Attachment H: Covered Benefits and Services

The covered benefits outlined below illustrate the covered benefits for the PPO plans currently offered by the Program. The AV of each plan (standard and high deductible health plan (HDHP)) is: eighty-nine percent (89%) for the standard plan; and, seventy-eight percent (78%) for the HDHP plan. The covered benefits are being provided as a reference only. Neither "Plan Design A" nor "Plan Design B" are required to match the listed covered benefits or applicable copayment and deductible amounts shown.

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Section 1: Standard PPO Option Summary of Benefits

This summary provides an overview of the Standard PPO Option. For further information on the coverage and benefits of this Plan, as well as applicable limitations and exclusions, please refer to sections 3 (Covered Services), 5 (Exclusions), 7 (Additional Required Provisions) and 15 (Definitions) of this booklet. **If you are enrolled in the PPO High Deductible Health Plan Option, please refer to section 2, entitled "PPO High Deductible Health Plan Option Summary of Benefits."**

Benefit Description	Network	Non-Network*
Calendar Year Deductible/Copays/Limits		
Calendar Year Deductible (CYD) Per person Family aggregate	 $250 $500	 $750 $1,500
Coinsurance Maximum (OOP) Per person Family aggregate	$2,500 $5,000	
Global Network (OOP) Maximum Per Person Family Aggregate	$7,900 $15,800	N/A
Emergency Room (ER) Facility Services Copay (per visit)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Urgent Care Center	$25 PVF	$25 PVF
Per Admission Deductible (PAD) Inpatient Hospital	$250 per admission	$500 per admission
Physician Office Per Visit Fee (PVF) Primary Care Physician (PCP) Specialist Convenient Care Center	 $15 PVF $25 PVF $15 PVF	 Coinsurance only; no CYD or PVF
Hospital Services		
Room and Board (R&B) (semi-private) Admission Certification/ Hospital Stay Certification (AC/ HSC) required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Intensive/Progressive Care AC/HSC required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Emergency Room	100% of Allowed Amt after ER copay	100% of Allowance after ER copay
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, operating room, etc.)	80% of Allowed Amt after PAD	60% of Allowance after PAD
Outpatient Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Partial Hospitalization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physician Services		
Emergency Room	80% of Allowed Amt after CYD	80% of Allowance after CYD
Hospital Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Office Visit	100% of Allowed Amt after applicable PVF	60% of Allowance (no PVF/CYD)
Outpatient Services (outpatient visits, consultations, maternity care, etc.)	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Physician Services		
Pathology/Radiology/ Anesthesiology	80% of Allowed Amt after CYD	60% of Allowance after CYD
Preventive Care-Adult (Screening mammograms are included in Preventive Adult Care)	100% of Allowed Amt	100% of Allowance
Preventive Care-Children	100% of Allowed Amt	100% of Allowance
Surgery (Inpatient/Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Urgent Care Center	100% of Allowed Amt after $25 PVF	100% of Allowance after $25 PVF
Other Covered Facility Services		
Ambulatory Surgical Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Birthing Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Osteopathic Hospital (Inpatient) AC/HSC required except for physical rehab admissions	80% of Allowed Amt after PAD	60% of Allowance after PAD
Outpatient Facility	80% of Allowed Amt after CYD	60% of Allowance after CYD
Rehab Hospital (Inpatient) AC/HSC not required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Rehab Hospital (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Skilled Nursing Facility Not subject to PAD; AC/HSC not required	70% of Allowed Amt	70% of Allowance
Specialty Facility (Inpatient) AC/HSC required	80% of Allowed Amt after PAD	60% of Allowance after PAD
Specialty Facility (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Home Health Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Residential Treatment Services	80% of Allowed Amt after PAD	60% Allowance after PAD
Other Covered Services		
Acupuncture	80% of Allowed Amt after CYD	60% of Allowance after CYD
Ambulance	100% of Allowed Amt	100% of Covered Charge
Autism	80% of Allowed Amt after CYD	60% of Allowance after CYD
Cleft Lip and Cleft Palate	80% of Allowed Amt after CYD	60% of Allowance after CYD
Contraceptives, supplies and related services	Paid according to the type of service rendered as noted above for Preventive Adult Care, Physician office visits, other Physician services, Durable Medical Equipment, and prescription drugs.	
Dental Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Durable Medical Equipment (DME)/Supplies	80% of Allowed Amt after CYD	60% of Allowance after CYD
Eye Glasses or Contacts	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Other Covered Services		
Limited Fertility Testing and Treatment	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hearing Tests	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mammograms (diagnostic and/or medical)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Manipulative Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mastectomy and Reconstructive Surgery	80% of Allowed Amt after CYD	60% of Allowance after CYD
Maternity Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Midwife Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physical/Massage/Occupational Therapy	80% of Allowed Amt after CYD	60% of Allowance after CYD
Prescription Drugs (CVS Caremark) Participating Retail Pharmacy (30-day supply) Participating Retail Pharmacy (90-day supply) Mail Order Pharmacy (90-day supply)	Generic/Preferred Brand/ Non-Preferred Brand $7 / $30 / $50 $14 / $60 / $100 $14 / $60 / $100	You pay in full and file claim (see section 9 for reimbursement information)
Prostheses	80% of Allowed Amt after CYD	60% of Allowance after CYD
Surgical Sterilization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Transplants	80% of Allowed Amt after CYD	60% of Allowance after CYD
Weight Loss Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Wigs	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hospice Care		
Hospice Inpatient	70% of Allowed Amt	70% of Allowance
Hospice Outpatient/Home	80% of Allowed Amt	80% of Allowance

Note: Certain categories of Network Providers may not currently be available in all geographic regions. Additionally, certain providers (e.g., radiologists, anesthesiologists, pathologists, emergency room Physicians, Hospitalists) rendering care at network facilities may not be Network Providers and are, therefore, subject to non-network benefits unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

These are the benefits provided the coverage is active (i.e., in effect) when the services are rendered. Oral and written statements cannot modify the coverage or benefits described in this Plan Booklet and Benefits Document.

*** The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance, except when provided in an emergency or an in-network facility.**

Plan Maximums

Hospice Care days per person per lifetime 210

Lifetime Benefit Maximum per person per lifetime . . . . . Not Applicable

Manipulative Services per person per calendar year . . . . . .26 treatments

Massage and/or Physical Therapy (excluding physical therapy for the treatment of Autism Spectrum Disorder and Down syndrome)

Treatments per day; and. 4
Days per 6-month period 21

Occupational Therapy (excluding occupational therapy for the treatment of Autism Spectrum Disorder, Down Syndrome, and under hospice and home health care services)

Days per 6-month period 21

Skilled Nursing Facility days per person per calendar year. 60

Weight Loss Services (non-surgical) per person per 12-month period. $150

Wigs per person per event. $40

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Office Visits

For office visits, the amount you pay depends on whether you use a network or non-network physician or other health care provider. You pay a set copayment per visit for network Physicians or other health care providers, while Coinsurance applies for most office visits to non-network physicians or other health care providers.

If you use non-network physicians or other health care providers, you will be under an obligation to pay any amount above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. See page 1-7 for more information about the Network Allowed Amount and the Non-Network Allowance.

Copayments for office visits do not count toward meeting the Plan's calendar year deductible or the calendar year coinsurance maximum. An office visit includes all services provided on the same day as the office visit, by the same health care provider. Therefore, the copayment you pay for the office visit applies to all covered services rendered in that office visit and does not count toward meeting the calendar year deductible.

Emergency Room Visits

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

1. Facility
   You pay a set Copayment per visit for the facility charges. This Copayment is waived if you are admitted to the Hospital directly from the emergency room. The per visit ER Copayment does not count toward meeting the Plan's calendar year deductible or the calendar year coinsurance maximum.
2. ER Physician or Other Health Care Provider
   You pay a percentage of the Network Allowed Amount or Non-Network Allowance after you meet the calendar year deductible. It is not uncommon to receive ER Physician or other health care provider services from a Non-Network Provider within a network facility.

Deductible for Hospital Stays (Per Admission Deductible)

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

Deductible for Most Other Covered Care

You must meet a calendar year deductible before this Plan pays benefits for most covered expenses. Please refer to the summary of benefits chart on pages 1-1 through 1-3 for information on services that are not subject to the calendar year deductible (e.g., services requiring a Copayment or per admission deductible). The calendar year deductible applies each January 1 to December 31. The deductible will not roll over to the following year.

Once the calendar year deductible is met, this Plan pays a percentage of the Network Allowed Amount for Network Providers and a percentage of the Non-Network Allowance for Non-Network Providers. Please refer to page 1-7 for more information regarding your share of expenses for Non-Network Providers.

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

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

1. two family members can each meet the individual calendar year deductible; or
2. all family members can combine their covered expenses to meet the family deductible.

How the Deductible Works

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

Joe	**$ 200**
Wife	**$ 125**
Daughter	**$ 100**
Son	**+ $ 75**
network family deductible	**$ 500**

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

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

Calendar Year Coinsurance Maximum

There is a limit on the amount of Coinsurance you pay out of your pocket toward covered expenses in any one calendar year for network and non-network care combined. Once your share of out-of-pocket Coinsurance expenses reaches the annual limit, this Plan begins paying 100 percent of the Network Allowed Amount for care from Network Providers and 100 percent of the Non-Network Allowance for care from Non-Network Providers, after any required Copayments or deductibles, for the rest of the calendar year. You meet the family out-of-pocket Coinsurance maximum (if applicable) when the Coinsurance expenses of two of your covered family members or a combination of covered family members adds up to the family coinsurance maximum.

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

1. calendar year and inpatient Hospital deductibles;
2. Copayments for office visits, urgent care visits and emergency room visits;
3. charges for services and supplies that are not covered by this Plan;
4. charges greater than the Non-Network Allowance for Non-Network Providers;
5. charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment; and
6. pre-admission certification or other penalties.

Global Network Out-Of-Pocket Maximum

There is a limit on the amount you will pay out-of-pocket toward covered expenses during any calendar year for network Covered Services and Supplies and prescription drugs. Under individual coverage, once your share of network out-of-pocket expenses reaches the global network out-of-pocket maximum, this Plan begins paying 100 percent of the Network Allowed Amount for network Covered Services and Supplies and prescription drugs for the remainder of the calendar year for you. You meet the family global network out-of-pocket maximum when two covered family members or a combination of covered family members meet the family global network out-of-pocket maximum. Only expenses for network Covered Services and Supplies and prescription drugs count toward the global network out-of-pocket maximum; expenses that apply to this maximum include:

1. Network expenses that applied to the annual calendar year deductible;
2. Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Network emergency room Copays;
4. Network hospital per admission deductibles;
5. Network office visit Copays; and
6. Network prescription drug Copays.

Expenses that do not apply to the global network out-of-pocket maximum include:

1. Non-Network expenses that applied to the annual calendar year deductible;
2. Non-Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Non-Network emergency room Copays;
4. Non-Network hospital per admission deductibles;
5. Non-Network office visit Coinsurance;
6. Charges for services, supplies and prescription drugs that are not covered by this Plan;
7. Charges for Covered Services and Supplies and prescription drugs that are greater than Plan limits for dollar amounts, number of treatments, or number of days of treatment;
8. Charges and/or penalties for not obtaining pre admission certification and/or exceeding approved days of hospital stay certification;
9. Non-Network prescription drugs;
10. Specialty drugs that are denied by the Specialty Guideline Management Program;
11. 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,
12. The difference between the cost of a generic drug and a 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.

The Plan Pays a Share of Covered Expenses

Benefits are paid at two different levels. The level you receive depends on whether your care is provided by Network Providers or Non-Network Providers.

This Plan pays benefits for covered services based on the Network Allowed Amount for network care and the Non-Network Allowance for non-network care. The Network Allowed Amounts are preferred rates Florida Blue has negotiated with Network Providers, and NetworkProviders are not allowed to charge you for any amounts above the Network Allowed Amounts. When you use Network Providers, you take advantage of the preferred rates of the Network Allowed Amounts and the Plan pays the highest level of benefits, keeping your cost down.

When you receive services from Non-Network Providers by choice or even if you have no choice in the selection of the Non-Network Provider, this Plan pays benefits based on the Non-Network Allowance, not the providers' billed charges. If your provider charges more than the Non-Network Allowance, you are responsible for any amounts above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. In addition, because the Plan often pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

In selecting Florida Blue as the Medical Claim Administrator for the State Employees' PPO Plan, DSGI agreed to accept the Non-Network Allowance schedule used by Florida Blue to make payment for specific health care services submitted by Non-Network Providers.

In the case of a Non-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Non-Network Provider for the specific Covered Services provided to you, the Non-Network Allowance will be the lesser of that Non-Network Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to:

- payment for such Covered Services under the Medicare and/or Medicaid programs;
- payment often accepted for such Covered Services by that Non-Network Provider and/or by other providers, either in Florida or in other comparable market(s), that Florida Blue determines are comparable to the Non-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Non-Network Provider and/or by other providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations);

- payment amounts which are consistent, as determined by Florida Blue, with our provider network strategies (e.g., does not result in payment that encourages providers participating in a Florida Blue network to become non-participating); and/or,
- the cost of providing the specific Covered Services.

In the case of a Non-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard® Program, the Non-Network Allowance for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the services were provided at the amount such organization would pay Non-Network Providers in its geographic area for such services.

In no event will the Non-Network Allowance be greater than the amount the Non-Network Provider actually charges.

If a particular Covered Service is not available from any provider that is in PPC℠, as determined by Florida Blue, the Non-Network Allowance, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar providers in a geographical area established by Florida Blue.

You may get an estimate of the Non-Network Allowance or the Network Allowed Amount for particular services by calling Florida Blue Customer Service toll-free at 1-800-825-2583. The fact that Florida Blue or DSGI may provide you with such information does not mean that the particular service is a Covered Service. All terms and conditions included in this Plan Booklet and Benefits Document apply. Please refer to Section 1 (Standard PPO Option Summary of Benefits), Section 2 (PPO High Deductible Health Plan Option Summary of Benefits), Section 3 (Covered Services), and Section 5 (Exclusions) for more detailed information on the Plan and member cost share amounts, covered services, and exclusions.

Keep in mind that you will receive benefits at the non-network level whenever you use Non-Network Providers.

See section 6 for more information about the PPC℠ network.

The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

Section 2: PPO High Deductible Health Plan Option Summary of Benefits

This summary provides an overview of the PPO High Deductible Health Plan Option. For further information on the coverage and benefits of this Plan, as well as applicable limitations and exclusions, please refer to sections 3 (Covered Services), 5 (Exclusions), 7 (Additional Required Provisions) and 15 (Definitions) of this booklet. **If you are enrolled in the Standard PPO Option, please refer to section 1, entitled "Standard PPO Option Summary of Benefits."**

Benefit Description	Network	Non-Network*
Calendar Year Deductible/Copays/Limits		
Calendar Year Deductible (CYD) Individual Purchaser Family Purchaser	CYD $1,350 $2,700	 $2,500 $5,000
Coinsurance Maximum (OOP) Individual Purchaser Family Purchaser	 $3,000 $6,000	 $7,500 $15,000
Global Network (OOP) Maximum Individual Purchaser Family Purchaser	 $4,350 $8,700 (no one person shall exceed $6,750)	 N/A
Emergency Room (ER) Facility Services Copay (per visit)	No copay, subject to CYD	
Per Admission Deductible (PAD) Inpatient Hospital	No PAD; subject to CYD	$1,000 after CYD
Physician Office Convenient Care Center Urgent Care Center	Subject to Coinsurance and CYD	
Hospital Services		
Room and Board (R&B) (semi-private) Admission Certification/ Hospital Stay Certification (AC/ HSC) required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Intensive/Progressive Care AC/HSC required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Emergency Room	80% of Allowed Amt after CYD	80% of Allowance after CYD
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, operating room, etc.)	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Outpatient Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Partial Hospitalization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physician Services		
Emergency Room	80% of Allowed Amt after CYD	80% of Allowance after CYD
Hospital Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Office Visit	80% of Allowed Amt after CYD	60% of Allowance after CYD
Outpatient Services (outpatient visits, consultations, maternity care, etc.)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Pathology/Radiology/ Anesthesiology	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Physician Services		
Preventive Care-Adult (Screening mammograms are included in Preventive Adult Care)	100% of Allowed Amt	100% of Allowance
Preventive Care-Children	100% of Allowed Amt	100% of Allowance
Surgery (Inpatient/Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Urgent Care Center	80% of Allowed Amt after CYD	80% of Allowance after CYD
Other Covered Facility Services		
Ambulatory Surgical Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Birthing Center	80% of Allowed Amt after CYD	60% of Allowance after CYD
Osteopathic Hospital (Inpatient) AC/HSC required except for physical rehab admissions	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Outpatient Facility	80% of Allowed Amt after CYD	60% of Allowance after CYD
Rehab Hospital (Inpatient) AC/HSC not required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Rehab Hospital (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Skilled Nursing Facility Not subject to PAD; AC/HSC not required	70% of Allowed Amt after CYD	70% of Allowance after CYD
Specialty Facility (Inpatient) AC/HSC required	80% of Allowed Amt after CYD	60% of Allowance after PAD and CYD
Specialty Facility (Outpatient)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Home Health Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Residential Treatment Services	80% of Allowed Amt after PAD	60% Allowance after PAD and CYD
Other Covered Services		
Acupuncture	80% of Allowed Amt after CYD	60% of Allowance after CYD
Ambulance	100% of Allowed Amt after CYD	100% of Covered Charge after CYD
Autism	80% of Allowed Amt after CYD	60% of Allowance after CYD
Cleft Lip and Cleft Palate	80% of Allowed Amt after CYD	60% of Allowance after CYD
Contraceptives, supplies and related services	Paid according to the type of service rendered as noted above for Preventive Adult Care, Physician office visits, other Physician services, Durable Medical Equipment, and prescription drugs.	
Dental Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Durable Medical Equipment (DME)/Supplies	80% of Allowed Amt after CYD	60% of Allowance after CYD
Eye Glasses or Contacts	80% of Allowed Amt after CYD	60% of Allowance after CYD

Benefit Description	Network	Non-Network*
Other Covered Services		
Limited Fertility Testing and Treatment	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hearing Tests	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mammograms (diagnostic and/ or medical)	80% of Allowed Amt after CYD	60% of Allowance after CYD
Manipulative Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Mastectomy and Reconstructive Surgery	80% of Allowed Amt after CYD	60% of Allowance after CYD
Maternity Care	80% of Allowed Amt after CYD	60% of Allowance after CYD
Midwife Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Physical/Massage/Occupational Therapy	80% of Allowed Amt after CYD	60% of Allowance after CYD
Prescription Drugs (CVS Caremark) Participating Retail Pharmacy (30-day supply) Participating Retail Pharmacy (90-day supply) Mail Order Pharmacy (90-day supply)	Generic/Preferred Brand/ Non-Preferred Brand 30% / 30% / 50% 30% / 30% / 50% 30% / 30% / 50% (after In-Network CYD)	You pay in full and file claim (see section 9 for reimbursement information)
Prostheses	80% of Allowed Amt after CYD	60% of Allowance after CYD
Surgical Sterilization	80% of Allowed Amt after CYD	60% of Allowance after CYD
Transplants	80% of Allowed Amt after CYD	60% of Allowance after CYD
Weight Loss Services	80% of Allowed Amt after CYD	60% of Allowance after CYD
Wigs	80% of Allowed Amt after CYD	60% of Allowance after CYD
Hospice Care		
Hospice Inpatient	70% of Allowed Amt after CYD	70% of Allowance after CYD
Hospice Outpatient/Home	80% of Allowed Amt after CYD	80% of Allowance after CYD

Note: Certain categories of Network Providers may not currently be available in all geographic regions. Additionally, certain providers (e.g., radiologists, anesthesiologists, pathologists, emergency room Physicians, Hospitalists) rendering care at network facilities may not be Network Providers and are, therefore, subject to non-network benefits unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

These are the benefits provided the coverage is active (i.e., in effect) when the services are rendered. Oral and written statements cannot modify the coverage or benefits described in this Plan Booklet and Benefits Document.

*** The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance except when provided in an emergency or an in-network facility.**

Plan Maximums

Hospice Care days per person per lifetime 210

Lifetime Benefit Maximum per person per lifetime (includes presciption drugs) . . . . . Not Applicable

Manipulative Services per person per calendar year . . . . . 26 treatments

Massage and/or Physical Therapy (excluding occupational therapy for the treatment of Autism Spectrum Disorder, Down Syndrome)

Treatments per day; and 4
Days per 6-month period 21

Occupational Therapy (excluding physical therapy for the treatment of Autism Spectrum Disorder and Down syndrome and under hospice and home health care services)

Days per 6-month period 21

Skilled Nursing Facility days per person per calendar year 60

Weight Loss Services (non-surgical) per person per 12-month period $150

Wigs per person per event $40

Understanding Your Share of Health Care Expenses

How the Plan Pays Benefits

Office Visits

For office visits, the amount you pay depends on whether you use a network or non-network physician or other health care provider. You pay a percentage of the Network Allowed Amount for Network Providers and a percentage of the non-Network Allowance for non-Network Providers, after the calendar year deductible is satisfied.

If you use non-network Physicians or other health care providers, you will pay any amount above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. See page 2-6 for more information about the network Allowed Amount and the Non-Network Allowance.

Emergency Room Visits

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

1. Facility
   The Plan pays a percentage of the Network Allowed Amount or Non-Network Allowance after you meet the calendar year deductible you pay the remaining coinsurance percentage.
2. ER Physician or Other Health Care Provider
   The Plan pays a percentage of the Network Allowed or Non-Network Allowance, after you meet the calendar year deductible. You are responsible for your share of the Coinsurance. It is not uncommon to receive ER Physician or other health care provider services from a Non-Network Provider in a network facility.

Deductible

Before this Plan pays benefits for covered expenses, you must meet a calendar year deductible. Both health and prescription expenses are applied to the calendar year deductible on the PPO High Deductible Health Plan Option. The calendar year deductible applies each January 1 to December 31. The deductible will not roll over to the following year.

Once the calendar year deductible is met, this Plan pays a percentage of the Network Allowed Amount for Network Providers and a percentage of the Non-Network Allowance for Non-Network Providers. Please refer to page 2-6 for more information regarding your share of expenses for Non-Network Providers.

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

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, you can meet the individual/family deductible in one of two ways:

1. one family member can meet the individual calendar year deductible, after which the Plan begins paying a percentage of that family member's eligible expenses; or
2. all family members can combine their eligible expenses to meet the family deductible, after which the Plan begins paying a percentage of all family members' eligible expenses

How the Deductible Works

Assume Joe and his family are covered under the PPO High Deductible Health Plan Option, and had the following covered medical expenses during the first three months in a calendar year. All the expenses are for care from Network Providers.

Joe	**$1,200**
Wife	**$1,125**
Daughter	**$ 300**
Son	**+ $ 75**
network family deductible	**$2,700**

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

The calendar year deductible on the PPO High Deductible Health Plan Option applies to all services you receive under the policy, except for preventive care.

Calendar Year Coinsurance Maximum

There is a limit on the amount of Coinsurance you pay out of your pocket toward covered expenses in any one calendar year for network and non-network care

combined. Under an individual contract/policy, once your share of out-of-pocket Coinsurance expenses reaches the individual annual coinsurance maximum, this Plan begins paying 100 percent of the Network Allowed Amount for care from Network Providers and 100 percent of the Non-Network Allowance for care from Non-Network Providers, for the rest of the calendar year. Under a family contract/policy, you meet the family aggregate out-of-pocket Coinsurance maximum (if applicable) when the Coinsurance expenses of one, or a combination of your covered family members, add up to the family maximum.

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

1. calendar year and inpatient Hospital deductibles;
2. charges for services and supplies that are not covered by this Plan;
3. charges greater than the Non-Network Allowance for Non-Network Providers;
4. charges greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment; and
5. pre-admission certification or other penalties

Global Network Out-of-Pocket Maximum

There is a limit on the amount you will pay out-of-pocket toward covered expenses during any calendar year for network Covered Services and Supplies and prescription drugs. Under individual coverage, once your share of network out-of-pocket expenses reaches the global network out-of-pocket maximum, this Plan begins paying 100 percent of the Network Allowed Amount for network Covered Services and Supplies and prescription drugs for the remainder of the calendar year for you. You meet the family global network out-of-pocket maximum when two covered family members or a combination of covered family members meet the family network out-of-pocket maximum. However, no one family member shall exceed $6,750. Only expenses for network Covered Services and Supplies and prescription drugs count toward the global network out-of-pocket maximum; expenses that apply to this maximum include:

1. Network expenses that applied to the annual calendar year deductible;
2. Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Network emergency room Coinsurance;
4. Network hospital per admission deductibles and Coinsurance;
5. Network office visit Coinsurance; and
6. Network prescription drug Coinsurance.

Expenses that do not apply to the global network out-of-pocket maximum include:

1. Non-Network expenses that applied to the annual calendar year deductible;
2. Non-Network expenses that applied to the annual coinsurance out-of-pocket maximum;
3. Non-Network emergency room Coinsurance;
4. Non-Network hospital per admission deductibles and Coinsurance;
5. Non-Network office visit Coinsurance;
6. Charges for services, supplies, and prescription drugs that are not covered by this Plan;
7. Charges for Covered Services and Supplies and prescription drugs that are greater than Plan limits for dollar amounts, number of treatments, or number of days of treatment;
8. Charges and/or penalties for not obtaining pre admission certification and/or exceeding approved days of hospital stay certification;
9. Non-Network prescription drugs;
10. Specialty drugs that are denied by the Specialty Guideline Management Program;
11. 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,
12. The difference between the cost of a generic drug and a 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.

The Plan Pays a Major Share of Covered Expenses

Benefits are paid at two different levels. The level you receive depends on whether your care is provided by Network Providers or Non-Network Providers.

This Plan pays benefits for covered services based on the Network Allowed Amount for network care and the Non-Network Allowance for non-network care. The Network Allowed Amounts are preferred rates Florida Blue has negotiated with Network Providers, and Network Providers are not allowed to charge

you for any amounts above the Network Allowed Amounts. When you use Network Providers, you take advantage of the preferred rates of the Network Allowed Amounts and the Plan pays the highest level of benefits, keeping your cost down.

When you receive services from Non-Network Providers by choice or even if you have no choice in the selection of the Non-Network Provider, this Plan pays benefits based on the Non-Network Allowance, not the provider's billed charges. If your provider charges more than the Non-Network Allowance, you are responsible for any amounts above the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies. In addition, because the Plan often pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

In selecting Florida Blue as the Medical Claim Administrator for the State Employees' PPO Plan, DSGI agreed to accept the Non-Network Allowance schedule used by Florida Blue to make payment for specific health care services submitted by Non-Network Providers.

In the case of a Non-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Non-Network Provider for the specific Covered Services provided to you, the Non-Network Allowance will be the lesser of that Non-Network Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to:

- payment for such Covered Services under the Medicare and/or Medicaid programs;
- payment often accepted for such Covered Services by that Non-Network Provider and/or by other providers, either in Florida or in other comparable market(s), that Florida Blue determines are comparable to the Non-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Non-Network Provider and/or by other providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations);
- payment amounts which are consistent, as determined by Florida Blue, with our provider network strategies (e.g., does not result in payment that encourages providers participating in a Florida Blue network to become non-participating); and/or,
- the cost of providing the specific Covered Services.

In the case of a Non-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard® Program, the Non-Network Allowance for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the services were provided at the amount such organization would pay Non-Network Providers in its geographic area for such services.

In no event will the Non-Network Allowance be greater than the amount the Non-Network Provider actually charges.

If a particular Covered Service is not available from any provider that is in PPC℠, as determined by Florida Blue, the Non-Network Allowance, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar providers in a geographical area established by Florida Blue.

You may get an estimate of the Non-Network Allowance or the Network Allowed Amount for particular services by calling Florida Blue Customer Service toll-free at 1-800-825-2583. The fact that Florida Blue or DSGI may provide you with such information does not mean that the particular service is a Covered Service. All terms and conditions included in this Plan Booklet and Benefits Document apply. Please refer to Section 1 (Standard PPO Option Summary of Benefits), Section 2 (PPO High Deductible Health Plan Option Summary of Benefits), Section 3 (Covered Services), and Section 5 (Exclusions) for more detailed information on the Plan and member cost share amounts, covered services, and exclusions.

Keep in mind that you will receive benefits at the non-network level whenever you use Non-Network Providers.

See section 6 for more information about the PPC℠ network.

The Non-Network Allowance is not the provider's billed charges and could be significantly less than the provider's billed charges. The patient is responsible for 100 percent of the difference between the billed charges and the Non-Network Allowance unless under applicable law the Non-Network Provider is under a duty to accept the applicable Non-Network Allowance plus applicable deductibles, Copays and Coinsurance as payment in full for Covered Services and Supplies.

Section 3: Covered Services

Covered Service Categories

Acupuncture

Services must be provided by a medical Doctor, a Doctor of Osteopathy, a chiropractor certified in Acupuncture, or a certified Acupuncturist.

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.

Autism Spectrum Disorder and Down Syndrome

Treatment for Autism Spectrum Disorder and Down syndrome is covered for an individual that was diagnosed as having a Developmental Disability at eight years 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 and Down syndrome, speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis. Applied Behavioral Analysis is covered when provided by Applied Behavioral Analysts, psychologists, clinical social workers, and others within the scope of their license. Coverage is limited to treatment prescribed by the treating physician in accordance with a treatment plan.

The PPO Plan covers Autism Spectrum Disorder and Down syndrome in accordance with s. 627.6686, Florida Statutes.

Cleft Lip and Cleft Palate

Treatment is covered for children less than 18 years of age, including medical, dental, speech therapy, audiology and nutrition services.

Clinical Trials

Routine patient care for Covered Services and Supplies provided in direct connection with your participation in an Approved Clinical Trial including the Florida Clinical Trial Compact may be covered when:

1. You are deemed eligible to participate in such Approved Clinical Trial, and
2. A Network Provider has indicated such Approved Clinical Trial is appropriate for you, or
3. You provide Florida Blue with medical and scientific information establishing that your participation in such Approved Clinical Trial is appropriate.

Routine patient care includes all Medically Necessary Services and Supplies that are otherwise covered under this Plan, such as doctor visits, prescription drugs, lab tests, x-rays and scans and hospital stays related to treatment of your covered Condition. Your cost share will be the same for this routine patient care as it would have been if such routine patient care had not been provided in connection with an Approved Clinical Trial.

Contraceptives

Medical services and supplies related to contraceptive management are covered under the medical component administered by Florida Blue. For contraceptive prescription coverage, please refer to the prescription drug program section.

With respect to Women's Preventive Services only, and to the extent required by federal law, contraceptive coverage is limited to at least one form of contraception in each of the eighteen methods identified in the FDA's most current Birth Control Guide and limited to generic products when available. Other contraceptives may be covered

based on medical necessity. The Plan will pay 100 percent of the network allowed amount or 100 percent of the non-network allowance. You will be responsible for the total amount above the non-network allowance.

Cosmetic Services

Cosmetic services, including any service to improve the appearance or self-perception of an individual, if the service is:

1. a result of a covered Accident and the surgery or treatment is performed while the person is covered by this Plan;
2. for correction of a Congenital Anomaly for an eligible dependent and performed while the dependent is covered by this Plan;
3. a Medically Necessary procedure to correct an abnormal bodily function;
4. for reconstruction to an area of the body that has been altered by the treatment of a disease;
5. for breast reconstructive surgery and the prosthetic devices related to a mastectomy; or
6. for hair loss related to a covered medical condition or covered immune related disorder.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician, and "breast reconstructive surgery" means surgery to re-establish symmetry between the two breasts.

Cosmetic services that are not identified in paragraphs 1-6 above are excluded under Section 5: Exclusions of this Plan.

Dental

Dental care is limited to the following:

1. Care and treatment rendered within 120 days of an **Accidental Dental Injury**, unless an extension is requested and approved in writing by Florida Blue, provided such services are for the treatment of damage to sound natural teeth. Services must be provided within 120 days of the Accidental Dental Injury unless a written explanation from the dentist or Physician stating any extenuating circumstances requiring treatment over a longer period of time is received and approved, in writing, by Florida Blue as Medically Necessary within 120 days. In no instance will any services be covered unless provided within 120 days of the termination of the person's coverage. Orthodontia is never covered, even if necessary as a result of an Accidental Dental Injury. No services will be covered if provided more than 120 days after the termination of the person's coverage.
2. Facility charges for Medically Necessary services provided in a Hospital, Ambulatory Surgical Center, Outpatient Health Care Facility, or Skilled Nursing Facility. Physician services (including general and specialty dentists and oral surgeons) and services provided by other treatment providers are not covered.
3. Anesthesia services, including general anesthesia and hospitalization services, required to assure the safe delivery of necessary dental care provided in a Hospital or Ambulatory Surgical Center if:

   a. the covered dependent is under 8 years of age and it is determined by a dentist and the covered dependent's Physician that:

      i. dental treatment is necessary due to a dental Condition that is significantly complex; or

      ii. the covered dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or

   b. you or your covered dependent have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Diabetes Outpatient Self-Management

Diabetes outpatient self-management training and educational services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes and pre-diabetes, if your treating physician or a physician who specializes in the treatment of diabetes certifies that such services are medically Necessary, are covered. In order to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed dietitian. Covered services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diabetes equipment and supplies will be covered in accordance with the terms and conditions of the prescription drug coverage section of this Plan Booklet and Benefits Document.

Drugs and Pharmaceutical Products

The following may be covered under the medical portion of the Plan:

1. Drugs, medicines, medications, treatments, and/or immunizations that are consumed and/or administered at a covered health care provider's office or other covered inpatient or outpatient health care facility; and,
2. Drugs, medicines, supplies, treatments, and/or medications that must be administered under the direct supervision of a covered health care provider.

The medical portion of the Plan does not cover drugs, medicines, supplies, medications, and treatments that are:

1. typically filled by a prescription order;
2. provided at no cost to the member;
3. over-the-counter drugs, supplies, and treatments;
4. injectable self-administered and do not require medical supervision; and,
5. take home drugs, supplies, treatments furnished by the health care provider that can be dispensed by a retail or mail order pharmacy.

Durable Medical Equipment (DME)

Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, Hospital beds, TENS units, CPAP devices and oxygen equipment. Repair or replacement of DME due to growth of a child or due to a change in your Condition may be covered. Supplies and service to repair DME may be covered only if you own or are purchasing the equipment.

1. Coverage is limited to the standard model unless an upgraded model is determined to be Medically Necessary.
2. Coverage for the purchase of equipment is limited to the Network Allowed Amount or Non-Network Allowance minus any amount already paid by the Plan for rental.
3. Coverage for the rental of DME will not exceed the Network Allowed Amount or Non-Network Allowance for the purchase of such equipment; if you continue to rent such equipment, no additional payments will be made by this Plan.
4. Coverage for DME purchased after being rented will be limited to the Network Allowed Amount or Non-Network Allowance less any amount already paid by the Plan for rental.
5. Coverage for one breast pump per birth; 100 percent of network allowed amount or 100 percent of non-network allowance.

Enteral Formulas

Prescription and non-prescription enteral formulas for home use when prescribed by a physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period are covered.

Coverage to treat inherited diseases of amino acid and organic acids, up to age 25, shall include coverage for food products modified to be low protein.

Eye Glasses or Contacts

Coverage is limited to standard frames and lenses for the first pair of eyeglasses or contacts following an accident to the eye or cataract surgery.

Fertility Testing and Treatment

Tests to determine the cause of infertility and the treatment of medical conditions resulting in infertility are covered services. Fertility tests and treatments considered experimental or Investigational are not covered. Please refer to the exclusions section for further information.

Hearing Tests

Hearing tests are covered after related covered ear surgery or when Medically Necessary for diagnosis of a covered condition other than hearing loss. Hearing tests for supplying or fitting of a hearing aid are not covered. Hearing tests may be covered under preventive care.

Newborn screening for the detection of hearing loss

All newborns in the State of Florida will be screened, or referred for screening in the case of home births or births at a Birthing Center, for the early detection of possible hearing loss. Hearing screening tests, when ordered by your treating physician, will include auditory brainstem responses, evoked otoacoustic emissions, or other appropriate technology as approved by the United States Food and Drug Administration. This Plan covers these services and any Medically Necessary follow-up re-evaluations

leading to a diagnosis. Hospitals are required to screen newborns for the detection of hearing loss prior to discharge, but no later than 30 days after discharge. If your child is born at a Birthing Center, the Birthing Center is required to refer your newborn within 30 days after discharge for these hearing screenings. If your child is born at home, the attending health care provider will refer your newborn within three months after your child's birth for these hearing screenings. A licensed audiologist, Physician, Hospital or other newborn hearing-screening provider can provide hearing screenings. You, as the parent or legal guardian, may object in writing, to the health care provider attending your child and prevent your child from receiving these hearing screenings.

Home Health Care

Services include, but are not limited to: nursing services, treatment, physical therapy, respiratory therapy, occupational therapy, equipment, medication and supplies.

Services must meet all the following criteria:

- You must be confined at home, restricted in ambulation, convalescing, or significantly limited in physical activity due to a Condition.
- Services must be provided directly by (or indirectly through) a Home Health Agency.
- Service must be prescribed by a Physician and include a formal written treatment plan that is reviewed and updated every 30 days by the prescribing Physician. A copy of the written treatment plan may be required.
- You must meet or achieve the treatment goals set forth in the treatment plan and documented in the clinical progress notes.

Hospice Care

Treatment for, and counseling of, terminally ill patients whose doctor has certified that they have less than six months to live are covered. In order to be covered, hospice services must be provided by an approved hospice program. Unless prior approval has been received from Florida Blue, services of a person who normally resides in the home of the terminally Ill patient or member of the patient's family or spouse's family are not covered.

Coverage includes the following services:

In-Home Care

1. Physician services;
2. physical, respiratory and occupational therapy;
3. drugs, medicines and Medical Supplies;
4. private duty nursing services in a series of shifts (e.g., three eight-hour shifts);
5. Home Health Aide services;
6. rental of Durable Medical Equipment; and
7. oxygen.

Hospice Outpatient Care

1. Physician services;
2. laboratory, x-ray and diagnostic testing; and
3. same covered services as in-home Hospice care.

Hospice Inpatient Care

1. room and board and general nursing services, including the cost of overnight visitations by covered family members;
2. inpatient care services same as inpatient Hospital care; and
3. same covered services as in-home and outpatient Hospice care.

While in the hospice program, regular Plan benefits are not payable for expenses related to the terminal illness.

Prospective reimbursement for hospice treatment can be requested. To do this, the hospice program submits a 90-day treatment plan for hospice care. If approved by Florida Blue, payments are made every 30 days as treatment is completed. A second 90-day treatment plan may be submitted if the patient continues in hospice care. One additional treatment plan for 30 days may be submitted after two 90-day plans are completed. No further benefits are payable after 210 days.

Occupational therapy is covered as a component of hospice care.

Mammograms

Screening mammograms are covered in accordance with current A and B recommendations of the U.S. Preventive Services Task Force and state law.

Medically Necessary (diagnostic) mammograms are covered at any age. Screening mammograms are included in adult preventive services benefit.

Manipulative Services

Payment for Manipulative Services is limited to 26 treatments per calendar year.

Mastectomy and Reconstructive Services

Coverage includes:

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.

Maternity Care

Maternity coverage includes covered hospital stays for the mother. Covered services related to an eligible newborn will be covered only if the newborn is added to the member's coverage within the enrollment guidelines specified in Section 10. If the newborn is not added to the coverage within the specified guidelines, the PPO Plan will only cover the initial newborn assessment as set forth in s. 627.6574, Florida Statutes.

About maternity care: coverage for mothers and newborns

Under federal law, group health plans offering group health insurance generally may not:

1. restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Cesarean section. However, the Plan may pay for a shorter stay if the attending provider (for example, the Physician, nurse Midwife or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier;
2. set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay; or
3. require that a Physician or other health care provider obtain authorization for prescribing a length of stay up to 48 or 96 hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. See section 7 or contact Florida Blue for information about pre-certification.

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

Breastfeeding support and/or lactation services are covered services when rendered:

1. in a physician office setting by a physician, advanced registered nurse practitioner under the supervision of a physician, certified lactation specialist, or other health care provider operating within the scope of their license; or
2. in an inpatient Hospital or outpatient Hospital setting.

NOTE: Covered services related to an eligible newborn will be covered only if the newborn is added to the member's coverage within the enrollment guidelines specified in Section 10. If the newborn is not added to the coverage within the specified guidelines, the PPO Plan will only cover the initial newborn assessment as set forth in s. 627.6574, Florida Statutes.

Mental Health and Substance Dependency Services

Physician office visits, Intensive Outpatient Treatment, Inpatient and Partial Hospitalization and Residential Treatment Services are covered based on medical necessity.

Nursing Services

Nursing care, including inpatient private duty nursing, by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) is covered.

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 shall not exceed 21 treatment days during any six-month period, counting backwards from the date of each treatment. 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 also covered for the treatment of Autism Spectrum Disorder and Down Syndrome and under both home health care and hospice services.

Physical Therapy and Massage Therapy

Physical therapy services must be for the purpose of aiding in the Rehabilitation of normal physical function lost due to a covered accident, injury or surgical procedure. Physical therapy is also covered for the treatment of Autism Spectrum Disorder and Down syndrome.

Payment for physical and massage Therapy is limited to a combined maximum of 4 treatments per day, not to exceed 21 treatment days during any six-month period, counting backwards from the date of each treatment. This maximum applies to all out-patient physical and massage therapy treatments, regardless of location of service.

Massage Therapy requires a physician's, Advanced Registered Nurse Practitioner's, or Physical Therapist's prescription noting medical necessity and specifying the number of treatments required, however, not to exceed the physical and massage Therapy maximum noted above. Massage Therapy may be provided by a physician, a chiropractor, a licensed physical Therapist or licensed massage Therapist. Physical therapy may be provided by a physician, chiropractor, or a licensed physical Therapist.

Physician Services

Physician office visits for services, related to disease, Illness, injury, accident and preventive care may be covered.

1. There are some special limits on how Doctor visits will be covered by this Plan.

    a. Whenever you are receiving medical care related to surgery, additional inpatient visits from your Doctor are covered only if:

        i. you need medical care that is not related to your surgery and is not part of your pre-operative or post-operative care; and

        ii. you are hospitalized for medical care and the need for surgery develops after you are first admitted to the Hospital. In this case, payment for Doctor visits for other medical care will generally end on the date of surgery.

    b. Non-surgical inpatient Doctor visits are limited to one visit by one Doctor each day. Visits from other Doctors may be covered, however, if needed because of the severity or complexity of your Condition.

    c. Inpatient or outpatient visits to one Doctor for a non-surgical Condition, or related Conditions, are limited to one visit per day.

    d. Outpatient Doctor visits on the same day you have inpatient surgery will not be covered unless the outpatient visit is unrelated to your surgery or is with a Doctor who is not performing your surgery.

2. Outpatient office visits on the same day you have outpatient surgery will not be covered if the charge for the office visit is determined by Florida Blue to be included in the surgery charge. An office visit to a Doctor who is not performing your surgery will be covered, provided the services rendered are covered services as described in this section.

Preventive Care Services

To be eligible for coverage, all services must be for routine preventive care, not for medical diagnosis. Immunizations are covered only within the provisions noted below or when medically Necessary as the result of an accident or injury.

If you use a network Provider, the Plan will pay 100 percent of the allowed amount and you will have no out-of-pocket expenses for eligible services and immunizations. If you use a Non-Network Provider, the Plan will pay 100 percent of the non-network allowance and you will be responsible for the total amount above the Non-Network Allowance. You will be responsible for any costs for services and immunizations in excess of those covered under this provision.

Preventive Care - Adult and Child

Preventive health care (including screening mammograms) and immunization benefits for all covered members shall be age and gender based in accordance with the current grade A and B recommendations of the U.S. Preventive Services Task Force as provided by the Patient Protection and Affordable Care Act and medical policy guidelines established by Florida Blue for preventive services. The assessment of the risk of falls for older adults is included in a preventive care wellness examination or E&M (evaluation and management) visit. Information on covered immunizations and preventive health care services can be found at

www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations, www.cdc.gov/vaccines/acip, and *www.healthcare.gov/coverage/preventive-care-benefits*.

Covered preventive care services are not subject to a Per Visit Fee (PVF) or calendar year deductible (CYD). Medical/diagnostic mammograms are not included in the preventive care benefit.

Additional Women's Preventive Services: to the extent required by federal law the following services are covered for all female members: human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus (HIV); screening and counseling for interpersonal and domestic violence; screening for gestational diabetes; breastfeeding support, supplies (limited to one breast pump per birth), and counseling; annual well woman visits expanded to include prenatal care, contraceptive counseling and at least one form of contraception in each of the eighteen methods identified in the FDA's most current Birth Control Guide and limited to generic products when available. Other contraceptives may be covered based on medical necessity. For all expanded women's preventive services the Plan will pay 100 percent of the network allowed amount or 100 percent of the non-network allowance. You will be responsible for the total amount above the non-network allowance.

Tobaccco screening, cessation counseling and 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 Task Force are covered.

Prostheses

Artificial limbs or eyes may be covered, limited to the first such permanent prosthesis. Coverage is limited to the standard model unless an upgraded model is determined to be medically Necessary. Coverage may be provided for Medically Necessary replacement of a prosthetic device which is owned by you when the replacement is due to irreparable damage, wear, or a change in your condition, or when necessitated due to growth of a child.

Skilled Nursing Facility

Skilled Nursing Facility services are limited to 60 days per calendar year. The patient must meet the following criteria:

1. transferred directly from a Hospital admission of at least three days; and
2. must require skilled care for a Condition that was treated in the Hospital, as certified by a Doctor.

Surgical Procedures

1. Surgery for Female Breast Reduction
   Payment for a reduction mammoplasty, which is surgery to reduce the size of the breast and the skin envelope, is not covered unless the patient is experiencing all of the following physical problems:
   a. back or neck pain requiring repeated treatment;
   b. deep grooves in the shoulder from bra straps; and
   c. dermatitis requiring long-term treatment with prescription medications.

   In addition to the physical symptoms listed above, the amount of tissue removed from each breast, according to the pathology report, must be at least:
   a. 400 grams for patients 5'2" tall and 110 pounds or less; or
   b. 500 grams for patients over 5'2" tall and 111 pounds or more.

   If fewer grams of tissue are to be removed from each breast, benefits may still be paid if:
   a. your Doctor sends a written request for approval to Florida Blue before the surgery is performed, documenting the physical problems and estimating the amount of tissue to be removed;
   b. your Doctor documents the medical reason why the actual amount of tissue was less than the guidelines;
   c. Florida Blue recommends approval; and
   d. DSGI approves the lesser amount.
2. Surgical sterilization
   Tubal ligations and vasectomies are covered, whether elective or Medically Necessary.
3. Reimbursement guidelines for multiple surgical procedures:
   If more than one surgical procedure is performed at the same time, the primary procedure will be covered at the usual benefit level for the type of provider, meaning the percentage payable for Network or Non-Network Providers.

For the secondary procedure, however, this Plan will pay the lesser of:

a. 50 percent of the Network Allowed Amount for network care, or 50 percent of the Non-Network Allowance for non-network care; or

b. 100 percent of the Doctor's fee.

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

Transplants

In order to be covered, all organ transplants require prior approval by Florida Blue except kidney or cornea. The following transplants may be covered, if prior approval is obtained (except kidney or cornea):

1. bone marrow; donor costs are covered in the same way, including limitations and non-covered services, as costs for the covered person. Donor search costs are limited to immediate family and the National Bone Marrow Donor Program;
2. heart;
3. heart/lung;
4. lung;
5. liver;
6. kidney;
7. kidney/pancreas; and
8. cornea.

Weight Loss Services

In the event that your surgeon requires you to lose weight before a Medically Necessary covered surgical procedure can safely be performed, office visits and non-surgical weight loss services may be covered.

1. Medically Necessary intestinal surgery, stomach bypass surgery or gastroplasty surgery, or
2. Medically related services, excluding prescription drugs, provided as part of a weight loss program when weight loss is required by the covered person's surgeon before performing a Medically Necessary covered surgical procedure. Coverage for these non-surgical weight loss services is limited to a maximum payment of $150 per person in any 12-month period.

Wigs

Wigs are covered 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.