by a doctor ✓ Room and board benefit payment is based on \$95/day allowance ✓ Inpatient hospital deductible does not apply to skilled nursing facility admission
<i>Surgical Sterilization</i>	80%	60%	<p><i>For surgical sterilization:</i></p> <ul style="list-style-type: none"> ✓ Does not include reversal of sterilization
<i>Weight Loss Services</i>	80%	60%	<p><i>For weight loss:</i></p> <ul style="list-style-type: none"> ✓ Must be required by a covered person's surgeon before performing a medically necessary covered surgical procedure ✓ Limited to \$150 per person in any 12-month period
<i>Wigs</i>	80%	60%	<p><i>For wigs:</i></p> <ul style="list-style-type: none"> ✓ Hair loss must be caused by chemotherapy, radiation therapy or cranial surgery ✓ Limited to \$40 for one wig and fitting in the 12 months following treatment or surgery

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Other Special Limits On Benefits For Covered Services

Doctor's Care

There are some special limits on how doctor visits will be covered by this health insurance plan.

- ◆ Whenever you are receiving medical care related to surgery, additional inpatient visits from your doctor are covered only if:
 - ◆ you need medical care that is not related to your surgery and is not part of your pre-operative or post-operative care
 - ◆ you are hospitalized for medical care and the need for surgery develops after you are first admitted to the hospital. In this case, payment for doctor visits for other medical care will generally end on the date of surgery.
- ◆ Non-surgical inpatient doctor visits are limited to one visit by one doctor each day. Visits from other doctors may be covered, however, if needed because of the severity or complexity of your condition.
- ◆ Inpatient or outpatient visits to one doctor for a non-surgical condition – or related conditions – are limited to one visit a day.
- ◆ Outpatient doctor visits on the same day you have inpatient surgery will not be covered unless the outpatient visit is unrelated to your surgery or is with a doctor who is not performing your surgery.
- ◆ Outpatient office visits on the same day you have outpatient surgery will not be covered if the charge for the office visit is determined by BCBSF to be included in the surgery charge. An office visit to a doctor who is not performing your surgery will be covered.

Surgical Procedures

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

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

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

Surgery for Breast Reduction

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

- ◆ back or neck pain requiring repeated treatment,
- ◆ deep grooves in the shoulder from bra straps, and
- ◆ dermatitis requiring long-term treatment with prescription medications

and

- ◆ the amount of tissue to be removed from each breast, according to the pathology report, is at least
 - ◆ 400 grams for patients 5'2" tall and 110 pounds or less, or
 - ◆ 500 grams for patients over 5'2" tall and 111 pounds or more.

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

- ◆ your doctor sends a written request for approval to BCBSF before the surgery documenting the physical problems and estimating that the amount of tissue to be removed would be equal to or greater than the above numbers
- ◆ BCBSF recommends approval of the request and DSGI approves the request
- ◆ your doctor documents the medical reason why the actual amount of tissue was less than the guidelines, BCBSF recommends approval and DSGI approves the lesser amount.

About The Health Screening Benefit – Coverage For Active Employees And COBRA Participants

Each year, active employees covered under this Plan and former active employees with COBRA coverage are eligible for a \$100 Health Screening benefit. The benefit covers up to \$100 toward the cost of:

- ◆ physical exams
- ◆ gynecological exams
- ◆ routine eye tests
- ◆ routine hearing tests
- ◆ tests associated with routine exams (lab work, EKGs)
- ◆ prostate specific antigen (PSA) tests (males age 50 years and above).

These tests must be for routine care only, not for a medical diagnosis. Immunizations are not covered.

If you use a network provider, the Health Screening benefit will pay the provider's charges up to the network allowed amount for the service up to the \$100 annual maximum. If payment for any health screening procedure is less than \$100, any remaining balance can be used toward additional routine procedures for the remainder of the year. Services that are submitted for payment after you have exhausted your \$100 Health Screening benefit will be denied as non-covered services. You will be responsible for 100% of the provider's charges regardless of the provider's network status.

If you use a non-network provider, the Health Screening benefit will pay the non-network provider's charge up to the non-network allowance for the service up to the \$100 annual maximum for Health Screening benefit. If the payment for any health screening procedure is less than \$100, any remaining balance can be used toward additional routine procedures for the remainder of the year. Services that are submitted for payment after you have exhausted your \$100 Health Screening benefit will be denied as non-covered services. You will be responsible for 100% of the provider's charges regardless of the provider's network status.

About Maternity Care – Coverage For Mothers And Newborns

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

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

In addition, a plan may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay up to 48 hours – or 96 hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. See page 9 or contact BCBSF for information about precertification.

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

Newborn Screening For The Detection Of Hearing Loss

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

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

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

Limitations And Exclusions

Pre-Existing Conditions And Creditable Coverage

Pre-Existing Conditions

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

- ◆ your date of hire if you enroll as a new hire
- ◆ January 1 if you are adding coverage during the annual open enrollment period, or
- ◆ the date your coverage becomes effective if you are adding coverage because of a qualified status change event or special enrollment period event.

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

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

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

Credit for Previous Coverage

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

Waiving Some or All of the Pre-Existing Condition Limitations

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

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

- ◆ is hired as an eligible employee 1/1/2004
- ◆ enrolls for coverage under the health insurance plan, effective 3/1/2004
- ◆ was treated for a knee injury several times during the six months before date of hire
- ◆ has four months of creditable coverage without a break in coverage under a previous health plan

Regular pre-existing condition limitation for this plan	12 months
<i>Minus</i>	
Creditable coverage under previous health plan	<u>- 4 months</u>
<i>Equals</i>	
Pre-existing condition limitation for this employee	8 months

Because this employee has four months of creditable coverage, the limitation on coverage for the pre-existing condition – the knee injury – is reduced to eight months. This means this health insurance plan will cover the knee injury starting 9/1/2004 – eight months from this employee's date of hire.

Proving Creditable Coverage

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

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

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

- ◆ a schedule of benefits or summary of benefits for the previous health insurance coverage

and

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

Requesting a Pre-Existing Condition Waiver

You or your agency personnel office(er) can submit your request for a pre-existing condition waiver to DSGI. Waiver requests should be mailed to the attention of the “Pre-Existing Waivers Coordinator.” To request a pre-existing condition waiver, you must include:

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

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

Services Not Covered By The Plan

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

1. Cosmetic surgery or treatment, unless it is:
 - ◆ a result of a covered accident and the surgery or treatment is performed while the person is covered by this health insurance plan
 - ◆ for correction of a congenital anomaly for an eligible dependent and performed while the dependent is covered by this health insurance plan
 - ◆ a medically necessary procedure to correct an abnormal bodily function
 - ◆ for reconstruction to an area of the body that has been altered by the treatment of a disease
 - ◆ for breast reconstructive surgery and the prosthetic devices related to a mastectomy. “Mastectomy” means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician, and “breast reconstructive surgery” means surgery to reestablish symmetry between the two breasts.
2. Services and supplies received as a result of war or act of war while in any active military, naval or air service.
3. Services, supplies or treatment provided without charge.
4. Any services or supplies which are not medically necessary, as determined by BCBSF clinical staff and DSGI.
5. Services or supplies received as a result of injury or disease caused by the covered person’s participation in a crime punishable as a felony or illegal occupation.
6. Services for any occupational condition, ailment or injury arising out of or in the course of employment by any employer. The covered person will not be eligible for benefits from this health insurance plan, even if the covered person waives rights to the benefits or services mentioned above.
7. Services provided to a covered person under the laws of the United States or any state or political subdivision. The covered person will not be eligible for benefits from this health insurance plan, even if the covered person waives rights to the benefits or services mentioned above.

8. Services and supplies for dental work, dental treatment, or dental examinations unless
- ◆ necessary as a result of an accident
 - ◆ it is medically necessary to be provided by a hospital, ambulatory surgical center, outpatient healthcare facility or skilled nursing facility. Only facility charges are covered in this circumstance; physician services (including general and specialty dentists and oral surgeons) are not covered.

Services must be provided within 120 days of the accident unless a written explanation from the dentist or physician stating any extenuating circumstances requiring treatment over a longer period of time is received and approved by BCBSF as medically necessary within 120 days. In no instance will any services be covered unless provided within 120 days of the termination of the person's coverage. In no case is orthodontia covered.

9. Services, supplies, care or treatment provided by:
- ◆ a person who usually lives in the covered person's home
 - ◆ a person or facility that is not included as covered in this booklet.
10. Services and supplies for treating or diagnosing refractive disorders including eye glasses, contact lenses, or the examination for the prescribing or fitting of eye glasses or contact lenses, unless required because of an accident or cataract surgery. This health insurance plan will cover the first pair of eye glasses or contact lenses following an accident to the eye or cataract surgery.
11. Hearing aids or the examination, including hearing tests, for the prescription or fitting of hearing aids. Hearing tests associated with a covered ear surgery or for the diagnosis of a covered condition are covered.
12. Services and supplies provided by a specialty facility or residential facility except as described on page 18.
13. Elective abortions, performed at any time during a pregnancy.
14. Services related to the pregnancy of eligible dependent children, except medically necessary services for these complications of pregnancy:
- ◆ conditions not related to pregnancy but adversely affected by pregnancy
 - ◆ conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity
 - ◆ a non-elective Cesarean section
 - ◆ an ectopic pregnancy which is terminated
 - ◆ a spontaneous termination of pregnancy that occurs before the twenty-second week.

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

15. Any services provided for custodial care – including but not limited to assistance with the activities of daily living. See page 50 for a definition of custodial care.
16. Immunizations – except those immunizations provided as part of the well-child health supervision services or when necessary as a result of an accident.
17. Any services provided for preventive care – except those services provided as part of the well-child health supervision services or those services obtained through the \$100 Health Screening benefit (see page 22).
18. All services, supplies, and prescription drugs related to obesity or weight reduction except:
 - ◆ medically necessary intestinal or stomach by-pass surgery, or
 - ◆ medically related services, excluding prescription drugs, provided as part of a weight loss program when weight loss is required by the covered person’s surgeon before performing a medically necessary covered surgical procedure. Coverage for these services is limited to \$150 in any 12-month period.
19. Any service or supply to eliminate or reduce a dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs, Nicorette gum or nicotine patch.
20. Any service or supply to correct baldness.
21. Services or supplies necessary to provide a testicular prosthesis.
22. Surgery to reverse surgical sterilization procedures.
23. Services or supplies necessary to treat sexual deviations and disorders or psychosexual dysfunction.
24. Services or supplies provided in connection with intersex surgery.
25. Insertion of penile prosthesis except when necessary in the treatment of organic impotence resulting from:
 - ◆ diabetes mellitus
 - ◆ peripheral neuropathy
 - ◆ medical endocrine causes of impotence
 - ◆ arteriosclerosis/postoperative bilateral sympathectomy
 - ◆ spinal cord injury
 - ◆ pelvic-perineal injury
 - ◆ postprostatectomy
 - ◆ postpriapism
 - ◆ epispadias and exstrophy.

26. Occupational (except when received as part of home health care services or hospice services), recreational, educational, vocal, sleep therapy.
27. Speech therapy (except for the treatment of cleft lip or cleft palate for children under 18 years old) and speech evaluations.
28. Marriage counseling.
29. Orthoptics.
30. Biofeedback.
31. Telephone consultations.
32. Exercise programs, including cardiac rehabilitation exercise programs, or visits for the purpose of exercise by bicycle ergometer or treadmill. These programs or visits are excluded even if the purpose is to determine the feasibility of an exercise program.
33. Autopsy or post mortem.
34. In-vitro fertilization, artificial insemination, ovum or embryo placement or transfer, gamete intrafallopian transfer, cryogenic and/or other preservation techniques used in such and/or similar procedures.
35. Genetic tests to determine the father of or the sex of a child.
36. Education or training, except for diabetes outpatient self-management training and educational services pursuant to s.627.6408, *Florida Statutes*.
37. Electrolysis.
38. Food, food substitutes or vitamins, except certain enteral formula food products pursuant to s.627.42395, *Florida Statutes*. Dietary, nutritional or herbal supplements; non-federal legend drugs; over-the-counter drugs.
39. Mind expansion or elective psychotherapy such as, but not limited to, Gestalt Therapy, Transactional Analysis, Transcendental Meditation, Z-therapy and Erhard Seminar Training (EST).
40. Services related to the treatment of mental retardation.
41. Air conditioners, humidifiers, dehumidifiers, air purifiers or filters, whirlpools and blood pressure kits.
42. Modifications to motor vehicles and/or homes such as wheelchair lifts or ramps.
43. Water therapy devices such as Jacuzzis.
44. Services for which a claim has been submitted for payment to BCBSF more than 16 months after the date services or supplies were received.
45. Services and procedures considered by BCBSF to be experimental or investigational, or services and procedures not in accordance with generally accepted professional medical standards, including complications resulting from these non-covered services.

46. Services and supplies provided by an institution that is used mainly as a nursing home or rest facility for the care and treatment of the aged.
47. Services and supplies provided by a skilled nursing facility for:
- ◆ custodial care, including but not limited to assistance with the activities of daily living
 - ◆ alcoholism, drug addiction or mental and nervous disorders
 - ◆ the convenience of the covered person or covered person's family.
48. Inpatient services provided by a hospital, specialty institution, residential facility or any other facility while a participant is confined for treatment of a mental or nervous disorder and/or alcoholism or drug addiction above the 31-day per calendar year limit.
49. The following services when they are provided for the treatment of alcoholism or drug addiction: ambulance; nursing care by an RN or LPN; artificial limbs or eyes; rental of trusses, braces or crutches; rental of wheel chair or hospital bed; oxygen; and durable medical equipment.
50. Complications resulting from non-covered services, except complications of pregnancy defined on pages 49-50.
51. Expenses for wigs unless hair loss is caused by chemotherapy, radiation therapy or cranial surgery. Coverage for wigs in those cases is limited to \$40 for one wig and fitting in the 12 months following treatment or surgery.
52. Services of a covered provider that are not patient specific. Such non-patient-specific services include, but are not limited to, the oversight of a medical laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, testing equipment, or laboratory technicians.

Prescription Drug Program

How The Program Works

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

	When To Use	Supply Of Medication You May Receive
Retail pharmacies	for short-term medications or medications that you need immediately, like antibiotics for a sick child	up to a 30-day supply at one time
Mail order program	for maintenance or long-term medications you take regularly, like high blood pressure medication	up to a 90-day supply at one time, as long as the prescription is written to allow dispensing of a 90-day supply

Purchasing Prescriptions At Retail Pharmacies

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

- ◆ you pay a set copayment for prescriptions
- ◆ you do not have to file a claim form

Participating pharmacies include most major drug chains – with over 45,000 pharmacies nationwide. To find out if your pharmacy participates call 1-800-378-4408 or visit www.caremark.com. You should receive a pharmacy network directory when you enroll in this plan. If you have not received yours, you may request one by calling the toll-free number. You can also use this toll-free number to locate a participating pharmacy if you are traveling anywhere in the United States.

Using a Participating Pharmacy

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

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

What If You Request A Brand Name At A Participating Pharmacy?

If your prescription is filled with a generic, you pay only the \$10 copayment. If a generic isn't available – or if your doctor writes on the prescription "dispense as written" or "brand name medically necessary" – you pay the applicable copayment for the brand name. But if you request a brand name instead of an available generic, you will pay the lesser of:

The brand name copayment
plus
The difference between the plan's cost
for the brand name drug and
the plan's cost for the generic drug
or
The actual retail price of the brand drug.

Take a look at an example showing how this works. In this example, you are using a network pharmacy. At network pharmacies, the plan's cost for a drug is less than the full retail price. Assume you request a preferred brand name drug that costs the plan \$50 instead of the available generic substitute that costs the plan \$25 – in this case, you would pay:

<i>Preferred Brand name copayment</i>	+	<i>Plan's cost difference between preferred brand name and generic</i>	=	<i>Your cost</i>
\$25	+	brand generic	=	\$50
		\$50		
		– \$25		
		\$25		

There is no paperwork when you use your prescription drug program card at a participating pharmacy. The pharmacist files claims for you.

Using a Non-Participating Pharmacy

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

If you fill your prescriptions at a non-participating pharmacy you will be reimbursed at 82% of the average wholesale price (AWP) for brand name drugs or 75% of the maximum allowable cost for generic drugs, plus a \$4.28 fill fee, minus your copayment amount. You pay any amount above the AWP. A fill fee is a fee that every pharmacist is paid for filling a prescription under the plan in addition to the cost of the drug.

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

An Example – Using A Non-Participating Pharmacy: Suppose you fill a prescription for a brand name drug with an AWP of \$50 and a retail price of \$85. You will pay \$85 for the prescription and submit a claim for reimbursement. You will be reimbursed:

82% of \$50 (AWP)	\$41.00
<i>plus</i>	
the fill fee	+ \$ 4.28
<i>minus</i>	
your copayment	- \$25.00
total reimbursement	\$20.28

In this example, the cost to you for using a non-participating pharmacy is \$64.72 (\$85.00 retail price *minus* reimbursement of \$20.28). If you had filled this prescription at a participating pharmacy and your physician requested the brand name drug, you would have paid only the \$25 copayment.

Using The Mail Order Program

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

- ◆ complete a mail order form available from your agency personnel office(er)
- ◆ enclose your prescription written for a 90-day supply, and the appropriate copayment.

What Are Generics?

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

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

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

How You Can Save With Mail Order

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

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

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

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

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

Drugs That Are Covered By The Prescription Drug Program

Covered drugs include:

- ◆ Federal legend drugs
- ◆ State restricted drugs
- ◆ Compounded medications
- ◆ Insulin and other covered injectable medications
- ◆ Needles and syringes for insulin and other covered injectables
- ◆ FDA-approved glucose strips, tablets and lancets.

Some medications require pre-approval before your prescription can be filled. Your pharmacist will let you know if your prescription requires pre-approval. If your prescription requires pre-approval, 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.

Approvals are valid for a one year period and must be renewed after expiration.

Drugs That Are Not Covered By The Prescription Drug Program

The prescription drug program does not cover:

- ◆ Retin-A for cosmetic purposes
- ◆ Anti-obesity drugs and amphetamines and/or anorexians for weight loss
- ◆ Devices or appliances
- ◆ Non-federal legend – or over-the-counter – drugs
- ◆ Drugs labeled “Caution – Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made
- ◆ Nicorette and similar drugs to deter smoking
- ◆ Immunization agents
- ◆ Medication that is covered by Workers’ Compensation or Occupational Disease Laws or by any state or governmental agency
- ◆ Medication furnished by any drug or medical service for which no charge is made
- ◆ Viagra, for psychosexual disorders, females, and males under the age of 18.

The plan’s general limitations and exclusions may also apply to the prescription drug program. See pages 27 to 31 for a complete listing of plan limitations and exclusions.

Special Plan Features

Healthy Addition[®] Pre-Natal Education Program

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

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

Personal Health Advisor[®] Program

The Personal Health Advisor[®] Program, a product of Access Health, Inc., is a healthcare information service offered through BCBSF. The program is designed to help you make more informed and appropriate healthcare decisions. The Personal Health Advisor[®] Program includes:

- ◆ an extensive audio health library available in English and Spanish, plus follow-up literature
- ◆ access to registered nurses available to discuss health issues and provide personalized health information research, preventive education, chronic disease and treatment/procedure education, and general information about immediate health problems
- ◆ information on network hospitals, physicians or other healthcare resources.

To use the Personal Health Advisor[®] Program, call 1-800-667-2546. This confidential service is available 24 hours a day, 7 days a week.

Medical Case Management Program

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

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

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

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

The case management alternative treatment plan will end if:

- ◆ the patient's condition changes and the level of care provided under case management is no longer necessary
- ◆ the patient has reached the plan's \$1,000,000 maximum lifetime benefit
- ◆ the case management approach costs more than traditional benefits
- ◆ the patient is no longer eligible to take part in this health insurance plan.

Patient-Auditor Program

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

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

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

Worldwide Coverage

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

See pages 46 and 47 for information on filing claims – including time limits.

BlueCard® PPO Program

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

When you are outside of BCBSF's service area and need health care, call 1-800-810-BLUE (2583) for the name of a participating Blue Cross and/or Blue Shield Plan PPO provider in the area. When you present your ID card, the provider will verify your coverage and handle any claims-related paperwork.

When you use a local Blue Cross and/or Blue Shield Plan's PPO provider through the BlueCard® PPO Program, this health insurance plan pays network level benefits for covered services. You are responsible for any applicable deductibles, copayments, coinsurance, and charges for non-covered services. Providers who participate in the BlueCard® PPO Program have agreed to accept negotiated amounts for covered services, so you will not receive an unexpected bill for amounts above those negotiated amounts. Also, please note that this health plan's calculation of your coinsurance and other out-of-pocket expenses for covered services will be at the lower of the allowed amount or the PPO network provider's billed charges. Here is an overview of how claims and benefits work, depending on the provider you use.

- ◆ *If you receive care from a BlueCard participating provider because a BlueCard PPO provider is not available to you, the provider files your claims for you and you receive network benefits. You are not responsible for charges above the network allowed amount.*
- ◆ *If you receive care from a BlueCard participating provider when a BlueCard PPO provider is available, the provider still files claims for you, but you receive non-network benefits. You are not responsible for charges above the non-network allowance.*
- ◆ *If you receive care from a non-network provider not associated with the BlueCard program, your claims are processed as non-network and you must file your own claims. This plan will pay non-network benefits. You are responsible for charges above the non-network allowance.*

In some areas, state law may affect how this health insurance plan pays benefits for services provided through the BlueCard® PPO Program. And, in a limited number of areas, the local Blue Cross and/or Blue Shield Plan may not have a PPO network available. So please call 1-800-810-BLUE (2583) to verify availability before receiving services.

Coordination Of Benefits With Other Coverage

Coordination With Other Group Insurance Plans

If you, your spouse or your dependents are covered by this health insurance plan and any other group medical insurance plan, no-fault automobile insurance, health maintenance organization or Medicare, benefits from this health insurance 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.

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

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

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

In order to ensure claims processing accuracy and appropriate coordination of benefits, DSGI requires that BCBSF verify if you, your spouse, or your other dependents have other insurance coverage or other carrier liability (OCL). Each year, approximately 365 days from the previous verification, you will be notified by BCBSF, on an explanation of benefits statement, that you should contact its office, by mail or telephone (800-477-3736, ext. 34743), to verify OCL information. BCBSF will automatically process or reprocess any claims, which may have been denied or suspended, once you have provided the requested OCL information.

How Coordination Works

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

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

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

For All Covered Individuals

- ◆ The plan covering a person as an employee or member, rather than as a dependent, pays first.
- ◆ 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

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

...unless a court decrees otherwise.

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

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

Coordination With Medicare

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

Active Employees

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

For active employees with a dependent who is disabled for reasons other than end-stage renal disease, this health insurance 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 health insurance plan will continue to be primary, paying benefits first, as long as you are an active employee.

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

Retired Employees

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

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

If you are covered under this health insurance 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 health insurance plan will pay benefits up to:

- ◆ the covered expenses Medicare does not pay, up to the Medicare allowance
- ◆ the amount this health insurance plan would have paid if you had no other coverage

... whichever is less.

Here are two examples showing how coordination of benefits with Medicare works. In both examples, assume that the provider accepts Medicare assignment – meaning the provider agrees to accept the Medicare allowance as full payment and will not bill the patient for any amount above the Medicare allowance.

Example 1 – Network Office Visit

Assume you go to the doctor for an office visit that includes an x-ray. The doctor's normal charge for these services would be:

<i>Type of Service</i>	<i>Charge</i>
Office Visit:	\$60
Radiology:	\$30

First, this health insurance plan benefits are calculated as if you have no other coverage.

<i>Network Allowance</i>	<i>Minus per visit network copayment</i>		<i>Total this plan would pay (80%)</i>
Office Visit: \$50	-\$15	= \$35	\$28.00
Radiology: \$25	-\$0	= \$25	\$20.00
			\$48.00

Next, Medicare benefits are calculated.

<i>Medicare Allowance</i>	<i>Medicare deductible</i>		<i>Medicare payment (80%)</i>	<i>What Medicare doesn't pay</i>
Office Visit: \$40	-\$0	= \$40	\$32.00	\$ 8
Radiology: \$20	-\$0	= \$20	\$16.00	\$ 4
			\$48.00	\$12

In this example, the amount Medicare does not pay – \$12.00 – is less than the amount this health insurance plan would pay if you had no other coverage – \$48.00. This health insurance plan will pay \$12.00 to the provider. You will not pay anything for these services because this health insurance plan payment and Medicare payment together equal the Medicare allowance.

Example 2 – Non-network Office Visit

For this example, assume the person goes to the doctor for minor surgery and lab work. The doctor's normal charge for these services would be:

<i>Type of Service</i>	<i>Charge</i>
Minor Surgery	\$200
Lab work	\$ 15
Lab work	\$ 10

First, this health insurance plan benefits are calculated as if you have no other coverage.

<i>Non-network Allowance</i>		<i>Expenses applied to non-network deductible</i>	<i>What this plan would pay</i>
Minor Surgery	\$100	\$100	\$0
Lab work	\$ 15	\$ 15	\$0
Lab work	\$ 10	\$ 10	\$0
		\$125	\$0

Next, Medicare benefits are calculated.

<i>Medicare Allowance</i>		<i>Medicare deductible</i>		<i>Medicare payment (80%)</i>	<i>What Medicare doesn't pay</i>
Minor Surgery	\$150	-\$75	=\$75	\$60.00	\$90
Lab Work	\$ 10	-\$ 0	=\$10	\$10.00	\$ 0
Lab Work	\$ 10	-\$ 0	=\$10	\$10.00	\$ 0
				\$80.00	\$90

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

An Important Note For Retirees

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

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

Plan's Right To Recover And Sue For Losses

This health insurance plan reserves the right to be reimbursed for benefits paid under this plan if the covered person has a right to recover those benefits from a third party. This provision helps the State continue providing cost-effective healthcare benefits. You will not be asked to reimburse this plan for an amount higher than the actual payments it made on your behalf.

If you or your dependents receive plan benefits for a claim that is in connection with a condition caused, directly or indirectly, by an intentional act or from the negligence or fault of any third person or entity, this health insurance plan will be subrogated to the right of recovery you or your dependent has against the other person or entity. This health insurance plan's subrogation rights apply to any settlement of a claim, regardless of whether there is a lawsuit, and will not be off-set by any premiums you have paid.

This right to subrogation will be for the amount of benefits paid by this plan for healthcare services. You, your dependent or your legal representative, will be required to:

- ◆ provide this plan with information pertaining to your settlement, settlement negotiations or litigation
- ◆ provide the assistance necessary to enforce this right to subrogation
- ◆ notify BCBSF of any settlement negotiations before entering into any settlement agreement
- ◆ notify BCBSF of any amount recovered from the person or entity that may be liable
- ◆ obtain the prior written consent of BCBSF or DSGI before entering into any settlement agreement.

No waiver, release of liability or other documents you execute without notice to BCBSF shall be binding upon this health insurance plan.

How To File A Claim

Medical Claims

When You Use Network Providers

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

When You Use Non-Network Providers

If you go to a non-network provider, you will be responsible for filing your own claim. You must file the claim within 16 months of the day you received services or supplies. Benefits will be paid directly to you. You can get medical claim forms from BCBSF, DSGI or your agency personnel office.

To submit the claim:

- ◆ Complete all information on the claim form, as indicated.
- ◆ Attach original bills to the claim form – make sure the bills include the patient’s name, date, place and nature of treatment, procedure and diagnosis codes, and the physician’s name and federal tax ID number.

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

Explanation of Benefits Statement

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

- ◆ the amount paid by this health insurance plan
- ◆ any deductibles or copayments applied to the claim
- ◆ the amount the patient must pay, if any.

If your claim is denied, the EOB will show:

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

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

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

Prescription Drug Claims

When You Use A Participating Pharmacy

When you use a participating pharmacy, you do not need to file a claim. The provider will file the claim for you and you will be responsible for your copayment.

When You Use A Non-Participating Pharmacy

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 your agency personnel office(er), DSGI, Caremark, or at www.caremark.com.

To submit the claim:

- ◆ Complete all information on the claim form, as indicated.
- ◆ Attach original bills to the claim form – make sure the bills include the patient’s name, date, pharmacy name, prescription name, quantity dispensed, dosage dispensed, and billed price of medication.
- ◆ Send the claim to Caremark, Inc. the company that provides prescription claims payment services, at the address on the prescription claim form.

Appealing A Denied Claim

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

Appealing To The Third Party Administrator – A Level I Appeal

Within 90 days of the date of the EOB denial notice you or your authorized representative can appeal a claim that is denied. Your appeal must be in writing and should include any information, questions or comments you think are appropriate. Mail your written appeal to the third party administrator – BCBSF for medical claims or Caremark, Inc. for prescription drug claims – at the address shown on the inside cover of this booklet. The third party administrator will review your claim and provide you with a written notice of the review decision. On this notice, you will also receive information about appealing the decision to DSGI.

Appealing To DSGI – A Level II Appeal

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

- ◆ a copy of the EOB
- ◆ a copy of your letter requesting the third party administrator to review the claim
- ◆ a copy of the third party administrator’s written notice of their review decision
- ◆ a letter to DSGI appealing the decision, and
- ◆ any other information or documentation you think is appropriate.

Mail your written appeal to DSGI at the address shown on page i. Send your appeal to the attention of the “Appeals Coordinator.”

Requesting An Administrative Hearing

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

Definitions Of Selected Terms Used By The Plan

Here are definitions of selected terms used by this health insurance plan.

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

Acupuncture . . . a technique for treating certain conditions by passing long, thin needles, with or without electrical stimulation, through the skin to specific points; application of a modality with or without electrical stimulation; massage including effleurage, petrissage, and/or tapotement (stroking, compression, percussion.)

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

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

Ambulatory surgical center . . . a facility:

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

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

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

Child Health Supervision Services . . . doctor-delivered or doctor-supervised services that include a history, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests based on prevailing medical standards under the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

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

Complications of pregnancy . . . complications of pregnancy include:

- ◆ conditions not related to pregnancy but adversely affected by pregnancy
- ◆ conditions caused by pregnancy, like acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity
- ◆ non-elective Cesarean section
- ◆ ectopic pregnancy which is terminated

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

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

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

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

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

Care or services that meet this definition are not covered by the health plan. See exclusion 15 on page 29.

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

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

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

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

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

- ◆ a licensed dentist who performs surgical or non-dental procedures covered by this plan, or provides treatment of injuries resulting from accidents
- ◆ a licensed optometrist who performs procedures covered by this plan
- ◆ a licensed psychologist or licensed mental health professional, as defined by state law, who provides covered services
- ◆ a licensed chiropractor who performs procedures covered by this plan.

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

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

- ◆ cannot be lawfully marketed without approval of the US Food and Drug Administration or the Florida Department of Health if approval for marketing has not been given at the time the service is provided to the covered person; or
- ◆ is the subject of ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation – or is under study to determine the maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the condition; or
- ◆ is generally regarded by experts as requiring more study to determine maximum dosage, toxicity, safety or efficacy, or to determine the efficacy compared to standard treatment for the condition; or
- ◆ has not been proven safe and effective for treatment of the condition based on the most recently published medical literature of the US, Canada or Great Britain using generally accepted scientific, medical or public health methodologies or statistical practices; or
- ◆ is not accepted in consensus by practicing doctors as safe and effective for the condition; or
- ◆ is not regularly used by practicing doctors to treat patients with the same or a similar condition.

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

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

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

Hospice . . . an autonomous, centrally administered, nurse-coordinated program providing home, outpatient and inpatient care for a covered person who is terminally ill and members of that person's family. At a hospice, a team of healthcare providers assist in providing palliative and supportive care to meet the special needs arising during the final stages of illness – and during dying and bereavement. This team of providers includes a doctor and nurse and may also include a social worker, a clergy member or counselor and volunteers.

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

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

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

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

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

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

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

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

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

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

The fact that a service is prescribed by a doctor does not necessarily mean that the service is medically necessary. BCBSF and DSGI determine whether a service or supply is medically necessary.

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

- ◆ ordered by a physician
- ◆ of no further use when medical need ends
- ◆ usable only by the particular patient
- ◆ not primarily for the patient's comfort or hygiene
- ◆ not for environmental control
- ◆ not for exercise, and
- ◆ specifically manufactured for medical use.

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

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

Network allowed amount . . . the maximum amount this health insurance plan will approve for covered services and supplies received from a covered provider who is a member of the preferred provider organization network.

Network provider . . . covered providers who are members of BCBSF's PPCsm Network or another Blue Cross and/or Blue Shield Plan under the BlueCard® Program.

Non-Network allowance . . . the maximum amount this health insurance plan will approve for covered services and supplies received from a covered provider who is not a member of the preferred provider organization network.

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

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

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

Payment for Professional Services (PPS) . . . providers not in the Preferred Patient Caresm Network but who have an agreement with BCBSF to provide services at a negotiated fee. These providers are also called participating BCBSF providers.

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

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

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

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

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

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

Purchasing of Hospital Services (PHS) . . . hospitals not in the Preferred Patient Caresm Network but who have an agreement with BCBSF to provide services at a negotiated fee.

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

Registered nurse or licensed practical nurse . . . a person licensed under state law to practice nursing.

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

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

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

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

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

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

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

APPENDIX 1

Enrollment And Eligibility

Who Is Eligible To Participate In The Plan

Employees

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

Retirees

You are eligible for the health insurance plan if you were a State officer or State employee and:

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

Dependents

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

- ◆ your spouse
- ◆ your unmarried children through the end of the month in which they reach age 19
- ◆ your unmarried children age 19 through the end of the calendar year in which they reach age 25 if they are:
 - ◆ dependent on you for greater than 50% of their financial support and live with you, or
 - ◆ dependent on you for greater than 50% of their financial support and are enrolled in any school, college, or university certified or licensed by a state or foreign country.

Your mentally or physically disabled children who are enrolled in the health insurance plan are eligible to continue coverage after reaching the age limits listed above as long as they are incapable of self-sustained employment and are dependent on you for greater than 50% of their financial support.

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

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

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

Other Eligible Dependents

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

Surviving spouses are eligible for coverage. The term "surviving spouse" means:

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

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

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

When Coverage Begins

How to Enroll

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

- ◆ initial enrollment period as a new hire
- ◆ annual open enrollment period for all eligible employees
- ◆ enrollment after a change in status that is a qualifying event
- ◆ enrollment after a legislatively mandated special enrollment period event.

As A New Hire – Initial Enrollment Period

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

- ◆ Contact your agency personnel office(r) for enrollment and dependent forms.
- ◆ Complete the necessary enrollment forms. If you are enrolling your dependents, you must complete the dependent form, too.
- ◆ Return the completed forms to your agency personnel office(r) within 60 days of your date of hire – or start of new term in office for State officers.

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

As An Eligible Employee – Annual Open Enrollment Period

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

The annual open enrollment period generally lasts 30 days. Any changes you make during the annual open enrollment period will become effective on January 1 of the next calendar year. Each year, enrollment materials are mailed to employees before the start of the annual open enrollment period. These materials include information on health insurance choices and instructions on how to make changes to your coverage.

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

Change in Status – Qualified Status Change Events Enrollment

You may enroll in or drop coverage for yourself and eligible dependents during the year if you experience a change in status that is a qualifying event. Any change you make to your coverage must be consistent with the change in status. For instance, if you marry, you could add your spouse to the health insurance plan – changing from individual to family coverage. You may obtain enrollment change forms from your agency personnel office(r). The following chart shows examples of qualifying events and the types of changes you may be able to make to your health insurance coverage for each event.

If you...	You may be able to . . .
Marry	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Add or drop coverage
Divorce	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Add or drop coverage
Add a dependent-for example, add a newborn or adopted child	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Add or drop coverage
Lose a dependent-for example, a child who no longer meets the definition of an eligible dependent	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Drop coverage
Lose other coverage-for example, eligibility for other coverage ends or COBRA coverage ends	<ul style="list-style-type: none"> ◆ Add coverage
Have a change in other coverage-for example, employer contributions for the other coverage end	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Add coverage
Have a spouse who begins or ends employment or changes employment status	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Add coverage
Have a spouse go on unpaid leave of absence when dependents are covered under spouse's plan	<ul style="list-style-type: none"> ◆ Change to or from individual/family coverage ◆ Change to or from individual/family coverage

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

Special Enrollment Periods

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

- ◆ eligibility for the other coverage ends
- ◆ employer contributions for the other coverage end, or
- ◆ COBRA coverage available through the other coverage ends because it has been completely used

then you can enroll in the health insurance plan – as long as you complete an enrollment form and return it to your agency personnel office(r) within 31 days of the date your other coverage ends. If your other coverage was through COBRA, you have until 31 days from the date your COBRA coverage ends to enroll in the health insurance plan.

If you acquire a new dependent because of marriage, birth, adoption or placement for adoption, you can enroll yourself, your new family members and any other eligible dependents in the health insurance plan by completing an enrollment form and returning it to your agency personnel office(r) within 31 days of the marriage, birth or adoption.

When Coverage Becomes Effective

As a New Hire

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

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

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

During Annual Open Enrollment

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

Qualified Status Change Events or Special Enrollment Period Events

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

Important Reasons to Contact Your Agency Personnel Office(r)

There are several important events that may affect your health insurance plan coverage.

Contact your agency personnel office(r) within 31 days if:

- ◆ your spouse becomes employed by or ends employment with the State
- ◆ you go off the payroll for any reason
- ◆ you transfer to another agency
- ◆ you move
- ◆ you or your spouse become eligible for Medicare – in this case, contact DSGI as well.

You should also contact your agency personnel office(r) 31 days before you plan to retire.

When Coverage Ends

When Coverage Ends

Your coverage under the health insurance plan ends on the last day of the month which:

- ◆ your employment is terminated
- ◆ you do not make the required contributions for coverage, including the months when you are on leave without pay, suspension or layoff status
- ◆ you are paid from Other Personnel Services (OPS) or contract accounts.
- ◆ you remarry, if you have coverage as a surviving spouse of an employee or retiree

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

- ◆ your coverage is terminated
- ◆ your spouse remarries after your death (see "Other Eligible Dependents", page 58 for details on surviving spouse coverage)
- ◆ you and your spouse divorce.

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

- ◆ your coverage is terminated
- ◆ your child marries
- ◆ your child no longer meets the definition of an eligible dependent.

Certificate of Coverage

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

Coverage Continuation

Family and Medical Leave

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

As an employee of the State of Florida you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for the State of Florida for at least

one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent) or a personal serious health condition. Under the laws of the State of Florida, this leave may be extended up to 6 months. Call your Personnel Office if you need further details.

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

Coverage Continuation When You Are Off Payroll

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

- ◆ authorized leave without pay
- ◆ suspension
- ◆ layoff
- ◆ Workers' Compensation disability leave
- ◆ less than year-round employment, or
- ◆ military leave.

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

COBRA

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

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

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

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

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

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

Dependent children covered by the health insurance 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 DSGI of a divorce, legal separation, death or a child's losing dependent status under the plan. Notice must be given within 31 days of the event. Involved individuals must also provide DSGI with a current and complete mailing address. If notice is not received within 31 days of the event, the dependent will not be entitled to choose continuation coverage.

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

- ◆ the date coverage is lost because of one of the events described above, or
 - ◆ the date the form is received from DSGI
- whichever is later.

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

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

- ◆ the State stops providing group health coverage for employees
- ◆ payment for continuation coverage is not made by the deadline, or your check is returned for insufficient funds
- ◆ 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
- ◆ the individual later becomes entitled to Medicare.
- ◆ If the employee became entitled to Medicare before the change in employment status from permanent status to Other Personal Services (OPS) or employment termination, coverage for other covered dependents may be continued for 18 months or for up to 36 months from the date the employee became entitled to Medicare, whichever is longer
- ◆ the 18-, 29-, or 36-month COBRA period ends.

Converting Health Insurance Plan Coverage To A Private Policy

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

If you choose COBRA continuation coverage when your health insurance plan coverage ends, you can convert to a private policy when COBRA coverage ends. In this case, you must still apply in writing and pay the first month's premium within 63 days of the date your COBRA coverage ends.

Continuation Of Benefits If You Are Disabled

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

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

For this continuation of benefits, total disability means:

- ◆ for an employee – you are unable to perform any work or occupation for which you are reasonably qualified and trained
- ◆ 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:

- ◆ as long as total disability lasts, up to a maximum of 12 months, or
- ◆ 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 Health Insurance Plan Is Terminated

If the health insurance plan is ever terminated, benefits will be extended for the following reasons only:

- ◆ 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.
- ◆ If you are pregnant when the plan is terminated, covered maternity benefits will continue to be paid for the rest of your pregnancy.
- ◆ 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.

APPENDIX 2

State Of Florida Employees' Group Health Insurance Program Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by plans – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for the State of Florida's Flexible Spending Account, and discusses administrative activities performed by the State for the State of Florida Employees' Group Health Self-Insurance Plan (the self-insured plan) and for insurance companies and HMOs in the State Group Insurance Program (the insured plans).

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

The plans' duties with respect to health information about you

The Plans are required by law to maintain the privacy of your health information and to provide you with a notice of the plans' legal duties and privacy practices with respect to your health information. Participants in the self-insured plan will receive notices directly from Blue Cross and Blue Shield of Florida (BCBSF), and from Caremark (which administers the plan's prescription drug coverage); the notices describe how BCBSF and Caremark will satisfy the requirements. Participants in an insured plan option will receive similar notices directly from their insurer or HMO.

It's important to note that these rules apply only with respect to the health plans identified above, not to the State as your employer. Different policies may apply to other State programs and to records unrelated to the plans.

How the plans may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

- ◆ Treatment includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the plans may share health information about you with physicians who are treating you.
- ◆ Payment includes activities by these plans, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well

as “behind the scenes” plan functions such as risk adjustment, collection, or reinsurance. For example, the plans may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- ◆ Health care operations include activities by these plans (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the plans may use information about your claims to review the effectiveness of wellness programs.

The amount of health information used or disclosed will be limited to the “Minimum Necessary” for these purposes, as defined under the HIPAA rules. The plans may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the plans may share your health information with the State

The plans will disclose your health information without your written authorization to the State for plan administration purposes. The State needs this health information to administer benefits under the plans. The State agrees not to use or disclose your health information other than as permitted or required by plan documents and by law.

The plans may also disclose “summary health information” to the State if requested, for purposes of obtaining premium bids to provide coverage under the plans, or for modifying, amending, or terminating the plans. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information have been removed.

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

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

Other allowable uses or disclosures of your health information

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

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

- ◆ 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 necessity of using your health information and treatment of the information during a research project
- ◆ Certain disclosures related to health oversight activities, specialized government or military functions and US Department of Health and Human Services investigations

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

Your individual rights

You have the following rights with respect to your health information the plans maintain. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right for the Flexible Spending Account and for the State activities relating to the self-insured plan and insured plans. Contact Division of State Group Insurance at www.dsgi.state.fl.us, or PO Box 5450, Tallahassee, FL 32314-5450 to obtain any necessary forms for exercising your rights. The notices you receive from BCBSF, Caremark, and your insurer or HMO (as applicable) will describe how you exercise these rights for the activities they perform.

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

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

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

Right to receive confidential communications of your health information

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

If you want to exercise this right, your request to the plans must be in writing and you must include a statement that disclosure of all or part of the information could endanger you. This right may be conditioned on you providing an alternative address or other method of contact and, when appropriate, on you providing information on how payment, if any, will be handled.

Right to inspect and copy your health information

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

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

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

The plans may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The plans also may charge reasonable fees for copies or postage.

If the plans do not maintain the health information but know where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

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

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

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

Right to receive an accounting of disclosures of your health information

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

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

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

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request must be in writing. Within 60 days of the request, the plans will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request. You may make one (1) request in any 12-month period at no cost to you, but the plans may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

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

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The plans must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on April 14, 2003. However, the plans reserve the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the plans maintain. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to a plan’s privacy policies as described in this notice, you will be provided with a revised Privacy Notice through posting on the DSGI website, or mailed to your last known home address.

Complaints

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

Contact

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

