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

Group Health Insurance Plan Booklet and Benefits Document

Effective January 1, 2018

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

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

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CONTACT INFO and SERVICE AREA	
Claims Administration: Capital Health Plan	2140 Centerville Place Tallahassee, Fl. 32308
Capital Health Plan Member Services – All Areas	850-383-3311
HMO Service Area	
Calhoun	Leon
Franklin	Liberty
Gadsden	Wakulla
Jefferson	
If you need information about…	Contact…
Medical benefits or claims administered by Capital Health Plan, or finding a medical Network Provider participating with Capital Health Plan within the State of Florida	CAPITAL HEALTH PLAN MEMBER SERVICES 850-383-3311 (Monday – Friday 7:00 am to 7:00 pm) Toll-free: 877-392-1532 CapitalHealth.com/State (plan information) CapitalHealth.com (Network Provider and user account access) **Level I Appeals:** Capital Health Plan, Inc. ATTN: Grievance Manager/Appeals P. o. Box 15349 Tallahassee, FL 32317-5349 For expedited reviews, fax to 850-383-3413
Pre-Admission Hospital Certification and Prior Authorization	Capital Health Plan, Inc.: 850-383-3311 ***Call this number to verify eligibility for Plan benefits** before **the charge is incurred.***
Prescription drug program information	CVS/caremark (888) 766-5490 *caremark.com/sofrxplan* (plan information) *caremark.com* (user account information)
	For paper Claims only: CVS/caremark P.O. Box 52010 MC003 Phoenix, AZ 85072-2010 **Level I Appeals:** CVS/caremark Attention: Appeals P.O. Box 52071 Phoenix, AZ 85072-2071 Fax: (866) 448-1172
	General correspondence, Customer Care correspondence: P.O. Box 7074, Lee's Summit, MO 64064-7074
Enrollment, eligibility, or changing coverage	People First Service Center P.O. Box 6830 Tallahassee, FL 32314 (866) 663-4735 *https://PeopleFirst.myFlorida.com* Fax: (800) 422-3128 (Include your People First ID number on the top right of each page)
Medicare eligibility and enrollment	The Social Security Administration office in your area

I. INTRODUCTION

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

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

The State of Florida may designate any third-party administrators or claims administrators to carry out certain Plan duties and responsibilities. The State of Florida is responsible for formulating and carrying out all rules and procedures necessary to administer the Plan. The State of Florida, as Plan Sponsor, has the discretionary authority to (1) make decisions regarding the interpretation or application of Plan provisions (2) determine the rights, eligibility, and benefits of Health Plan Members and beneficiaries under the Plan, and (3) review claims under the Plan. The State of Florida may delegate to a third party any or all such discretionary authority described above. Benefits under the Plan will be paid only if the State of Florida, as Plan Sponsor, or its designee or delegate decides in its discretion that the Health Plan Member is entitled to them. Whether such Third Party Administrators have been delegated any such discretionary authority shall be determined solely on the basis of the contract between them and the State, and no such delegation shall be assumed to have been made expressly stated in their contract.

Capital Health Plan, in arranging for the delivery of Medical Services or benefits, does not directly provide these Medical Services. Capital Health Plan arranges for the provision of Medical Services and administers Claims in connection therewith in accordance with the covenants and conditions contained in this Summary Plan Description.

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

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

This SPD describes enrollment and eligibility, Covered Services and Supplies, the amount the Plan pays for Covered Services and Supplies, amounts that are your responsibility, and services and supplies that are not covered.

The State of Florida has contracted with Capital Health Plan to arrange for the provision of Medical Services which are Medically Necessary for the diagnosis and treatment of Health Plan Members through a Network of contracted independent physicians and Hospitals and other health care providers and to administer Claims in connection therewith.

You Must Enroll to Receive Benefits!

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

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

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

Medical Claims

The Plan is not intended to and does not cover or provide any Medical Services or benefits that are not Medically Necessary for the diagnosis and treatment of the Health Plan Member. Capital Health Plan determines whether the services are Medically Necessary on the basis of the terms, conditions, and criteria established by the Plan as interpreted by the State, and as set forth in medical guidelines. The State's interpretations of the Plan shall be communicated to Capital Health Plan by such means as may be agreed upon between them including, but not limited to, the appeals process set forth in Section XIII below and the final determination of DSGI on behalf of Capital Health Plan.

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

Prescription Drug Claims

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

Important: Timely Filing of Claims

All Claim forms must be submitted within 6 months after the date of service. Otherwise, we will not pay any benefits for that eligible expense or benefits will be reduced as determined by State of Florida. For inpatient stays, the date of service is the date your inpatient stay ends. This 6-month requirement does not apply if

you are legally incapacitated.

Rights to Employment

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

Rights to Amend or Terminate the Plan

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

Primary Care Physician

We strongly encourage you to select a participating Primary Care Physician (PCP) who is responsible for providing and managing all of your primary health care. You may change PCPs anytime by calling in advance Capital Health Plan. Your PCP does not need to refer you when you need to see most Specialists for an office visit. Go to Capital Health Plan's website listed in this document's contact section to access the most current list of participating providers and hospitals.

NOTICE: as prohibited by the terms of the Plan, the following acts will be treated as fraud or misrepresentation of material fact:

- Falsifying dependent information;
- Falsely certifying ineligible persons as eligible;
- Falsifying dependent documentation;
- Falsely enrolling ineligible persons in Coverage;
- Falsifying the occurrence of QSC Events; or
- Falsifying QSC Event documentation.

Such acts will require you to reimburse the Plan for any fraudulent Claims incurred, or if still within the COBRA election window, for paying COBRA premiums for any months ineligible persons were covered.

II. DEFINITIONS

As used in this Summary Plan Description (SPD), each of the following terms shall be capitalized and have the meaning indicated:	
Adverse Benefit Determination	A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Health Plan Member's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental and/or investigational or not Medically Necessary; and including a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.
Applied Behavior Analysis	The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Applied Behavior Analysis services shall be provided by an individual certified pursuant to Section 393.17, Florida Statutes, or an individual licensed under Chapter 490 or Chapter 491, Florida Statutes.
Accidental Dental Injury	An injury to sound natural teeth caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.
Autism Spectrum Disorder	Any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: • Autistic disorder; • Asperger's syndrome; • Pervasive developmental disorder not otherwise specified.
Claim	A request for benefits under the Plan made by a Health Plan Member in accordance with Capital Health Plan's procedures for filing benefit Claims, including Pre-Service Claims and Post-Service Claims.
Coinsurance	The amount a Health Plan Member must pay once the Deductible has been met, if applicable, and is expressed as a percentage of the contracted rate for the covered benefit.
Copayment	The portion of the cost, in addition to the prepaid premium amounts, which the Health Plan Member is required to pay at the time certain health services are provided under the Plan. The Copayment may be a specific dollar amount or a percentage of the cost. The Health Plan Member is responsible for the payment of any Copayments directly to the provider of the health services at the time of service.

Covered Services and Supplies	Health care services and supplies, including pharmaceuticals as described in Section VIII, for which reimbursement is covered under this Plan.
Deductible	The first payments up to a specified dollar amount which a Health Plan Member must make in the applicable calendar year for covered benefits. The Deductible applies to each Health Plan Member, subject to any family Deductible listed on the Schedule of Benefits. For purposes of the Deductible, "family" means the Enrollee and covered Health Plan Members. The Deductible must be satisfied once each calendar year.
Dental Care	Dental x-rays, examinations and treatment of the teeth or any services, supplies or charges directly related to: • The care, filling, removal or replacement of teeth, or • The treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, that are customarily provided by dentists (including orthodontics reconstructive jaw surgery, casts, splints and services for dental malocclusion).
Developmental Disability	A disorder or syndrome that is: 1) attributable to an intellectual disability, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome, 2) manifests before the age of 18, and 3) constitutes a substantial handicap that can reasonably be expected to continue indefinitely.
Down Syndrome	Means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following: • Serious jeopardy to the health of a patient, including a pregnant woman or fetus. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. With respect to a pregnant woman: • That there is inadequate time to effect safe transfer to another Hospital prior to delivery; • That a transfer may pose a threat to the health and safety of the patient or fetus; or • That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes. Examples of Emergency Medical Conditions include, but are not limited to, heart attack, stroke, massive internal or external bleeding, fractured limbs or severe trauma. • Emergency (In area) – Does not include elective or routine care, care of minor illness or care that can reasonably be sought and obtained from the Health Plan Member's Primary Care Physician. The initial determination as to whether or not an illness or injury constitutes an Emergency shall be made by Capital Health Plan and may be made retrospectively based upon all information known at the time the patient was present for treatment, subject to the appeals process set forth in Section XIII below and the final determination of the Independent Review Organization on behalf of the Plan. • Emergency (Out of area) – Does not include care for conditions for which a Health Plan Member could reasonable have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area. The initial determination as to whether or not an illness or injury constitutes an Emergency shall be made by Capital Health Plan and may be made retrospectively based upon all information known at the time the patient was present for treatment; such initial determinations are subject to the appeals process set forth in Section XIII below and the final determination of the Independent Review Organization on behalf of the Plan.
Emergency Medical Services and Care	A medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the Hospital.

Enrollee	All state officers and employees, retired state officers and employees, surviving spouses of deceased state offices and employees, and terminated employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program. "Enrollee" includes all state university officers and employees, retired state university officers and employees, surviving spouses of deceased state university officers and employees, and terminated state university employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program.
Exclusion	Any provision of the Plan whereby coverage for a specific hazard or condition is entirely eliminated.
Experimental and/or Investigational	For the purposes of this Plan a medication, treatment, device, surgery or procedure may initially be determined by Capital Health Plan to be Experimental and/or Investigational if any of the following applies: • The FDA has not granted the approval for general use; or • There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or • There is no consensus among practicing physicians that the medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing physicians in treating other patients with the same or a similar condition; or • Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard for treatment or diagnosis of the condition in question. Such determination shall be subject to the appeals process set forth in Section XIII below and the final determination of the Independent Review Organization on behalf of the Plan.

Health Plan Member	Any person participating in a state group health insurance plan or a health maintenance organization plan under the state group insurance program, including Enrollees and other Health Plan Members.
Health Maintenance Organization or "HMO"	An entity certified under part I of chapter 641. The organization named on page one of this document.
Health Professionals	Physicians, osteopaths, podiatrists, chiropractors, physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health care services, who are licensed and practice under an institutional license, individual practice association or other authority consistent with State law and who are Participating Providers of Capital Health Plan.
Home Health Care Services (Skilled Home Health Care)	Services that are provided for a Health Plan Member who does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under the Plan. A visit is limited to a period of two hours or less.
Hospice	A public agency or private organization that is duly licensed by the State, to provide Hospice services. Such licensed entity must be principally engaged in providing pain relief, symptom management and supportive services to terminally ill Health Plan Members.
Hospital	Any general acute care facility which is licensed by the State.
Hospital Services	Except as expressly limited or excluded by the Plan, means those services for registered bed patients that are: • Generally and customarily provided by acute care general Hospitals in accordance with the standards of acceptable communitypractice; • Performed, prescribed or directed by Participating Providers;and • Medically Necessary for conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.
Limitation	Any provision, other than an Exclusion, which restricts coverage under the Plan.

Medically Necessary	The use of any appropriate medical treatment, service, equipment and/or supply as provided by a Hospital, skilled nursing facility, physician or other provider which is necessary for the diagnosis, care and/or treatment of a Health Plan Member's illness or injury, and which is: • Consistent with the symptom, diagnosis, and treatment of the Health Plan Member's condition; • The most appropriate level of supply and/or service for the diagnosis and treatment of the Health Plan Member's condition; • In accordance with standards of acceptable community practice; • Not primarily intended for the personal comfort or convenience of the Health Plan Member, the Health Plan Member's family, the physician or other health care providers; • Approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Health Plan Member's condition; and • Not Experimental or investigational.
Medical Office	Any outpatient facility or physician's office.
Medical Services	Except as limited or excluded by the Plan, means those professional services of physicians and other Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services and supplies, including pharmaceuticals and chemical compounds as described in Prescription Drug Program section, that are: • Generally and customarily provided in the Service Area; • Performed, prescribed or directed by Participating Providers; and • Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness.

Medical Office	Any outpatient facility or physician's office.
Medical Services	Except as limited or excluded by the Plan, means those professional services of physicians and other Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services and supplies, including pharmaceuticals and chemical compounds as described in Prescription Drug Program section, that are: • Generally and customarily provided in the Service Area; • Performed, prescribed or directed by Participating Providers; and • Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness.
Mental and Nervous Disorder	Any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD10-CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder.
Network	The providers and facilities that have contracted with Capital Health Plan to provide covered services to Health Plan Members. The Health Plan Members' Copayment, Deductible and/or Co-insurance responsibilities are outlined in the Schedule of Benefits. Sometimes referred to as "Participating Provider."
Non-participating Provider	Any Health Professional or group of Health Professionals, Hospital, Medical Office or Other Health Care Facility with whom Capital Health Plan has neither made arrangements nor contracted to render the professional health services set forth herein as a Participating Provider. Sometimes referred to as "Non-Network."
Other Health Care Facility	Any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services such as skilled nursing care and rehabilitative services.
Participating Physician	Any Participating Provider licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), Florida Statutes.
Participating Provider	Any Health Professional (or group of Health Professionals), Hospital, Medical Office or Other Health Care Facility with whom Capital Health Plan has made arrangements or contracted to render the professional health services set forth herein.
Plan Administrator	State of Florida, Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL 32314-5450.
Post-Service Claim	Any Claim for benefits under the Plan that is not a Pre-Service Claim.
Pre-Service Claim	Any Claim for benefits under the Plan for which (in whole or in part), a Health Plan Member must obtain authorization from Capital Health Plan in advance of such services being provided to or received by the Health Plan Member.

Primary Care Physician	Any Participating Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, or any specialty physician from time to time designated by Capital Health Plan as a "Primary Care Physician" in Capital Health Plan's current list of physicians and Hospitals.
Private Duty Nursing	Services provided by registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular Health Pan Member by arrangements between the Health Plan Member and the private-duty nurse or attendant. Such persons are engaged or paid by an individual Health Plan Member or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the Health Plan Member for reimbursement for such services.
Retired state officer or employee or "Retiree"	A state or state university officer or employee who retires under a state retirement system or a state optional annuity or retirement program or is placed on disability retirement, and who was insured under the state group insurance program at the time of retirement, and who begins receiving retirement benefits immediately after retirement from state or state university office or employment. The term also includes any state officer or state employee who retires under the Florida Retirement System Investment Plan established under part II of chapter 121 if he or she: 1. Meets the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29); or 2. Has attained the age specified by s. 72(t)(2)(A)(i) of the Internal Revenue Code and has six years of creditable service.
Service Area	Those counties in the State of Florida where Capital Health Plan has been approved to conduct business by the Agency for Health Care Administration (AHCA).
Sound Natural Tooth	A tooth that is whole or properly restored (restoration with amalgams only) and is not in need of the treatment provided for any reason other than an Accidental Dental Injury. For purposes of this Plan, a tooth previously restored with a crown inlay, inlay or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

State Group Health Insurance Plan	The state self-insured or fully insured health insurance plan or plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section.
State Group Insurance Program or Programs	The package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan or plans, health maintenance organization plans and other plans required or authorized by law.
Specialist	Any Participating Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), Florida Statutes, other than the Health Plan Member's Primary Care Physician.
Substance Abuse	A condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.
Summary Plan Description (SPD)	This document which describes Capital Health Plan's benefits, Exclusions, cost-share amounts, claim administration procedures and other Plan features. Also called "Plan Booklet and Benefits Document."
Surviving Spouse	The widow or widower of a deceased state officer, full-time state employee, part-time state employee, or Retiree if such widow or widower was covered as a dependent under the state group health insurance plan or a health maintenance organization plan established pursuant to this section at the time of the death of the deceased officer, employee, or Retiree. "Surviving spouse" also means any widow or widower who is receiving or eligible to receive a monthly state warrant from a state retirement system as the beneficiary of a state officer, full-time state employee, or Retiree who died prior to July 1, 1979. For the purposes of this section, any such widow or widower shall cease to be a surviving spouse upon his or her remarriage.
Urgent	A medical condition manifesting itself by acute symptoms that are of lesser severity than that recognized for an Emergency Medical Condition, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the illness or injury to place the health or safety of the Health Plan Member or another individual in serious jeopardy, in the absence of medical treatment within 24 hours. Examples of Urgent Medical Conditions include, but are not limited to: high fever, dizziness, animal bites, sprains, severe pain, respiratory ailments and infectious illnesses.
Urgent Care	Medical screening, examination and evaluation in an ambulatory setting outside of a Hospital Emergency department, including an urgent care center, retail clinic or Primary Care Physician office after-hours, on a walk-in basis and usually without a scheduled appointment and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

Utilization Management Program	Those comprehensive initiatives that are designed to validate medical appropriateness and to coordinate Covered Services and Supplies. These include, but are not limited to: • Concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate; • Case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a skilled nursing facility) and for outpatients when deemed appropriate; and • The benefit coordination program which is designed to conduct prospective reviews for select Medical Services to ensure that services are covered and Medically Necessary. The benefit coordination program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.

III. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

Active Employees

To be eligible to participate in the Plan, you must be a full-time or a part-time employee as defined in s. 110.123(2)(c) and (f), Florida Statutes.

Plan eligibility is determined by whether an employee's position is salaried career service, select exempt service (SES), or senior management service (SMS); and, in the case of an other personal services (OPS) position, the expected hours of service of the employee.

Full-time state employees are eligible to participate in the Plan. These employees are salaried career service, SES, and SMS employees; and other personal services (OPS) employees expected to work an average of 30 or more hours per week.

Part-time state employees are eligible to participate in the Plan. These employees are salaried career service, SES, and SMS employees who work less than 30 hours per week. Employees in these positions are eligible to participate in the Plan but pay a pro-rated share of the employer premium.

OPS employees expected to work less than 30 hours per week on average are not eligible to participate in the Plan.

Seasonal workers in OPS positions are not eligible to participate in the Plan. These employees hold positions for which the customary annual employment is six months or less and begins each year at approximately the same part of the year, such as summer or winter.

Plan eligibility is initially determined at the point of hire. For OPS employees who are not reasonably expected to work 30 or more hours per week, eligibility for subsequent plan years is determined using a look-back measurement method.

The 12-month look-back measurement method involves three different periods:

1. Measurement period – counts hours of service to determine Plan eligibility.
    a. Initial Measurement Period – If you are an OPS employee who is not reasonably expected to work at least 30 hours per week at the point of hire, your hours of service from the first day of the month following your date of hire to the last day of the 12th month of employment will be measured.

       An example: Assume you are hired October 5, 2017. Your initial measurement period will run from November 1, 2017 through October 31, 2018. If your hours worked during the initial measurement period average 30 hours or more per week, you are eligible to enroll in the Plan with an effective date of December 1, 2018.

       If you are an OPS employee and become reasonably expected to work 30 hours or more per week during the initial measurement period, you become eligible to participate in the Plan at that time.

    b. Open enrollment measurement period –If you have been employed long enough to work through a full measurement period, you are considered an ongoing employee. Your hours of service are

measured during the open enrollment measurement period. This period runs from October 3 through the following October 2 of each year and will determine Plan eligibility for the plan year that follows the measurement period.

If you are an employee who is reasonably expected to work an average of 30 hours or more per week upon hire you are eligible to enroll in the Plan. Plan eligibility will continue until your hours are measured during the next or second (depending on date of hire) open enrollment measurement period to determine Plan eligibility for the next plan year. If you were a non-full-time OPS employee at the time of your initial hire but become reasonably expected to work 30 hours or more per week during the open enrollment measurement period, you become eligible to participate in the Plan at that time.

An example: Assume you are hired January 5, 2017, in an OPS position and are expected to work an average of at least 30 hours per week. You are eligible to enroll in the Plan at your point of hire and will continue Plan eligibility through December 31, 2018. You will then be measured on October 3, 2018, by looking back at the previous 12-month period to determine if you worked at least 30 hours per week. Your eligibility for the 2019 plan year will depend on whether you worked an average of 30 hours or more per week during the 12-month measurement period or whether your employer reasonably expects you to work 30 or more hours per week.

2. Stability Period –follows a measurement period. If you are an OPS employee, the hours of service during the measurement period determines whether you are a full-time employee who is eligible for coverage during the stability period. If you are a full-time employee in the stability period, your eligibility is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the State of Florida. However, if you were a non-full-time OPS employee but become reasonably expected to work 30 hours or more per week during the stability period, you become eligible to participate in the Plan at that time. For ongoing employees, the stability period lasts 12 consecutive months.

3. Administrative Period –the time between the measurement period and the stability period when administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment, are performed. If you are determined to be eligible, a benefits package showing your available options, costs, and effective dates will be mailed to your mailing address in People First, the system of record.

The rules for the look-back measurement method are complex, and this is a general overview of how the rules work. More complex rules may apply to your situation. The State of Florida intends to follow applicable IRS final regulations (including any future guidance issued by the IRS) when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, call the People First Service Center at (866) 663-4735 weekdays from 8 a.m. to 6 p.m. Eastern time.

Retirees

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

1. Retire under a State of Florida retirement system or a state optional annuity or state retirement program or go on disability retirement under the State of Florida retirement system, as long as you were covered under health and life insurance at the time of your retirement and you begin receiving retirement benefits immediately after you retire; or
2. Retire under the Florida Retirement System Investment Plan, and you

- Meet the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29), Florida Statutes; or have attained the age specified by s. 72(t)(2)(A)(i), Internal Revenue Code, and you have 6 years of creditable service; and
- Take an immediate distribution; and
- Maintained continuous coverage under the program from termination until receiving your distribution (you must continue health insurance coverage through COBRA until you take your immediate distribution); or

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

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

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

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

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

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

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

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

In accordance with Chapter 60P, Florida Administrative Code, your dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. For purposes of this Contract, the definition of eligible dependents includes the following:

Enrollee's legal spouse	• As defined in section 741.212, Florida Statutes
Enrollee's children from birth through the end of the calendar year in which they turn age 26:	• Natural children, legally adopted children and children placed in the home for the purpose of adoption in accordance with chapter 63, Florida Statutes • Stepchildren, provided the Enrollee is still married to the children's parent • Foster children • Children for whom the Enrollee has established legal guardianship in accordance with Chapter 744, Florida Statutes, or unmarried children where Enrollee was granted court-ordered temporary or other custody • Children with a qualified medical support order requiring the Enrollee to provide coverage
Children ages 26 to 30 as over-age dependents if:	• They are unmarried; and • They have no dependents of their own; and • They are a resident of Florida or a full-time or part-time student; and • They have no other health insurance. Over-Age Dependent (ages 26-30) Coverage is individual health coverage for an additional monthly premium. You and your eligible over-age dependents must be enrolled in the same health plan. The amount of financial support you provide determines if the monthly premium for coverage comes out of the active employee's paycheck pretax or if you must mail in payment post-tax. If you are interested in this program, please call the People First Service Center at (866) 663-4735 for more information.

Children with intellectual or physical disabilities after they reach age 26 if:	• They were enrolled before they turned 26 and remain covered or they were over the age of 26 at the time of the Enrollee's initial enrollment; and • They are incapable of self-sustaining employment because of intellectual or physical disability; • They are dependent on the Enrollee for care and financial support; and • The treating physician provides documentation supporting the intellectual or physical disability while the dependent is still covered under the Plan. You must submit documentation to the health plan you selected upon request for review and confirmation. Disability status is verified at least every five years. If you fail to provide the required documentation or your dependent no longer meets eligibility requirements, you may be liable for medical and prescription drug Claims or premiums back to the date you enrolled your dependent. Enrollees who have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria may enroll that child in the Plan the **first** time they enroll in a State-sponsored Plan.
Dependent of a dependent – you may cover your dependent's newborn from birth up to age 18 months if:	A newborn child born to a dependent while the dependent is covered under the Plan. The newborn must be added within 60 days of the birth. Coverage may remain in effect for up to 18 months or until the covered dependent is no longer covered. You may be asked to provide documentation for your eligible dependents. Failing to provide the required documentation may make you liable for medical and prescription Claims or premiums back to the date of enrollment. You must fax required documentation to (800) 422-3128 or mail to People First Service Center, P.O. Box 6830, Tallahassee, Florida 32314. Please include your People First ID number on the top right corner of each page of your fax or other documentation. Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.
Enrollee's Surviving spouse	• The Enrollee's surviving spouse • Eligible children of an Enrollee's surviving spouse
Line of duty death	• Children of law enforcement, probation, or correctional officers who were killed in the line of duty and who are attending a college or university beyond their 18th birthday

When Coverage Suspends

If you are an employee, your coverage under the Plan will suspend on the last day of the month in which you do not make the required contributions (premiums) for coverage. Your coverage will not be reinstated until People First receives the total amount due, applies the remittance (payment of premium) to your account, and notifies the Health Plan and CVS/caremark of the reinstatement

When Coverage Ends

Your coverage in the Plan ends:	• When your employment is terminated. Active employees pay premiums one month in advance, so coverage ends on the last day of the month following the month they end employment. For example, if their last day of work is April 23, their coverage ends May 31 because they already paid for May coverage. • On the last day of the month in which you do not make the required contributions for coverage, including the months when you are in layoff status. Payment is due the tenth of the month prior to the month of coverage. For example, payment for July coverage is due June 10. • When an OPS employee a) is measured during Open Enrollment and determined to be ineligible for coverage for the next plan year, coverage ends the last day of the current plan year, or b) when an OPS employee is receiving coverage during a health insurance stability period and is determined to be ineligible for coverage, coverage ends the last day of the health insurance stability period. • On the last day of the month in which a Surviving Spouse remarries. (see "Surviving Spouse Coverage" section for details.)
If your spouse is enrolled as a covered Health Plan Member, your spouse's coverage ends on the last day of the month in which:	• Your coverage is terminated. • You and your spouse divorce. **In the event of divorce, you have 60 days, including the date of divorce, to provide the final judgment of divorce to People First.** If you fail to timely notify People First of a divorce, you will be responsible for reimbursing the Plan for any Claims incurred by ineligible dependents (e.g., ex-spouse, any ex-stepchildren) or for paying COBRA continuation of coverage premiums for any months ineligible dependents were covered. • Your spouse dies.

Coverage for dependent children (as defined above) ends:	• On the last day of the month in which your coverage ends. • The end of the calendar year in which the children turn 26 (30 for over-age health coverage). • On the last day of the month the children no longer meet the definition of an eligible dependent (e.g., if you divorce the children's parent, you may no longer cover stepchildren). • On the last day of the month in which they die. If a dependent becomes ineligible for coverage, you must go to the People First website to remove them from all applicable plans or call the People First Service Center at (866) 663-4735 within 60 days of the ineligibility, including for death. Service Center hours are 8 a.m. to 6 p.m. Eastern Standard Time. You must also send required documentation to People First to remove ineligible dependents from coverage (e.g., a divorce decree). Failing to provide the required documentation means you risk losing coverage or paying for more coverage than you need.

Enrolling and Making Changes

Part I of Chapter 110, Florida Statutes, Chapter 60P, Florida Administrative Code, and this SPD govern eligibility and enrollment for the State Group Insurance Program. In addition, this Program falls under Internal Revenue Code cafeteria plan guidelines. Consequently, you are required to stay in the health insurance plan you select. Per the Internal Revenue Code, you can only make changes during Open Enrollment or if you have an appropriate Qualifying Status Change event ("QSC"), such as a birth, marriage, or change in employment status. (Retirees may decrease or cancel coverage at any time. Those who cancel will not be allowed to reenroll as a Retiree.)

If you are a retiree that returns to active employment as a full-time equivalent ("FTE") or OPS employee and you are enrolled in the Plan at the time of retirement you will automatically be enrolled in active employee health insurance coverage. When you later terminate employment or return to retirement you will be allowed to continue retiree coverage provided you have had continuous coverage.

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

Five options are available to enroll or change coverage.

Option 1 – Hired as a New Employee

Newly-hired employees have 60 days from the date of hire to enroll in State Group Insurance benefits. New employees should enroll online at peoplefirst.myflorida.com.

Employees who do not enroll within 60 days of their hire date can only enroll during the next Open Enrollment period or if they experience a QSC event (see Option 2 below). New employees should choose their health insurance plan carefully. Once you make new-hire elections, you can only make changes during the next Open Enrollment unless you have an appropriate QSC event.

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

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

For OPS/variable hour employees, the earliest health coverage will start is the first day of the third month of employment. For example, employees hired in March will begin coverage in May.

Option 2 –QSC Event

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

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

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

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

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

Option 3 – Open Enrollment

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

Option 4 – Spouse Program

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

- Complete and sign the Spouse Program Election Form located on the myBenefits website in the *Forms* section and list all eligible dependents, and
- Attach a copy of your marriage license to the Spouse Program Election Form when you submit it to the People First Service Center. Include both you and your spouse's People First ID numbers on each page, and
- Enroll in the same health plan, and
- Agree to notify the People First Service Center within 60 days of becoming ineligible for the Spouse Program. The employed spouse becomes ineligible for the Spouse Program if:

    - One or both end employment with the state, including retirement, or
    - You divorce, or
    - Your spouse dies.

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

Option 5 – Surviving Spouse

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

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

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

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

Certificate of Creditable Coverage

If you or a dependent loses coverage under the Plan, you will receive a certificate showing your creditable coverage under Capital Health 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.

Coverage Continuation Family and Medical Leave and Job-Protected Leave

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

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

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

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

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

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

Coverage Continuation When You Are Off Payroll

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

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

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act is referred ("COBRA"), you can continue healthcare coverage that would otherwise end because dependent eligibility and because of voluntary or involuntary

termination for reasons other than gross misconduct. You may also continue healthcare coverage that would otherwise end because you did not return to work after an unpaid leave under FMLA. You may keep this continuation coverage for up to 18 months, provided you pay the required cost of the continued coverage. The monthly premium is 102 percent of the cost of coverage (you pay the full premium plus 2% administrative fee).

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

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

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

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

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

If you acquire a new dependent by marriage during the time you are covered by COBRA continuation coverage, that dependent can also be enrolled under the continuation coverage. Your new spouse can keep continuation coverage for as long as your COBRA coverage continues. Dependent children covered by the Plan may also choose continuation coverage and keep it for up to 36 months if their group coverage ends because they no longer qualify as an eligible dependent under the Plan.

Under COBRA, the employee or spouse is responsible for notifying People First of a divorce, legal separation, death or a child's losing dependent status under the Plan. Notice must be given within 60 days of the event. Involved individuals must also provide People First with a current and complete mailing address. If notice is not received within 60 days of the event, the dependent will not be entitled to choose continuation coverage.

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

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

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

1. On the last day of the month in which the event, such as divorce, that caused ineligibility for coverage took place; or
2. On the last day of the month following the month you were terminated.

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

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

Continuation of Benefits if You are Disabled

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

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

For this continuation of benefits, total disability means:

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

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

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

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

Extension of Benefits if the Plan is Terminated

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

1. If you are in the Hospital when the Plan is terminated, your covered services will be eligible for payment

for 90 days following Plan termination.

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

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

IV. SCHEDULE OF BENEFITS

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

It is your responsibility when seeking benefits under the Plan to identify yourself as a Health Plan Member and to ensure that the services received are rendered by Participating Providers. Please understand that services will not be covered if they are not, in Capital Health Plan's opinion, Medically Necessary. Any and all decisions made by Capital Health Plan in administering the provisions of this Contract, including without limitation, the provisions of the Definitions, Medical Benefits and Limitations and Exclusion sections, are made only to determine whether payment for any benefits will be made by the Plan are subject to the appeals process set forth in Section XIII below and the final determination of the Independent Review Organization on behalf of Capital Health Plan.

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

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

Understanding Your Share of Health Care Expenses

Deductibles and Copayments are paid by Health Plan Members

Copayments are dollar amounts you pay to the provider at the time of service before the Plan pays. A Copayment is the amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services while other services will not have any Copayments. A Deductible (applies only to Health Investor Health Plan) is an amount of money you pay one time each Benefit Year before this Plan pays anything. Typically, there is one Deductible amount per Plan Participant and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1, a new Deductible amount is required to be met.

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

If you have family coverage:

- **Standard Plan:** when one Health Plan Member in a family contract meets the individual amount, Health Plan pays 100%. When a person meets the individual Global Network out-of-pocket max, Plan pays 100% for all covered in-Network Medical Services, supplies, and prescription drugs for *that* Health Plan Member (called embedded). The balance of each family Medical and Global out-of-pocket max amounts may be met by another or combination of remaining family members.

- **Health Investor Health Plan:** when one Health Plan Member or combination of family members meets the family amount, Health Plan pays 100% (not embedded).

Preventive services are paid at 100% when provided by *Participating* Providers and not subject to the Deductible.

Global Network Out-of-Pocket Maximum (Rx Only or Medical and Rx)

There is a limit on the amount you pay out of your pocket toward covered expenses in any one calendar year for in-Network care. Once your share of Network out-of-pocket expenses reaches the annual limit, this Plan begins paying 100% of the Claims for Network Covered Services and Supplies and prescription drugs for the remainder of the calendar year for you.

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

If you have family coverage:

Standard Plan: when one Health Plan Member in a family contract meets the individual amount, Health Plan pays 100%. When a person meets the individual Global Network out-of-pocket max, Plan pays 100% for all covered Network Medical Services, supplies, and prescription drugs for *that* Health Plan Member (called embedded). The balance of each family Medical and Global out-of-pocket max amounts may be met by another or combination of remaining family members.

Only expenses from Network Covered Services and Supplies and prescription drugs count toward the global out-of-pocket maximum. Expenses that apply to this maximum include the applicable cost share until the aggregate out-of-pocket limit is met. Preventive services are paid at 100% when provided by Participating Providers.

Health Investor Health Plan: when one person or combination of family members meets the family amount, the Plan pays 100% (not embedded).

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

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

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

Services that require prior authorization from Capital Health Plan include, but are not limited to:	• All inpatient admissions (including but not limited to Hospital and observation stays, skilled nursing facilities, Ventilator Dependent Care Unit and/or acute rehabilitation); • Complex diagnostic testing, therapeutic, and sub-specialty procedures (including but not limited to CT, CTA, MRI, MRA, PET Scans, Nuclear Cardiac Studies and Nuclear Medicine); • Surgical procedures or services performed in an outpatient Hospital, Hospital-affiliated ambulatory surgery center or free-standing ambulatory surgery center; • All medications administered in an outpatient Hospital or infusion therapy setting • Select medications administered in a physician's office; • Non-emergency transportation; • Care rendered by Non-participating Providers (except for Emergency Medical Services and Care); • Transplant services; and • Dialysis services Ventilator Dependent Care Unit means care received in any facility which provides services to ventilator dependent patients other than acute Hospital care, including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers and all other like facilities, whether maintained in a free standing facility or maintained in a Hospital or skilled nursing facility setting. For more information about which services require prior authorization, contact Capital Health Plan at the number in the contact section within this document.

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

Primary Care Physician

We strongly encourage you to select a participating primary care physician (PCP) who is responsible for providing and managing all of your primary health care. You may change PCPs anytime by calling in advance Capital Health Plan. Your PCP does not need to refer you when you need to see most specialists for an office

visit. Go to Capital Health Plan's website listed in this document's contact section to access the most current list of participating providers and hospitals.

Health Professionals may from time to time cease their affiliation with Capital Health Plan. In such cases, you must receive services from another Participating Provider.

If you do not follow the access to care rules, there is substantial risk that the services and supplies you received will not be covered under Capital Health Plan and you will have to pay for them.

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

	SCHEDULE OF MEMBER COST SHARE		
	Benefit Description	**Cost to Member**	
		Standard Option	**Health Investor Option**
Deductible (Per Calendar Year)		None	$1,350 Single $2,700 Family
Medical Out-of-Pocket Maximum – (Per Calendar Year)	Includes covered medical expenses only.	$1,500 Single $3,000 Family (not to exceed $1,500 per Health Plan Member)	Included in Global Out-of-Pocket (not a separate max amount)
Global **Out-of-Pocket Maximum – including Rx (Per Calendar Year)**	Includes covered expenses for both medical and prescription drugs.	$7,350 Single $14,700 Family (not to exceed $7,350 per Health Plan Member)	$3,000 Single $6,000 Family

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Preventive Care **Not Subject to Deductible**	Preventive care services include, but are not limited to: • Well-woman examinations, including Pap smears • Annual physical examinations • Immunizations • Well-child care and immunizations, including routine vision and hearing screenings by a pediatrician for children under 18 • Screening mammograms • Colorectal cancer screening, including colonoscopies • HIV screening	No Charge	No Charge
Primary Care Physician	Services at participating doctor's offices include, but are not limited to: • Routine office visits • Minor surgical procedures • Medical hearing examinations	$20 per visit	20% of the contracted rate after you pay Deductible
Specialty Care Physician Services	Your primary care physician and/or Capital Health Plan must authorize services in advance for: • Certain Office visits, consultation, diagnosis and treatment	$40 per visit	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Hospital	Your treating physician must obtain prior authorization from Capital Health Plan for admissions not related to Emergency Services. Inpatient Care at participating Hospitals includes: • Room and board – unlimited days (semi-private) • Physician's, Specialist's and surgeon's services • Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication • Intensive care unit and other special units, general and special duty nursing • Laboratory and diagnostic imaging • Required special diets • Radiation and inhalation therapies	$250 per admission; 100% coverage thereafter	20% of the contracted rate after you pay Deductible
Surgery	• Outpatient • Inpatient Your Primary Care Physician must obtain prior authorization from Capital Health Plan prior to surgery including preparation services and treatment.	No Charge $250 per admission; 100% coverage thereafter	20% of the contracted rate after you pay Deductible
Vision Benefits	Annual eye exam • Primary Care Physician • Specialist Services (office visits, refractions) o Participating Optometrist and ophthalmologist	$20 Copayment $40 Copayment	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Outpatient Laboratory and X-ray	• Diagnostic Tests • CAT scan, PET scan, MRI • Outpatient Laboratory Tests • Mammograms (not subject to deductible)	No Charge	20% of the contracted rate after you pay Deductible. No Charge for mammograms or preventive diagnostic tests and services
Emergency Services	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. • Emergency room at participating Hospitals, facilities and/or physicians Hospital and/or referring or admitting physician must call Capital Health Plan as soon as possible and within 24 hours of emergency admission or as soon as reasonably possible.	$100 Copayment (waived if admitted)	20% of the contracted rate after you pay Deductible
Urgent/Immediate Care	• Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office • Medical Services at a participating retail clinic • Medical services at a non-participating Urgent/ Immediate Care facility or non-participating retail clinic outside Capital Health Plan's Service Area.	$25 Copayment	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Mental Health and Alcohol/Drug Treatment	• Inpatient • Outpatient	$250 per admission, 100% coverage thereafter $20 per visit	20% of the contracted rate after you pay Deductible
Family Planning	Family planning services • Primary Care Physician Services • Specialist Services • Contraceptives, supplies and related services • Sterilization Except for contraceptives and sterilization where no Copayment applies, Copayment amount depends on type of service as noted within this chart for Preventive Adult Care, physician office visits, other physician services, Durable Medical Equipment and prescription drugs. Maternity Care • Outpatient • Inpatient	$20 per visit $40 per visit $40 first visit only $250 per admission, 100% coverage thereafter	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Allergy Treatments	Injections • Primary Care Physician Services • Specialist Services Skin Testing • Primary Care Physician Services • Specialist Services	 $20 per visit $40 per visit $20 per visit $40 per visit	20% of the contracted rate after you pay Deductible
Ambulance	• When pre-authorized or in the case of an emergency	No Charge	20% of the contracted rate after you pay Deductible
Autism Spectrum Disorder, Diagnosis and Treatment of	• Applied Behavior Analysis Services • Physical, speech or occupational therapy	$40 per visit	20% of the contracted rate after you pay Deductible
Home Health Care	• Per Occurrence	No Charge	20% of the contracted rate after you pay Deductible
Durable Medical Equipment	• Per Device	No Charge	20% of the contracted rate after you pay Deductible
Rehabilitative Services	• Outpatient Services limited to 60 visits per injury	$40 per visit	20% of the contracted rate after you pay Deductible
Skilled Nursing Facilities	• Pre-authorization required • Up to 60 days maximum per calendar year	No Charge	20% of the contracted rate after you pay Deductible
Prosthetic or Orthotic Devices	• Per Device	No Charge	20% of the contracted rate after you pay Deductible

	Benefit Description	Cost to Member	
		Standard Option	**Health Investor Option**
Prescription Drugs **CVS/caremark**	Participating Retail Pharmacy (up to a 30-day supply) • Generic • Brand Name, Preferred • Brand Name, Non-Preferred Participating Retail Pharmacy (up to a 90-day supply) • Generic • Brand Name, Preferred • Brand Name, Non-Preferred Mail Order Pharmacy (up to a 90-day supply) • Generic • Brand Name, Preferred • Brand Name, Non-Preferred	 $7 $30 $50 $14 $60 $100 $14 $60 $100	After you pay Deductible: 30% 30% 50%
	• If a generic is available and you, rather than your physician, request the brand name drug, your cost is the brand Copayment (or Coinsurance if HIHP) *plus* the difference in the Plan's cost between brand name and the generic. • For oral cancer treatment medications, your cost is the lesser of the appropriate Copayment (or Coinsurance if HIHP) or $50.		

V. MEDICAL BENEFITS

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

Coverage Access Rules

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

You should understand that the ordering of a service by a physician does not in itself conclusively establish that the service is a Medically Necessary covered service. Final decisions concerning the existence of coverage or benefits under Capital Health Plan is the responsibility of the Plan and cannot be delegated, or deemed to be delegated by the State, to other persons including the providers. However, Capital Health Plan is responsible for processing Claims in accordance with the terms of this document and its contract with the State. Among its other obligations in determining whether a Claim presents a benefit covered by Capital Health Plan, CHP must make an initial determination whether the service was Medically Necessary.

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

Capital Health Plan pays the cost of covered care and medical supplies, less the Copayment or Coinsurance, as long as the care or supplies are:

- Ordered by a Network provider (a provider who is in Capital Health Plan's network);
- Considered Medically Necessary for the Health Plan Member's treatment because of a covered accident, illness, condition, or Mental and Nervous Disorder;
- Not specifically limited or excluded under this Plan; and
- Rendered while this Plan is in effect.

Covered Services	Special Limits/Circumstances
Ambulance Ground Ambulance Services must be Medically Necessary to transport a patient: 1. from a Hospital unable to provide care to the nearest Hospital that can provide the Medically Necessary level of care; 2. from a Hospital to a home or nearest skilled nursing facility that can provide the Medically Necessary level of care; or 3. from the place of an Emergency Medical Condition to the nearest Hospital that can provide the Medically Necessary level of care. Air, helicopter and boat Ambulance services are covered to transport a patient from the location of an Emergency Medical Condition to the nearest Hospital that can provide the Medically Necessary level of emergency care, when: 1. the pick-up point is inaccessible by ground; 2. speed in excess of ground speed is critical; or 3. the travel distance by ground is too far to safely treat the patient.	
Anesthesia Services • Both inpatient and outpatient	

Covered Services	Special Limits/Circumstances
Autism Spectrum Disorder • Diagnosis and treatment through speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis services for an individual that was diagnosed as having a Developmental Disability at eight years of age or younger and is either 1) under 18 years of age or 2) eighteen years of age or older and in high school. • Coverage includes well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder, speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis. Applied Behavior Analysis is covered when provided by Applied Behavioral Analysts, psychologists, clinical social workers, and others within the scope of their license.	• Coverage limited to services prescribed by the Enrollee's treating physician in accordance with a treatment plan. The required treatment plan includes, but is not limited to, a diagnosis; proposed treatment by type, frequency and duration of treatment; anticipated outcomes stated as goals; frequency with which treatment plan will be updated; and a signature from the treating physician. • The Plan covers Autism Spectrum Disorder and Down Syndrome as required by sections 627.6686 and 641.31098, Florida Statutes, and as further amended by state and federal law.
Bone Marrow Transplants	• If the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not Experimental pursuant to rules adopted by the Florida Agency for Health Care Administration. • Includes costs associated with the donor-patient.
Cancer Services • Diagnosis and Treatment	• Includes both inpatient and outpatient diagnostic tests and treatment (including anti-cancer medications administered by Network providers), including cancer clinical trials as set forth in the Florida Clinical Trial Compact. Does not include Experimental or Investigational Treatment.
Cleft Lip and Cleft Palate	• Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology and nutrition services only as required by sections 627.64193 and 641.31(35), Florida Statutes.

Covered Services	Special Limits/Circumstances
Clinical Trials	• Includes routine patient care costs incurred by an insured individual who participates in an approved Phase I, II, III or IV clinical cancer trials relating to cancer and other life threatening diseases if those services, including drugs, items and devices that would otherwise be covered under the plan or contract if those drugs, items, devices and services were not provided in connection with an approved cancer clinical trial program. Experimental treatment is excluded.
Child Health Supervision Services	• Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. • Services as defined by the Patient Protection and Affordable Care Act.
Contraceptive Supplies • Insertion and removal of IUD • Diaphragm • Insertion and removal of contraceptive implants • Contraceptive injections • Oral contraceptives	• With respect to Women's Preventive Services (see also *Preventive Services)*, coverage is limited to at least one form of contraception in each of the eighteen methods identified in FDA's most current Birth Control Guide and limited to generic products when available. • Other contraceptives may be covered based on medical necessity. For additional information on medical coverage, please call Capital Health Plan's Member Services Department listed in the contact section within this document. For additional information on prescription coverage, please call CVS/caremark at 1-888-766-5490.

Covered Services	Special Limits/Circumstances
Cosmetic Surgery • Plastic and reconstructive • Reduction mammoplasty	• Repair or alleviation of damage if the result of an accident. • Correction of a congenital anomaly for an eligible dependent. • Correction of an abnormal bodily function. • For an area of the body which was altered by the treatment of a disease. • All stages of reconstruction of a breast on which a mastectomy was performed in accordance with federal law. However, if there is no evidence of malignancy, such reconstruction and initial prosthetic device shall only be covered if received within two years after the date of the mastectomy.
Dental Care and ***Accidental Dental Injury***	• General anesthesia and facility services to the extent required by section 641.31, Florida Statutes. Only in cases of Dental Care provided to a person under age 8 if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a Hospital or surgical center is necessary. • Accidental dental injury coverage is limited as defined. General Dental Care is not covered as stated in the Exclusion section of this document. • Benefits for accidental dental injury are limited to care and treatment rendered within 120 days of an accidental dental injury
Dermatology Services	• Direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a Network dermatologist, as required by sections 627.6472(16) and 641.31(33) Florida Statutes.

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

Covered Services	Special Limits/Circumstances
Durable Medical Equipment • For the care and treatment of a condition covered under this Plan, the Plan shall either rent or purchase medical equipment and supplies including, but not limited to: o Trusses, braces, walkers, canes, crutches, casts and splints o Occlusal guards, bite or dental splints, repositioning devices, and TMJ models for the treatment of temporomandibular joint (TMJ) syndrome o Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products o Oxygen and rental of equipment for the administration of oxygen, ventilator or other mechanical equipment for the treatment of respiratory paralysis or insufficiency o Ambulatory home uterine activity monitoring devices (AHUM) o Wheelchairs, Hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment • Other medical equipment and supplies as determined to be Medically Necessary	• Durable Medical Equipment: o Shall not serve as a comfort, hygiene, or convenience item o Shall not be used for the sole purpose of exercise o Shall not be used by any other party o Shall have been manufactured specifically for medical use o Shall not include shoe buildups, shoe orthotics, shoe braces or shoe supports unless the shoe is attached to a brace o Shall not include water therapy devices, modification to motor vehicles and/or homes or similar items
Emergency Care • Coverage, without prior authorization, for screening and stabilization based on determination by either a Network or Non-Network provider.	

Covered Services	Special Limits/Circumstances
Eye Care • Routine or refractive eye examinations as part of the adult preventive medical care or child health supervision services benefit	• For eyeglasses or contact lenses: o Limited to standard frames and lenses for the first pair following an accident to the eye or cataract surgery o Includes the examination for the prescribing or fitting thereof o For treatment of a covered condition: ▪ Aphakic patients and soft lenses or sclera shells ▪ Following an injury, disease or accident
Family Planning Services	• Includes counseling and information on birth control, sex education and the prevention of sexually transmitted diseases.
Hearing Tests	• Only when associated with a covered ear surgery, in accordance with child and adult preventive health care benefits, or for the diagnosis of a covered condition. • Hearing tests to determine if a hearing aid is needed are not covered.
Hemodialysis for Renal Disease • Includes equipment, training and medical supplies for home dialysis and dialysis centers.	

Covered Services	Special Limits/Circumstances
Home Health Care • Services by a home health care agency for a Health Plan Member confined and convalescing at home for a covered condition • Home Health Care Services include: o Part-time, intermittent or continuous nursing care by registered nurses or licensed practical nurses, nurse registries or home health agencies; o Physical, speech, occupational and respiratory therapy, and infusion therapy o Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by the treating physician and other covered services provided by or for a home health agency through a licensed nurse registry or by an independent nurse licensed under chapter 464, Florida Statutes, to the extent that they would have been covered if the person had been confined in a Hospital	• For approval of Home Health Care Services by your PCP or the Plan: o The treating physician must submit a home health care plan of treatment to your PCP; and o The plan of treatment must document that home health care is Medically Necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and o Home health care benefits would be less costly than confinement to a Hospital or skilled nursing facility • Services which shall not be covered under this benefit include: o Any service that would not have been covered had the Health Plan Member been confined to a Hospital o Services which are solely for the convenience of the Health Plan Member ▪ Therapy is subject to outpatient Limitations described under rehabilitative services o A visit is limited to a period of two hours or less

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

Covered Services	Special Limits/Circumstances
Hospital Inpatient Care • Hospital room, board and general nursing care for a semi-private room unless the Plan determines that a private room is Medically Necessary • Room, board and treatment in an intensive, progressive, cardiac or neonatal care unit • Other necessary services and supplies including, but not limited to: • Use of operating room, labor room, delivery room and recovery room • Drugs and medicines used by the patient • Intravenous solutions • Dressings, ordinary casts, splints and trusses • Anesthesia and related supplies • Transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced • Respiratory therapy, including oxygen • Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms • Basal metabolism examinations • X-ray, including therapy • Diathermy • All covered rehabilitative services	• Services and supplies must be furnished at a Network Hospital and must be authorized by the Primary Care Physician or Capital Health Plan in order to be covered. Exceptions to this include emergency services and other special circumstances, as approved by Capital Health Plan. • Excludes services and supplies provided when the Health Plan Member is admitted to a Hospital or other facility primarily to provide rehabilitative services.
Immunizations • Includes flu shots	See *Preventive Services*.

Covered Services	Special Limits/Circumstances
Mammograms • Screening • Diagnostic service	• One baseline mammogram for women age 35 through 39 • One mammogram every one to two years – ages 40 through 49 • One mammogram every year – age 50 and over • At any age if deemed Medically Necessary (diagnostic)
Maternity Care • Pre-natal and post-natal care and monitoring of the mother • Delivery in a Hospital or birth center • Postpartum care • Newborn care and assessment, including initial exam from pediatrician • Medically Necessary clinical tests and immunizations • Routine well-baby nursery services • Midwife services • Breastfeeding and/or lactation services, support, supplies and counseling	• Covered Hospital stays for the mother and newborn child will be no less than: o 48 hours for a normal delivery o 96 hours for a Cesarean-section delivery unless agreed to by the provider and the patient • With respect to Women's Preventive Services, coverage for breast feeding supplies is: o Limited to one manual breast pump per birth. o Breastfeeding support and/or lactation services are covered when 1) rendered in a physician's office by a physician, ARNP under the physician's supervision, certified lactation Specialist, or other health provider operating within the scope of their license, or 2) in an inpatient Hospital or outpatient Hospital setting.
Mental Health, Alcoholism and Substance Abuse Care • Inpatient • Outpatient • Any other treatment or treatment setting, as administered by CHP, that is mandated by the Mental Health Parity Act as a result of the medical/surgical benefits provided by this SPD.	• Treatment program must be accredited by the Joint Commission or approved by the state. • Providers must be licensed in accordance with applicable law. • For inpatient care: • Alcoholism and Substance Abuse care includes detoxification. • For outpatient care: • Mental and Nervous Disorders treatment includes diagnostic evaluation, psychiatric treatment, and individual and group therapy. • For learning and behavioral disabilities or intellectual disabilities, coverage is limited to evaluation and diagnosis.

Covered Services	Special Limits/Circumstances
Newborn Care • Coverage includes, but is not limited to: o Coverage for injury or sickness, including Medically Necessary care or treatment for medically diagnosed congenital defects, birth abnormalities or prematurity. o The transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.	• Coverage for the unenrolled newborn child of a covered eligible Enrollee or dependent is limited to well-baby Hospital nursery services. • Newborn must be enrolled in Capital Health Plan within 60 days of the birth to be covered for other services.
Nutrition Counseling	
Nursing Services • Nursing care by a registered nurse (RN) or licensed practical nurse (LPN)	• Includes inpatient Private Duty Nursing when authorized by the Plan. • Includes Home Health Care Services and Hospice Services.
Occupational Therapy • Occupational therapy services are covered for conditions resulting from a physical or mental illness, injury, or impairment.	• Coverage and payment for occupational therapy is limited to 60 treatments per injury. This maximum applies to all out-patient occupational therapy treatments regardless of location of service. • Occupational therapy services must be provided by a healthcare professional licensed to provide such services. • Occupational therapy is covered for the treatment of Autism Spectrum Disorder and Down syndrome under both home health care and hospice services.

Oral Surgery • Surgical treatment of non-dental injury to teeth, fractured or dislocated jaw, excision of tumors, cysts, abscesses and lesions of the mouth and surgical treatment of temporomandibular joint (TMJ) syndrome • Treatment of bones or joints of the jaw or facial region as required by section 641.31094, Florida Statutes, when Medically Necessary for conditions caused by congenital or developmental deformity, diseaseor injury	• Does not include care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes.

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

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

Covered Services	Special Limits/Circumstances
Pre-admission Tests	• Tests shall be ordered or authorized by the Health Plan Member's PCP or admitting Specialist; and • Tests shall be performed in a facility accepted by the Hospital and Capital Health Plan in lieu of the same tests which would normally be done while Hospital confined.
Preventive Services • Additional Women's Preventive Services: to the extent required by federal law; the following services are covered for all female Health Plan Members: o Human papillomavirus (HPV) testing; o Counseling for sexually transmitted infections; o Counseling and screening for human immune-deficiency virus (HIV); o Counseling and screening for interpersonal and domestic violence; o Screening for gestational diabetes o Counseling and support for breastfeeding and supplies (limited to one manual breast pump per birth) o Annual well woman visits expanded to include prenatal care, contraceptive counseling and methods (see *Contraceptive Services* within this table of covered services)	• Preventive Medical Services will be as defined by the Patient Protection and Affordable Care Act, which include: o Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; o Assessment of the risk of falls for older adults is included during the preventive care wellness examination or evaluation and management (E&M) visit; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; o With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration o With respect to Women's Preventive Health Services, coverage is provided to the extent mandated by federal law. o For additional information on immunizations and preventive health care services go to: www.healthcare.gov https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and https://www.healthcare.gov/preventive-care-women/
Prostheses and Orthotic Devices • Initial placement of the most cost effective prosthetic or orthotic device, fitting, adjustments and repair	• Replacements covered if due to growth or change and approved by the Plan as Medically Necessary. • Shoe orthotics shall be covered only when attached to a brace. • Penile prosthesis shall be covered only when necessary to treat organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post prostatectomy, postpriapism, and epispadias and exstrophy.

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

Covered Services	Special Limits/Circumstances
Second Medical Opinions • May be requested by the Health Plan Member or the Health Plan for: o Elective surgery o When the appropriateness or necessity of a covered surgical procedure is questioned o Serious injury or illness	The Health Plan Member: o Must provide prior notice to Capital Health Plan o The use of second medical opinions in connection with a particular diagnosis or treatment may be restricted to a maximum of three per calendar year. • Capital Health Plan shall review the second medical opinion, once rendered, and make a determination about whether the services are covered under the Plan. That judgment shall be controlling. Any treatment obtained that is not authorized by the Health Plan shall be at the Health Plan Member's expense. • Covered expenses for the second opinion: o If a Network physician is selected, the only cost to the Health Plan Member will be the applicable member cost share amount. o If a Non-Network physician is selected, the member may be required to pay for up to 40 percent of the usual and customary charges for those services in the community where they were rendered as determined by Capital Health Plan.
Skilled Nursing Facility Care • Room, board and general nursing care • Services and supplies for necessary treatment	• Primary Care Physician (PCP) or Capital Health Plan shall approve a written plan of treatment • Health Plan Member must require skilled care for a condition (or a related condition) which was treated in the Hospital and such care can be provided at a skilled nursing facility in lieu of hospitalization or continued hospitalization • The Health Plan Member must be admitted to the facility immediately following discharge from the Hospital • Skilled nursing care or services are provided on a daily basis • Limited to 60 days of confinement per calendar year • Services shall be ordered by and provided under the direction of a physician
Surgical Procedures • Both inpatient and outpatient	
Surgical Sterilization	• Limited to tubal ligations and vasectomies
Wigs	• Covered only when hair loss is caused by chemotherapy, radiation therapy, or cranial surgery. Coverage is limited to a maximum payment of $40 for one wig and fitting in the 12 months following treatment or surgery.

VI. LIMITATIONS AND EXCLUSIONS

Services Not Covered by the Plan The following services and supplies are excluded from coverage under this Plan unless a specific exception is noted. Exceptions may be subject to certain coverage Limitations.	
Abortion	Which is elective, performed at any time during a pregnancy.
Acupuncture	Services, supplies, care or treatment in connection with acupuncture (except when used in lieu of an anesthetic agent for covered surgery).
Arch Supports	Orthopedic shoes, sneakers, or support hose, or similar type devices/appliances, regardless of intended use.
Autologous transfusion	In which blood is removed from a donor and stored before it is returned to the donor's circulation.
Autopsy	
Biofeedback services	And other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, mind expansion, elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard seminar training (EST)**.**
Complications of non-covered services	Including the diagnosis or treatment of any condition which arises as a complication of a non-covered service**.**
Cosmetic surgery/services	Including plastic and reconstructive surgery (except as noted as a covered service), dental care, and any other service and supply to improve the Health Plan Member's appearance or self-perception.
Costs incurred by the Plan related to…	Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy, telephone consultations, failure to keep a scheduled appointment or complete any form and/or medical information.

Custodial care	Including any service or supply of a custodial nature primarily intended to assist the Health Plan Member in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services and respite care. Also includes services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking, and taking oral medications. "Custodial Care" also means services and supplies that can be safely and adequately provided by persons other than licensed Health Professionals, such as dressing changes and catheter care, or that ambulatory patients customarily provide for themselves, such as ostomy care, administering insulin and measuring and recording urine and blood sugar levels.
Dental Care	Or any treatment relating to the teeth, jaws, or adjacent structures (e.g. periodontium), including but not limited to extraction or cleaning of the teeth; implants, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic treatment; rapid palatial expanders; continuous passive motion (CPM) devices.
Dietary regimens	Treatments, food, food substitutes, vitamins or exercise programs for reducing or controlling weight.
Experimental/Investigational or Not Medically Necessary Treatment	With the exception of routine care in connection with a clinical trial in cancer, pursuant to the Florida Clinical Trial Compact and the Patient Protection and Affordable Care Act
Eye care	• Including the purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the covered benefits section; • Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or astigmatic error; and • Training or orthoptics, including eye exercises
Foot care (routine)	Including any service or supply in connection with foot care in the absence of disease, injury or accident. This Exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Plan to be Medically Necessary.
Gender reassignment or modification services and supplies	
Genetic tests	To determine paternity or sex of a child.
Hearing aids	External or implantable or the examination, including hearing tests, for the prescription or fitting of hearing aids, including tinnitus maskers.

Human Growth Hormone	For diagnosis and/or treatment of idiopathic short stature.
Hypnotism	Medical hypnotherapy or hypnotic anesthesia.
Immunizations and physical examinations	When required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such immunizations and examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements and/or the preventive care requirements of the Patient Protection and Affordable Care Act.
Infertility treatment and supplies	Including infertility testing; treatment of infertility, diagnostic procedures and artificial insemination to determine or correct the cause or reason for infertility or inability to achieve conception, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.
Marriage counseling	
Massage therapy	
Non-prescription drugs and supplies	Including any non-prescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods or blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.
Obesity and weight reduction treatment	Including surgical operations and medical procedures for the treatment of morbid obesity, such as intestinal or stomach by-pass surgery and a weight loss program required by the Health Plan Member's Primary Care Physician prior to surgery, unless determined to be Medically Necessary by the Plan.
Orthomolecular therapy	Including nutrients, vitamins, and food supplements.
Personal comfort, hygiene or convenience items	Including but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel or other housing accommodations (even if recommended or approved by a physician), air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment. Also excluded are services not directly used to render treatment.
Pharmacy claims for services that have been submitted for payment to CVS/caremark more than 16 months after the date the prescription drugs or supplies were received	
Recreational therapy	
Reversal of voluntary, surgically-induced sterility	Including the reversal of tubal ligations and vasectomies.

Sexual deviations, disorders or psychosexual dysfunctions services and supplies	
Sleep therapy	
Tobacco Cessation Programs and Products	Including any service or supply to eliminate or reduce a dependency on, or addiction to, tobacco including but not limited to nicotine withdrawal programs, vapor and e-cigarettes, nicotine gum, patches, lozenges, or inhalers, unless specifically provided by law.
Training and educational programs	Including programs primarily for pain management or vocational rehabilitation unless specifically provided by law.
Volunteer services	Or services which would normally be provided free of charge to a Health Plan Member.
Weight control/weight loss	
Work related condition services	To the extent the Health Plan Member is covered or required to be covered by a workers' compensation law. If the Health Plan Member enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, this Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. In addition, if the Health Plan Member is covered by a workers' compensation program that limits benefits if other than specified health care providers are used and the Health Plan Member receives care or services from a health care provider not specified by the program, this Plan shall not cover the balance of any costs remaining after the program has paid.

Additional Exclusions include, but are not limited to:	• Bulk powders, bulk chemicals, and proprietary bases used in compounded medications and over the counter products used in compounded medications. • Services or supplies not Medically Necessary as determined by the Plan and/or the Prescription Drug Plan clinical staff and the state. • Services or supplies that are not specifically listed in the covered benefits section unless such services are specifically required by state or federal law. • Court ordered care or treatment, unless otherwise covered by this Plan, including testing required as a condition of parole or probation; • Testing for aptitude, ability, intelligence or interest. Treatment of a condition resulting from: • War or an act of war, whether declared or not • Participation in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony • Engaging in an illegal occupation • Services in the armed forces • Services or supplies received prior to a Health Plan Member's effective date or received on or after the date a Health Plan Member's coverage terminates under this Plan, unless coverage is extended in accordance with extension of benefit provisions

Additional Exclusions include, but are not limited to:	• Services provided by a physician or other health care provider who normally resides in the Health Plan Member's home • Services rendered from a medical or dental department maintained by or on behalf of a public health entity • Non-medical conditions related to hyperkinetic syndromes, learning disabilities, intellectual disability, or inpatient confinement for environmental change • Services or supplies supplied at no charge, or determined by the Plan not to be the most cost-effective setting, procedure or treatment. • The following services: o Social work o Bereavement and pastoral o Financial o Legal o Dietary counseling o Day care o Homemaker and chore o Funeral • Agreements you or your covered dependent signs with a Network provider for special pricing or for expedited services may negate the Network provider's agreement with this Plan to accept Network contracted amounts and your cost share as payment in full resulting in additional out-of-pocket expenses for you. • Services rendered by any provider that are outside the scope of such provider's license or certification.

VII. Capital Health Plan Features

Managing your health care is easy with Capital Health Plan, your *Medical Home*.

- You are covered for routine, preventive, specialty, and emergency services.
- Your primary care physician provides or coordinates your care.
- Many services and specialists don't require a referral.
- There is little or no paperwork once you join.
- You are covered when traveling away from home.

How Capital Health Plan Works

Capital Health Plan is a comprehensive medical plan, sometimes called a Health Maintenance Organization or HMO. This means that we arrange in advance with physicians and hospitals to provide your care. Generally members only pay copayments for services, and there are no claims to file. We keep costs low by delivering efficient, effective services and by emphasizing preventive care such as office visits, physicals, immunizations, and well-baby care. As a member, your covered benefits are available only from Capital Health Plan physicians and affiliated providers, except during a medical emergency.

Accessing Specialty Care

To receive the most appropriate and efficient care, talk with your Primary Care Physician (PCP) before seeing a specialist. Your PCP can help coordinate specialty care with your unique needs and medical history in mind. As a Capital Health Plan member, you can access specialty care through a direct appointment, with a referral from your PCP, or with authorization/precertification for certain services. Capital Health Plan's network of over 425 affiliated specialists is listed in the *Directory of Physicians and Service Provider*s

Fitness Reimbursement

Capital Health Plan members can receive up to $150 per calendar year (per household) for membership at a qualified health and fitness center or either Weight Watchers or TOPS (Take Off Pounds Sensibly) during that year. Visit capitalhealth.com or contact Member Services to find out more.

Capital Health Plan Health Information Line

The Health Information Line is a 24-hour/day phone line staffed by health care professionals who are able to assist you with your health related questions. While not a substitute for a visit with your physician, the Health Information Line staff can provide you with tips, tools, and resources to help you manage your health. You may access the Health Information Line by calling (850) 383-3400. In addition to the Health Line, you can access online tools to manage your health at capitalhealth.com.

Member website – www.capitalhealth.com/state

CHP*Connect*

Capital Health Plan offers our members the opportunity to access their Capital Health Plan medical history, change their primary care physicians, and much more through our CHP*Connect*.

With a CHP*Connect* account, you now have access to:

1. A personal history of your doctor visits and procedures
2. Healthy Conversations
    - Multi-Media Presentations on topics such as Diabetes, Improving Sleep, Smoking Cessation, Healthy Eating, Exercise, and more!
3. Health Trackers:
    - the ability to track blood pressure, blood sugar, body mass index, cholesterol, Hemoglobin A1C, and more. A graph or linear reading can be printed and taken to your next physician's office visit.

4. Health Risk Appraisal (HRA) –
    - A personal health questionnaire that evaluates your health risks and quality of life. When completed, you will receive a wellness score, and suggestions on how to improve your quality of life.
5. Certain lab results
6. Benefits and copayments
7. Request replacement Capital Health Plan ID Card(s)
8. and more!

Healthwise® Knowledgebase

A searchable medical encyclopedia providing descriptions of symptoms, videos, interactive decision-making tools, and treatment options. Healthwise® Knowledgebase is available on CHP's website www.capitalhealth.com.

Referrals and Authorizations
It is important to understand the difference between a referral and an authorization, and how to obtain each one. The information below is continually updated and can be found on http://www.capitalhealth.com/Members/About-Your-Care/Utilization-Management/Referrals-and-Authorizations.

Referral is the process of sending a patient to another practitioner (i.e., a specialist) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Your primary care physician will refer you to a participating specialist or a health care service provider if he or she cannot personally provide the care you need. Many referrals do not require an authorization number.

Authorization, also known as precertification, is a process of reviewing certain medical, surgical or behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered. The review also includes a determination of whether the service being requested is a covered benefit under your benefit plan. Authorizations are only required for certain services. Your physician will submit authorization/precertification requests electronically, by telephone, or in writing by fax or mail. If approved, an authorization number is then generated by Capital Health Plan and is available to you via CHPConnect. If the requested service is not authorized, the member and provider are notified in writing with the specific reasons for the denial and appeal rights.

Disease Management
The Disease Management Program at Capital Health Plan offers comprehensive programs to help members manage chronic conditions. Health and wellness education, symptom management, decision support and health coaching are available to members.

Disease management programs are designed to support and reinforce the treatment plans of each member's primary care physician. Program members are eligible to receive:

- Access to nurses and other health professionals who can assist with self-management
- Educational materials regarding self-management and shared-decision making
- Online resources, including CHPConnect and Capital Health Plan Health Information Line
- Periodic notices regarding timely blood screenings and follow-up

Capital Health Plan members do not have to enroll; they are automatically enrolled when they are identified as having a chronic condition. For example:

- Atherosclerotic Vascular Disease Management (AVD)
- Diabetes Disease Management

Disease management programs are based on clinical practice guidelines approved by Capital Health Plan's Quality Improvement Committee.

Case Management

Capital Health Plan reserves the right (but, in no event shall it be required) to offer its case management program to Health Plan Members. If the Health Plan Member and the Health Plan Member's physician agree, Capital Health Plan may use its case management program then in effect. Capital Health Plan's use of the case management program with respect to any Health Plan Member shall not restrict or otherwise modify Capital Health Plan's right to administer covered
and/or benefits in strict accordance with the terms of this Summary Plan Description with respect to the Health Plan Member, or with respect to any other Health Plan Member or other individual under any other policy or contract. Furthermore, whether cost of providing alternative or equivalent services varies, depending on whether a particular provider or supplier is used to provide the service, Capital Health Plan may (but shall not be required to) take variations into consideration when authorizing or approving payment, coverage, or benefits for services under the case management program.

Obstetrical Case Management (OB)

As you make plans for the arrival of your baby, Capital Health Plan would like to assist you in your preparations. This site contains information that will be helpful to you during your pregnancy. It also includes important information regarding enrollment of your baby into Capital Health Plan.

To find out more useful information for each of the stages in your pregnancy go to http://www.capitalhealth.com/Members/Live-Healthy/Congratulations-You-re-Having-a-Baby .

Services described will be provided at one of Capital Health Plan's primary care physician locations or in other designated Network provider offices or in facilities authorized by a Capital Health Plan physician.

Pediatric Case Management

The Capital Health Plan Case Management Program is a service offered to all Capital Health Plan members. Our nurse case managers can offer assistance to members and their families who are facing a serious illness or injury and need help navigating the sometimes complex systems of medical care.

Participation in case management services is voluntary and does not alter a member's benefit plan. Members can discontinue participation in the case management program at any time.

Members are encouraged to work closely with their Primary Care Physician in determining if these services are appropriate in their individual circumstance. Members or Caregivers may also self refer by contacting the Capital Health Plan Member Services Department at 383-3311 or (877) 247-6512. The Case Management team evaluates each referral to determine whether the member is appropriate for inclusion into the program.

INTER-PLAN PROGRAMS

Out-of-Area Services

Capital Health Plan has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

Capital Health Plan covers only limited healthcare services received outside of our service area. As used in this section "Out-of-Area Covered Healthcare Services" include *emergency care, urgent care, or care authorized by Capital Health Plan* obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your primary care physician ("PCP").

BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Capital Health Plan will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers. The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment amount, as stated in your Schedule of Copayments.

Emergency Care Services: If you experience a Medical Emergency while traveling outside Capital Health Plan's service area, go to the nearest Emergency (or Urgent Care) facility.

Whenever you access covered healthcare services outside the State of Florida and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Capital Health Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

1. Your Liability Calculation

When Out-of-Area Covered Healthcare Services (*emergency care, urgent care, or care authorized by Capital Health Plan)* are received from nonparticipating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Capital Health Plan will make for the covered services.

2. Exceptions

In certain situations, Capital Health Plan may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Capital Health Plan will make for the covered services.

MEMBER RIGHTS AND RESPONSIBILITIES

Capital Health Plan is committed to provide and/or arrange for the provision of quality health care in a cost-effective manner. Consistent with our commitment, the following statement of Member's Rights and Responsibilities has been adopted.

RIGHTS

Each Health Plan Member has the right to:

- Receive information about Capital Health Plan, the services, benefits, member rights and responsibilities, and participating practitioners who providecare.
- Receive medical care and treatment from practitioners and providers who have met the credentialing standards of Capital Health Plan.
- Expect Capital Health Plan participating practitioners to permit each Health Plan Member to participate in decision-making about his or her health care consistent with legal, ethical, and relevant patient-practitioner relationship requirements. If a Health Plan Member is unable to fully participate in treatment decisions, he or she has a right to be represented by parents, guardians, family members, health care surrogates, or other conservators to the extent permitted by applicable laws.

- Expect health care practitioners who participate with Capital Health Plan to provide treatment with courtesy, respect, and with recognition of each Health Plan Member's dignity and right to privacy.
- Communicate complaints or appeals about Capital Health Plan or the care provided through the established appeal or grievance procedures found in the Member Handbook and the master policy or contract provided to the State of Florida.
- Have candid discussion with practitioners about the best treatment options no matter what the cost of the treatment or the benefit coverage.
- Refuse treatment if the Health Plan Member is willing to accept the responsibility and consequences of that decision**.**
- Have access to medical records, request amendments to records, and have confidentiality of these records and member information protected and maintained in accordance with state and federal law and Capital Health Plan policies.
- Make recommendations regarding Capital Health Plan's member rights and responsibilities policies.
- Call or write us anytime with helpful comments, questions, and observations, whether concerning something that the Health Plan Member likes about our plan, or something that the Health Plan Member feels is a problem area**.**

RESPONSIBILITIES

Each Health Plan Member has the responsibility to:

- Seek all non-emergency care through the Health Plan Member's primary care physician (PCP), obtain a referral from his or her PCP for medical services by a specialist, and cooperate with those providing care and treatment.
- Be courteous; respect the rights, needs and privacy of other patients, office staff, and providers of care.
- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care.
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that the Health Plan Member has agreed to with his or her practitioners.
- Ask questions and seek clarification to enable the Health Plan Member to participate fully in his or her care.
- Pay copayments or coinsurance and deductible and provide current information concerning the Health Plan Member's Capital Health Plan membership status to any Capital Health Plan participating practitioner or provider.
- Follow established procedures for filing a complaint, appeal, or grievance concerning medical or administrative decisions that the Health Plan Member feels are in error.
- Review and understand the benefit structure, both covered benefits and exclusions, as outlined in the Member Handbook. Cooperate and provide information that may be required to administer benefits.
- Seek access to medical and member information through the Health Plan Member's Primary Care Physician, CHPConnect, or through Capital Health Plan Member Services.
- Follow the coverage access rules in the Member Handbook**.**

VIII. PRESCRIPTION DRUG PROGRAM

How the Program Works
You automatically participate in the State Employees' Prescription Drug Plan. The Plan features a select Network of participating 30-day retail pharmacies, 90-day retail pharmacies, and mail service pharmacies. Below is an overview describing when and which feature to use.

Medication Synchronization at Retail Pharmacies

Medication Synchronization (Med Sync) allows you to save time and reduce the number of trips to your retail pharmacy by requesting that your retail pharmacist "synchronize" all your medication refills so you can pick them all up on the same day. Med Sync is optional and only allowed once per calendar year at a network pharmacy. A controlled substance, a prescription drug dispensed in an unbreakable package, or a multidose unit of a prescription drug are not eligible for synchronization. When synchronizing or aligning your refills some prescriptions will be for a shorter day supply. When this happens your copay or coinsurance will be prorated to the shortened-day supply that is actually dispensed. For example: assume by synchronizing your prescription you will only be picking up an eight-day supply of what would normally be a 30-day supply. If your cost is $7.00 for this 30-day supply the cost per day is $0.23 ($7 ÷ 30= .23), but since you are only getting an eight-day supply you will pay $1.87 ($0.23 x 8). Important Note: Any short or sync prescription fill that would have normally been filled for a 30-day supply will count as one of the three fills of maintenance medications allowed at a retail pharmacy before being required to use mail order or a 90-day participating retail pharmacy.

Participating Retail pharmacies: 30-Day Supply

Use for short-term medications, or medications that you need immediately, like antibiotics for a sick child, up to a 30-day supply at one time. Maintenance medications may also be filled through a 30-day participating retail pharmacy.

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

Use for maintenance or long-term medications you take regularly like high blood pressure drugs, up to a 90-day supply at one time, provided the prescription is written to allow dispensing of a 90-day supply. Maintenance medications may be filled through the mail order program or by a participating 90-Day Maintenance Retail pharmacy.

Purchasing Prescriptions at 30-day Retail Pharmacies

When your doctor prescribes a medication, you may fill the prescription at any participating pharmacy. Call (888) 766-5490 or go to caremark.com/sofrxplan to locate a participating pharmacy.

Take your prescription and present your prescription drug program identification card to the pharmacist. You pay a Copayment (Coinsurance for Health Investor Health Plan option) for up to a 30-day supply of each covered prescription (90-days maintenance at participating retailers). There is no paperwork when you use your prescription drug card at a participating pharmacy; Claims are submitted electronically.

What if you Request a Brand Name at a Participating Pharmacy

- If your prescription is filled with a generic drug, you pay only the applicable Copayment or Coinsurance. If a generic equivalent is not available, or if your doctor writes on the prescription "dispense as written" or "brand name medically necessary," you pay the applicable Copayment or

Coinsurance for the brand name drug. However, if you request a brand name instead of an available generic equivalent, you will pay the lesser of: The brand name drug Copayment or Coinsurance, *plus* the difference between the Plan's cost for the brand name drug and the Plan's cost for the generic drug; or

- The actual retail price of the brand name drug.

Using a Participating Pharmacy (an example):

At participating Network pharmacies, the Plan's cost for a drug is less than the full retail price. Assume you request a preferred brand name drug that costs the Plan $50 instead of the available generic substitute that costs the Plan $25. In this case, you pay:

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

If you request the brand name drug when a generic equivalent is available, you will pay the lesser of: the brand name drug Copayment plus 100 percent of the difference between the Plan's cost for the generic drug and the Plan's cost for the brand name drug or the actual retail price of the brand drug. If the prescribing physician or other Participating Provider authorized to prescribe drugs within the scope of his or her license indicates on the prescription "brand name Medically Necessary" or "dispense as written" for a brand name drug for which there is a generic equivalent, you will only pay the applicable Copayment for the brand name drug.

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

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

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

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

If you are taking long-term or maintenance medications, ReadyFill at Mail™ provides easy and convenient refill and/or renew options through mail order for many, but not all, medications.

If you sign up for this program (and have refills remaining) CVS/caremark will automatically fill and mail your medications at the appropriate refill time saving you time from ordering online or by phone. Also, CVS/caremark will contact your physician and request a new prescription automatically after your last available refill and alert you in advance.

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

Standard HMO Option

The Copayments are:

Retail 30-Day **Mail Order and Retail 90-Day**	• $7 for a generic drug • $30 for a preferred brand name drug • $50 for a non-preferred brand name drug • $14 for a generic drug • $60 for a preferred brand name drug • $100 for a non-preferred brand name drug The copayment *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your doctor, request the brand name drug.
Retail 30-Day, Mail Order, and Retail 90-Day **Subject to the Calendar Year Deductible**	• 30% for a generic drug • 30% for a preferred brand name drug • 50% for a non-preferred brand name drug The calendar year deductible and/or coinsurance *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your doctor, request the brand name drug.

Health Investor Option

The Coinsurance amounts are:

Retail 30-Day, Mail Order, and Retail 90-Day **Subject to the Calendar Year Deductible**	o 30% for a generic drug o 30% for a preferred brand name drug o 50% for a non-preferred brand name drug The calendar year Deductible and/or Coinsurance *plus* the difference in the Plan's cost between the brand name and the generic if a generic is available and you, rather than your doctor, request the brand name drug.

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

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

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

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

What are Generics?

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

- Generic equivalent drugs have the same active ingredients as the brand name, but they are less expensive because the brand name manufacturer makes the initial investment for product research and development

- The Food and Drug Administration (FDA) doctors and pharmacists review generic products regularly to make sure they are safe and effective.

Drugs That Are Covered by the Prescription Drug Program

Covered drugs include, but are not limited to:

a) Federal legend drugs
b) State restricted drugs
c) Compound medications when all of the following criteria are satisfied:
    i. All active ingredients are federal legend drugs
    ii. The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation unless Medically Necessary
    iii. The compounded medication is specifically produced for use by a Health Plan Member to treat a covered condition
    iv. The compounded medication including all sterile compounded products is made in compliance with Chapter 465, Florida Statutes.

    Additionally:
    i. Over-the counter (OTC) products and bulk powders, bulk chemicals, and proprietary bases used in the compounded products are not covered; and
    ii. Reconstitution of oral powders is not considered compounding. The compounding pharmacist must bill the NDC of the product used in the quantity of final reconstituted volume.
d) Tobacco cessation medications, including prescription and over-the-counter medications, when prescribed by a health care provider and that have a current rating of A or B by the United States Preventive Services Task Force, are covered.
e) Insulin and other covered injectable medication
f) Needles and syringes for insulin and other covered injectable drugs
g) FDA-approved glucose strips, tablets and lancets
h) Zostavax (administration of this vaccine is not covered under the Prescription Drug Program).

An injectable medication is one that has been approved by the U.S. Food and Drug Administration for administration by one or more of the following routes: intramuscular injection, intravenous injection, intravenous infusion, subcutaneous injection, intrathecal injection, intra-articular injection, intracavernous injection or intraocular injection. Prior authorization is required for injectable medications.

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

Drugs That Are Covered by Capital Health Plan

Covered drugs shall include, but are not limited to:

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

Drugs NOT Covered by the Prescription Drug Program

The prescription drug program does not cover:

1. Retin-A for cosmetic purposes
2. Anti-obesity drugs and amphetamines and/or anorexiants for weight loss
3. Infertility and fertility drugs
4. Devices or appliances
5. Non-federal legend or over-the-counter (OTC) products, and bulk powders, bulk chemicals, and proprietary bases used in compounded medications.
6. Drugs labeled "Caution-Limited by Federal Law to Investigational Use" or Experimental drugs
7. Non-prescription drugs, aids and supplies to deter smoking (i.e., gums, patches, lozenges), unless prescribed by a health care provider and have a current rating of A or B by the United States Preventive Services Task Force
8. Immunizing agents such as flu vaccine, except Zostavax
9. Medication that is covered by Worker's Compensation or Occupational Disease Laws or by any state or governmental agency
10. Medication furnished by any drug or medical service for which no charge is made
11. Viagra and other drugs prescribed solely for psychosexual disorders; Viagra and similar drugs prescribed for males under the age of 18 years; Viagra and similar drugs prescribed for females.
12. Enteral formulas exceeding for individuals 25 years of age or older
13. Growth hormones for the diagnosis of idiopathic short stature syndrome
14. Overlapping therapies within the same drug classifications, even if used for different conditions. For example, an erectile dysfunction drug for the treatment of benign prostate hyperplasia (BPH) and an erectile dysfunction drug for treatment of erectile dysfunction, as both are in the same drug classification of erectile dysfunction drugs
15. Prescriptions filled at a non-participating pharmacy, except for prescriptions required during Emergency care which visit is subject to approval by Capital Health Plan.

The Plan's general Limitations and Exclusions apply to the prescription drug program. See "Limitations and Exclusions" section within this document.

Important Information about the Prescription Drug Program

1. The Preferred Drug List (PDL) is updated and subject to change on a quarterly basis. Contractually, CVS/caremark has full authority over the development of the PDL; therefore, DSGI cannot require that specific drugs be included.
2. Generic substitution: Prescriptions written for brand name drugs that have a generic equivalent will be automatically substituted unless the prescribing physician writes "dispense as written" or "DAW" on the prescription. Generally, even if the prescription includes "DAW," CVS/caremark will still contact the physician to ask if the generic equivalent may be substituted.
3. Only the prescribing physician or an authorized agent of the physician can authorize changes to or provide clarifications to a prescription. Authorizations may be obtained verbally or in writing. If CVS/caremark is unable to contact the physician or an authorized agent of the physician, the prescription may be returned unfilled to the member.
4. CVS/caremark mail order facilities will only substitute with generic drugs that have received an "A" or "AB" rating by the Federal Drug Administration (FDA). Retail pharmacies may choose to dispense drugs with a different FDA rating.
5. Certain medications, including most biotech and/or specialty drugs, are only available through

CVS/caremark Specialty Pharmacy. Generally, these drugs are for chronic or genetic disorders including, but not limited to, multiple sclerosis, growth hormone deficiency and rheumatoid arthritis and may require special delivery options, such as temperature control. Your prescribing physician may contact CVS/caremark Specialty Pharmacy at (800) 237-2767.

6. CVS/caremark may contact the prescribing physician when a prescription for a non- preferred brand name drug is submitted and a therapeutically equivalent preferred drug is available. If the physician or an authorized agent of the physician authorizes a change to the preferred drug, CVS/caremark will dispense the alternative drug and provide written notification of the change to the member.
7. CVS/caremark will contact the prescribing physician if the prescribed dosage differs from the dosage recommended by the FDA or the manufacturer's guidelines. Dosage is the number of units, the strength of such units, and the length of time to take the medicine. If the physician or an authorized agent of the physician authorizes a change to the dosage, CVS/caremark will change the dosage amount, dispense the new dosage, and provide written notification of the change to the member.
8. During the prescription review process, your mail order and retail pharmacy prescription history, age, self-reported allergies, and self-reported disease states are reviewed along with the FDA drug interactions and manufacturer's guidelines to determine if there are any interactions, side effects, and/or contraindications. CVS/caremark will contact the prescribing physician if any questions, conflicts or issues are identified. CVS/caremark may contact the prescribing physician if any indication of fraud or excessive usage is identified. If the physician or an authorized agent of the physician authorizes any changes, pharmacy benefits manager will change the prescription accordingly, dispense the drug accordingly, and provide written notification of the change to the member.
9. CVS/caremark will contact the prescribing physician to verify the prescription if the prescription is illegible, written in different pen and/or penmanship, or altered in any way. If the pharmacy benefits manager cannot reach the physician or an authorized agent of the physician, the prescription will be returned to the member unfilled.
10. Prescriptions for treatment of conditions for unapproved indications or "off-label" use will not be filled if not proven safe and effective for the treatment of the Condition based on the most recently published medical literature of the United States, Canada or Great Britain, using generally accepted scientific, medical or public health methodologies or statistical practices.
11. 75% of the previous prescription must be utilized, if used as prescribed, before a request for a refill will be processed.
12. Requests for mail order refills that are received within 90 days of the "too soon to fill" date (based on the previous paragraph) will be held and filled when eligible to be filled. You may check your medication label for the next available refill date, or if the prescription was filled through mail order, you may log onto *www.caremark.com* for the next available mail order refill date.
13. CVS/caremark Specialty Pharmacy administers the Specialty Guideline Management Program for this Plan. This program is intended to optimize outcomes and promote the safe, clinically appropriate and cost-effective use of specialty medications supported by evidence based medical guidelines. Failure to meet the criteria for this program during the coverage review will result in denial of medication coverage for the Health Plan Member and discontinuation of medication coverage for the Health Plan Member.

Specialty Prescription Drugs

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

category call CVS/caremark Customer Care toll-free at (888) 766-5490.

Prior Authorization – Specialty Prescription Drugs

Specialty Drugs are high-cost injectable, infused, oral, or inhaled drugs that are used to treat certain chronic or complex disease states. Specialty Drugs may include genetically engineered drugs (sometimes called Biotech drugs) that are used to treat rare or chronic Conditions, including but not limited to rheumatoid arthritis, hepatitis C, multiple sclerosis, growth hormone deficiency and cancer. These therapies often require customized management and frequent monitoring as well as having unique handling, distribution and administration requirements.

The majority of all Specialty medications are delivered through CVS Caremark Specialty Pharmacy. Your prescribing Physician must contact CVS/caremark in advance at www.cvs specialty.com or www.covermymeds.com or call (800) 237- 2767 to verify coverage and to receive authorization for the specialty medication.

Specialty Drugs are subject to the clinical review under the Specialty Guideline Management Program that provides specific treatment guidelines for specialty medications covered under this Plan. Through this Program, CVS/caremark will work with your Physician to ensure that the most appropriate drug treatment is being prescribed and utilized including but not limited to diagnosis review in accordance with the most recent evidenced-based medical guidelines, U.S. Food and Drug Administration, lab results, safety requirements, and day supply quantity limits.

If prior authorization for a Specialty Drug is denied in accordance with the treatment guidelines of the Specialty Guideline Management Program, and you elect to receive the Specialty Drug anyway, you will be responsible for the total cost of the Specialty Drug.

If prior authorization is not requested and received, you may be responsible for the total cost of the Specialty Drug if the drug is ultimately considered not Medically Necessary or is not in compliance with treatment guidelines under the Specialty Guideline Management Program.

IX. HOW TO FILE A CLAIM

Medical Claims
A claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving notification of the Adverse Benefit Determination. Capital Health Plan shall notify the claimant, in accordance with the grievance section within this document, of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review of the Adverse Benefit Determination.

Send appeal to:	Capital Health Plan Attn: Grievance Manager P. O. Box 12400 Tallahassee, FL 32317-2400

Prescription Drug Claims

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

Non-Participating Pharmacies – Emergency Only
If you use a non-participating pharmacy in an emergency situation, 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 the pharmacy benefits manager – see contact information listed at the beginning of this document.

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

Send drug claim to:	CVS/caremark P.O. Box 52010 MC 003 Phoenix, AZ 85072-2010

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

A claimant may appeal an Adverse Benefit Determination within 180 days or receiving notification of the Adverse Benefit Determination in accordance with Section XIII, Grievance and Appeals Procedures. A Claimant is a Health Plan member or authorized representative acting on his/her behalf, subject to the Plan's

determination. Call the customer service number on the back of your member ID card (call CVS/caremark for denied prescriptions) to obtain and complete specific documentation, such as Appointment of Representative form, if you want to authorize someone to appeal a claim on your behalf.

X. COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

For All Covered Individuals

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

For Eligible Dependent Children

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

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

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

Coordination with Medicare

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

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

Active Employees

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

If you are an active employee or the spouse or an active employee and become eligible for Medicare because of age or disability, you may choose to properly defer Medicare Part B benefits until you are no longer on the policy if active state employee, such as when you or your spouse retires. The Social Security Administration provides a Special Enrollment Period to allow you to enroll in Medicare Part B without incurring an additional

Medicare premium in this situation. However, the Medicare Special Enrollment Period rules have no bearing on the provisions of this Plan. If you are Medicare eligible and Medicare Part A and B are not in effect at the time of your retirement, benefits for this Plan will be paid as if Medicare Part A and Part B had paid first as the primary plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Part B requires that the retail, mail order, or specialty pharmacy obtain a signed Assignment of Benefits/Assignment of Billing/Medical Release Authorization form. This form is required in order to bill Medicare on your behalf. Since some drugs are only eligible under Medicare Part B for specific diagnoses, Medicare Part B requires that each prescription include a written diagnosis. There may be other situations when Medicare Part B requires additional specific documentation before accepting a prescription drug Claim for payment. In most cases, Medicare Part B will only accept Claims for a prescription fill for up to a 30-day supply. Generally, Medicare eligible items are covered under Medicare Part B and are subject to the Medicare calendar year Deductible.

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

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

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

IMPORTANT NOTE:
Medicare automatically notifies the State of Florida of any of its Plan members who are enrolled in a Medicare Part D Prescription Drug Plan. Upon such notification from Medicare, this Plan will automatically become the secondary coverage.

This Plan will not change to become primary coverage until you provide the pharmacy benefits manager a letter of creditable coverage or disenrollment from the Medicare Part D Plan. Such letter of creditable coverage must include your name and the effective and termination dates of your Medicare Part D coverage. Due to the confidential nature of your prescription drug information, Medicare will not discuss your Medicare Part D coverage with the State of Florida.

Special Notice about the Medicare Part D Drug Program
January 1, 2018

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

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

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

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

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

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

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

If you drop or lose your coverage with the State Health Program and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare

prescription drug coverage later. Additionally, if you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage, and you may have to wait until the following Nov. to enroll.

Additional information about Medicare prescription drug plans is available from:

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

For people with limited income and resources, payment assistance for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). Contact your local SSA office, call (800) 772-1213, or www.socialsecurity.gov for more information. TTY users call (800) 325-0778.

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

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

XI. SUBROGATION AND RIGHT OF RECOVER, RECOUP, AND SUE FOR LOSSES

If the Plan provides health care benefits to a Health Plan Member for injuries or illness for which another party is or may be responsible, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on behalf of the Health Plan Member that are associated with the injury or illness for which another party is or may be responsible. The Plan's rights of recovery apply to any recoveries made by or on behalf of the Health Plan Member from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Health Plan Member for injuries resulting from an accident or alleged negligence. For instance, personal injury protection insurance is designated as the primary payer under Section 627.736, Florida Statutes, and the State has the right to recover payments for benefits that are also covered under a personal injury protection policy. These rights and the state's rights also extend to benefits which may be payable through any kind of insurance coverage including but not limited to uninsured/underinsured motorist's coverage. For purposes of this SPD, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

Health Plan Member specifically acknowledges the Plan's right of subrogation, and further acknowledges that as a condition precedent to his or her right to receive covered benefits, Health Plan Member has granted the Plan a first priority lien on any compensation, damages or other form of financial relief received from, or on behalf of, a tortfeasor who has caused an injury to Health Plan Member requiring health care services that were covered by the Plan. When the Plan provides health care benefits for injuries or illnesses for which a third party is or may be responsible, the Plan shall be subrogated to the Health Plan Member's rights of recovery against any party to the extent of the full cost of all benefits provided by the Plan, to the fullest extent permitted by law. The Plan may proceed against any party with or without the Health Plan Member's consent.

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

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

1. Notify the Plan promptly and in writing when notice is given to any third party of the Health Plan Member's intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Health Plan Member that may be the legal responsibility of a third party; and
2. Contemporaneously provide the Plan a complete and accurate copy of any complaint or pleading asserting a Claim against an alleged tortfeasor for relief in connection with an injury requiring health care services that were covered by the Plan at the time such complaint or pleading is filed;

3. Cooperate with the Plan and do whatever is necessary to secure the Plan's rights of subrogation and/or reimbursement under this SPD; and Acknowledge in writing at the request of the Plan that the Plan has a first- priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and
4. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due the Plan as reimbursement for the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by the Plan in writing; and
5. Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by the Plan, or purports to exclude from the settlement, or not include, medical expenses and costs attributable to the health care services received by the Health Plan Member consequent to the injury caused by the tortfeasor from thesettlement.

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

Right to Recovery and Recoupment. The State, Capital Health Plan, and CVS/caremark have recoupment rights whenever it is discovered that payments for health services, supplies, and prescription drugs have been made in excess of the maximum provided for under this Benefit Document. The State, Capital Health Plan, and CVS/caremark will pursue any action available up to and including use of a collection agency to recover excess payments from you, your dependents, or any other person, entity, or organization.

XII. DISCLAIMER OF LIABILITY

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

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

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

XIII. APPEALS AND GRIEVANCE PROCEDURE

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

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

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

A grievance may be submitted in writing to:	Level 1 Appeals: Capital Health Plan, Inc. ATTN: Grievance Manager/Appeals P. o. Box 15349 Tallahassee, Fl. 32317-5349 For expedited reviews, fax to 850-383-3413

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

Appealing to Capital Health Plan – A Level I Appeal

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

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

There are three types of appeals: urgent pre-service, pre-service, and post-service. You may request an urgent pre-service appeal if the timeframe to complete a Level I Pre-Service Appeal would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent appeal. If your appeal is for the denial of an urgent pre-service claim or a concurrent care decision, you may verbally request an urgent Level I Appeal by calling the Customer Service toll-free telephone number on your member ID card (Capital Health Plan or the pharmacy benefits manager, as appropriate) and stating that you are requesting an urgent Level I Appeal. Concurrent care means an ongoing course of treatment to be provided over a period of time or number of treatments that was previously approved by Capital Health Plan.

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

Level I Appeal (Medical)	Level I Appeals: Capital Health Plan, Inc. ATTN: Grievance Manager/Appeals P. o. Box 15349 Tallahassee, FL 32317-5349 For expedited reviews, fax to 850-383-3413
Level I Appeal (Prescription)	CVS/caremark Attention: Appeals Department MC 109 P.O. Box 52071 Phoenix, AZ 85072-2071 Level I Appeals: Non-specialty drugs fax (866) 443-1172 Specialty drugs fax: (855) 230-5548

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

Capital Health Plan or the pharmacy benefits manager will review your Level I Appeal and provide a written notice of the review decision. If the appeal is for a pre-service denial, Capital Health Plan or the pharmacy benefits manager will respond within 15 days from receipt of your appeal; if the appeal is for a post-service denial, Capital Health Plan or pharmacy benefits manager will respond within 30 days from receipt of your appeal; and, if your appeal is urgent, Capital Health Plan or pharmacy benefits manager will respond within 72 hours from receipt of your appeal. If Capital Health Plan or pharmacy benefits manager's review is unfavorable (Level I Appeal is denied), the notice from Capital Health Plan or pharmacy benefits manager will include information about appealing the decision to the Independent Review Organization (or DSGI for pharmacy).

Appealing to Division of State Group Insurance (DSGI) – A Level II Appeal – PRESCRIPTION DRUG ONLY
If you are not satisfied with the Level I Appeal decision relating to a prescription drug benefit, you may file a Level II Appeal to DSGI. You may request a Level II urgent appeal if the timeframe to complete the pre-service Level II

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

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

Your Level II Appeal must be in writing or filed verbally (for urgent appeals) and must be postmarked within 60 days of the written notice of Capital Health Plan or pharmacy benefits manager's denial of your Level I Appeal. Your Level II Appeal must include:

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

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

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

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

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

Requesting an Administrative Hearing – PRESCRIPTION DRUG ONLY

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

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

You have the right to request an external review from an Independent Review Organization (IRO) after the finalization of Level I Appeal process relating to an HMO medical benefit, or after the finalization of both the Level I and Level II Appeal processes relating to a prescription drug benefit. You may call the Customer Service toll-free

telephone number on your member ID card (Capital Health Plan or pharmacy benefits manager, as appropriate) for additional information about requesting or to request an external review. External review is not available for claim denials based on an individual's eligibility under a plan. You must request an external review in writing within four months after receipt of the Level I HMO appeal decision or the Level II prescription drug benefit appeal decision.

Standard External Review
You may request a standard external review of your Level I HMO appeal decision or the Level II prescription drug benefit appeal denial if the decision involved a:

1. denial of your request for payment of a claim and the decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is experimental or investigational; or
2. rescission (cancellation) of coverage; and
3. An external review is requested by you within four months of the Level I HMO appeal decision or the Level II prescription drug benefit appeal date.

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

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

1. denial of your request for payment of a claim and the decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is experimental or investigational; or
2. rescission (cancellation) of coverage; and
3. An external review is requested by you within four months of the Level II appeal denial date.

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

<u>Important Notes:</u>

1. Throughout the appeal and review process, you have the right to present evidence and testimony as well as request and receive, free of charge, copies of all documents and other information relevant to your claim and/or appeal, including, but not limited to, the following information about the processing of your claim:
    a. the specific rule, guideline, protocol or other similar criterion used, if any, in making the benefit or payment decision, and/or

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

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

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

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

XIV. MISCELLANEOUS

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

Division of State Group Insurance
Privacy Notice for the State Group Health Insurance Program

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 Florida Blue and CVS/caremark (which provides third-party medical and pharmacy support to the self- insured plan); the notices describe how Florida Blue and CVS/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 or more health care providers or doctors. Treatment can also include coordination or management of care between a

provider and a third party, and consultation and referrals between providers. For example, the plans may share health information about you with physicians who are treating you.

- Payment includes activities by these plans, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the plans may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.
- Health Care Operations include activities by these plans (and in limited circumstances other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the plans may use information about your claims to review the effectiveness of wellness programs.

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

How the plans may share your health information with the State

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

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

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

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

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts).

You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

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

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

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

Your individual rights

You have the following rights with respect to your health information the plans maintain. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right for the Flexible Spending Account and for the State activities relating to the self-insured plan and insured plans. Contact the Division of State Group

Insurance, PO Box 5450, Tallahassee, FL 32314-5450 to obtain any necessary forms for exercising your rights. The notices you receive from Florida Blue, CVS/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 your providing an alternative address or other method of contact and, when appropriate, on your providing information on how payment, if any, will be handled.

Right to inspect and copy your health information

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

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

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

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

The plans also may charge reasonable fees for copies or postage. If the plans do not maintain the health information but know where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

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

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

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

Right to receive an accounting of disclosures of your health information

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

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

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

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

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

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

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

Changes to the information in this notice

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

Complaints

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

Contact

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

Special Notice about the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Removal of all or part of the breast for medical necessity;
2. Reconstruction of the breast on which the mastectomy was performed;
3. Surgery and reconstruction of the other breast for a symmetrical appearance;
4. Treatment of physical complications of all stages of mastectomy including lymphedemas; and
5. Prostheses and mastectomy bras.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan Booklet and Benefits Document. The deductibles and coinsurance for the Standard PPO Option are found in Section 1 of this Plan Booklet and Benefits Document, and the deductibles and coinsurance for the Health Investor PPO Option are found Section 2 of this Plan Booklet and Benefits Document.
For more information, contact the Plan Administrator, the Division of State Group Insurance, at (800) 226-3734.

SUMMARY PLAN DESCRIPTION INFORMATION

Official Plan Name:	State of Florida Employees' Group Insurance Program Health Maintenance Organization (HMO) Plan
Plan Administrator:	State of Florida Division of State Group Insurance P.O. Box 5450 Tallahassee, FL 32314-5450 (850) 921-4600
HMO (Claims Administrator)	Capital Health Plan P. O. Box 12400 Tallahassee, Fl. 32317-2400
Plan Year:	January 1 – December 31
Effective Date of the Plan:	January 1, 2018
Employer Identification No.:	59-3458983
Plan Type:	Fully-insured Plan
Source of Contribution:	State of Florida Employees
Organization that Provides the Benefit:	Benefits under the plan are provided through a contract with Capital Health Plan.