PHYSICIAN MANUAL

For the Gulf Coast Health Plans
Revised October 2018

Note:

No authorizations required for colonoscopies. Cologuard coverage

Any service rendered in the office over $1000.00 and J codes (except steroids) over $500.00 will require an authorization.

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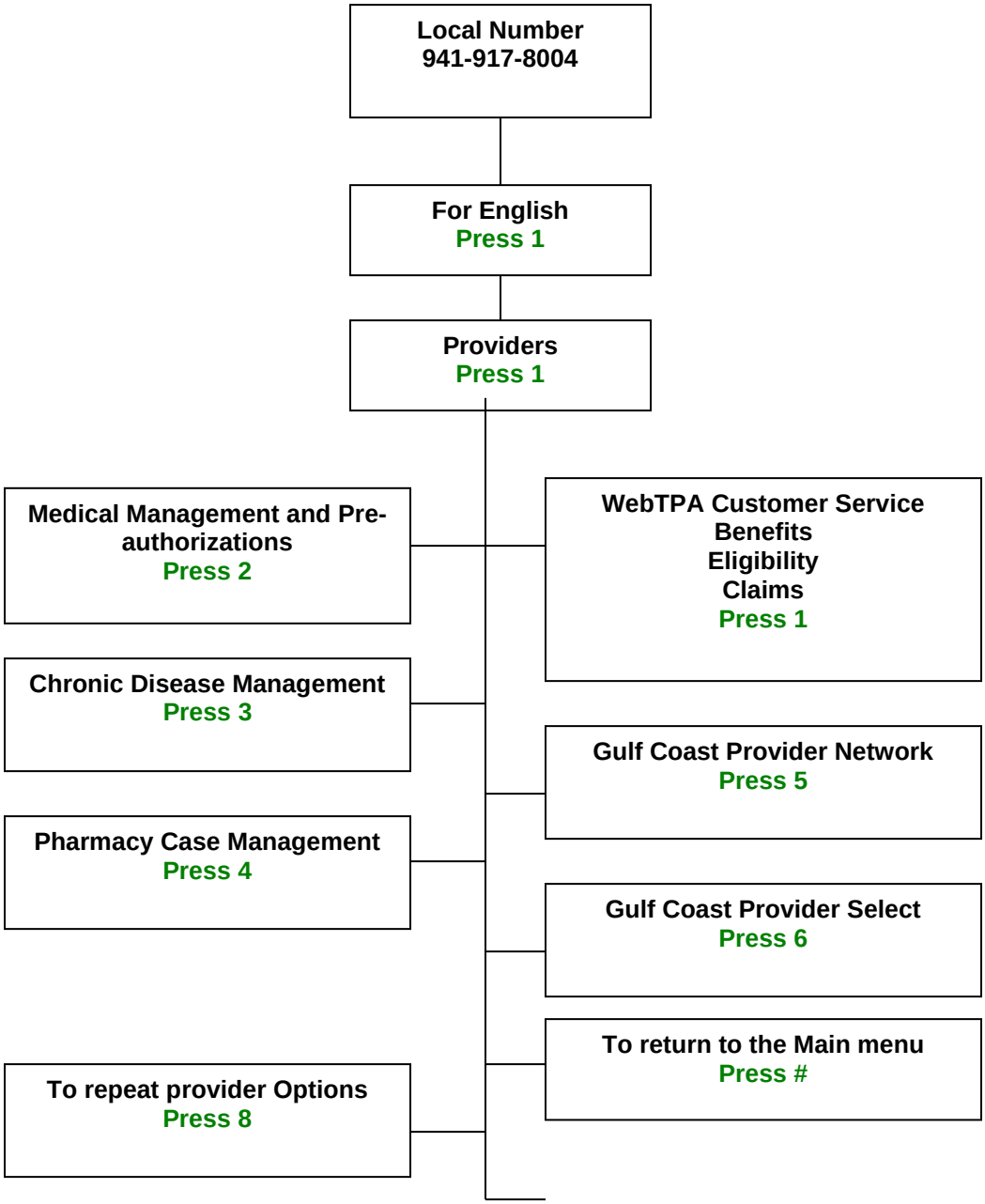
Contact Number for Gulf Coast Provider Services



Additional Contact Numbers

EAP Sarasota:	**800-425-7764 or 941-917-1240** **Behavioral Health and Substance Abuse**
Genetic Education:	**941-917-2005**
Navitus Health Systems (Pharmacy):	**800-218-1488**

Other Website Locations

WEBTPA:	***www.webtpa.com***
Gulf Coast Provider Network Select:	***www.gulfcoastprovider.net***
SMH PHO:	**www.smhpho.org**
Gulf Coast Medical Management:	**www.gulfcoastmemberservices.org**

PARTICIPATION CRITERIA

General Participation Criteria

In order to become a Gulf Coast Health Plan provider, physicians must meet the following criteria:

- Pass credentialing process
- Accept gatekeeper model
- Follow GCHP referral/authorization process
- Use in-network ancillary services for all patient encounters when required by plan design
- Perform patient/member management
- Participate in health care guideline development as requested
- Adhere to GCHP guidelines and policies
- Accept the GCHP reimbursement model
- Access and utilize healthcare management guidelines endorsed by the PHO Board
- Comply with inpatient and outpatient case management standards
- Have and use current ICD-9 (ICD 10 in 2014) and CPT-4 codes
- Meet Customer Satisfaction requirements
- Participate in orientation & education sessions for physicians and their office staff
- Exclusive use of GCHP network providers when required by plan design
- Adhere to Pharmacy Utilization guidelines and Participate with Pharmacy Case Management Program
- Participate in PHO and GCHP committees as requested
- Physician office must have internet access

Primary Care Physician Criteria and Responsibilities
A Primary Care Physician (PCP) is an Internist, Family Practitioner or Pediatrician, chosen by the GCHP member, who coordinates all care for the member, including preventive care, referrals to specialists and hospital admissions, when necessary.
PCPs are responsible for the following:

- Ensuring availability and timely scheduling of appointments
- Following referral/pre- authorization guidelines processes
- Participating in profiling and Best Practice guideline development as requested
- Adhering to guidelines
- Accepting reimbursement arrangement
- Coding and billing according to HCFA guidelines
- Having internet and fax capability at the office
- Passing GCHP credentialing requirements
- Complying with GCHP case management standards
- Referring to in-network providers when required by plan design
- Participating, along with office managers in GCHP Performance Reviews as requested

First Visit
Unless a relationship is already established with a PCP, each GCHP member is encouraged to schedule an appointment with his or her Primary Care Physician within 90 days of enrollment. This initial visit serves as the first step toward establishing a successful relationship between member and Primary Care Physician.

Specialist Criteria

All GCHP physicians are responsible for the following:

- Ensuring availability and timely scheduling of appointments
- Following referral/pre-authorization guidelines processes as defined in the GCHP Plan Design
- Participating in profiling and Best Practice guideline development as requested
- Adhering to guidelines
- Accepting reimbursement arrangement
- Coding and billing according to HCFA guidelines
- Having internet and fax capabilities at the office
- Passing GCHP credentialing requirements
- Complying with GCHP case management standards
- Referring, through the PCP, to in-network providers
- Participating, along with office managers in GCHP Performance Reviews as requested

Additionally, specialists are responsible for the following:

- When required by the plan design, Specialist must ensure that the PCP has provided a referral prior to providing services to a GCHP member.
- Specialist must ensure that all diagnostics interventions and laboratory evaluations are performed within the approved network based on plan design.
- Prior to obtaining an authorization for services that require one, specialist must ensure that the PCP provides a referral for such service.
- Obtain pre-authorizations
- Refer members back to PCP upon completion of the referral for the service perform

Note: Specialists co-pay's may be reduced from $50 to $30 after the second visit when member receives approval from the Chronic Disease Manager. Confirm with WebTPA.

On Call Coverage

GCHP Physicians engaging the services of a covering physician, who is not a participating GCHP provider, are responsible for ensuring that the covering physician accepts the GCHP fee schedule and does not "balance bill" the GCHP member.

Physicians must notify GCHP of any non-participating GCHP physician(s) in their on-call group. GCHP Physicians must instruct all covering physicians, whether GCHP or not, to write "ON CALL FOR Dr. <GCHP Physician's Name>" on the claim form.

Consultation Referral Process

1. *Plan Design*

   Aside from the exclusions* listed below:

   1. **GCHP Basic Plan**- Medical care other than that provided by a Primary Care Physician will require referral for all specialty consultations.
   2. **GCHP Comprehensive Plan**- Members are allowed two (2) visits to any specialty before a referral is required. With the exceptions outlined below, the third visit in any benefit year (10-1 to 10-1) to the same specialty will require a referral from the PCP.
   3. The first visit to the pcp **in the new benefit year requires no co-pay**

   ***Exclusions for all three GCHP Plan Designs**: The following services do not require a referral from a Primary Care Physician:

   - Visits to OB/GYN
   - Podiatry
   - Chiropractic Care
   - Dermatologists – any surgical procedure or treatment plan lesser than five visits per calendar year.
   - Mental health care does not require a referral from the member's Primary Care Physician, but it must be coordinated by EAP Sarasota.

Referral for Consultation<u>***---All referrals start on the benefit year 10-1***</u>
When a member requires medical care other than that provided by a Primary Care Physician, a referral to a specialist or ancillary provider may be required based on plan design. The referral for consultation must come from the member's Primary Care Physician. **Please note referrals expire on 9-30 and all new referrals are required starting 10-1. All referrals are approved from 10-1 <u>up to</u> 9-30 each benefit year.**

GCHP has set procedures for Primary Care Physicians to follow when making referrals for consults or referrals to network specialists and other network providers, and/or when authorization is needed for certain types of care. The procedure works like this:

1. If a visit is required, the Primary Care Physician sees the patient. If not, the patient's record is updated as necessary.

2. If specialist care is necessary, the Primary Care Physician, if required by plan design, completes a referral online at Gulfcoastmemberservices.org for consultation to the appropriate network specialist. When feasible, they should specify number and type of services and number of visits.

3. If the patient needs additional services not included in the initial referral from the PCP, they can complete another online referral and include clinicals if more that 50 visits.

4. This information will be reviewed by the Medical Management Team and after review will reply on the referral form -- approved or denied. The patient may call WebTPA for additional information.

5. The following services do not require a referral from a Primary Care Physician:
   - Visits to OB/GYN
   - Podiatry
   - Chiropractic Care
   - Dermatologists – any surgical procedure or treatment plan greater than five visits per benefit year will require a referral.
   - Mental health care does not require a referral from the member's Primary Care Physician, but it must be coordinated by EAP Sarasota.
   - Durable Medical Equipment – However an authorization is required for DME if over $500.
   - Allergy testing does not require a referral
   - Allergy serum and shots do not require a referral unless an office visits occurs with these services.
   - <u>PLEASE NOTE: Referrals are not required for any services in the office that is not billed as an office visit.</u>

All Referrals must be entered online at www.gulfcoastmemberservices.org Only Primary Care Physician offices can request Referrals using a secure login.

Note: Specialists co-pay's may be reduced from $50 to $30 after the second visit when member receives approval from the Chronic Disease Manager. Confirm with WebTPA.

New Coverage starting 10-1-2018

1. Allow Colonoscopy at any age for screening and **does not require an authorization**
    - Cover one colonoscopy (screening or diagnostic) at age 45 or older, every 5 years at 100%
2. Cologuard coverage every three years starting at age 45 (Note: Cologuard standard is age 50 so they may follow up with a phone call) Use Z12.11 and Z12.12 only for 100% benefit.
3. Required retinal eye exams can now be done by the medical plan physicians
4. Hearing Aids--Hearing aids will now be covered for dependents age 18 years old or younger with hearing lossrelated to medical conditions
    - Hearing aids for children will be covered under the medical plan Durable Medical Equipment(DME) benefits
    - Basic Plan Excludes this benefit
    - Annual limit of $2,600
    - One pair of hearing aids every three years
    - Hearing aids will be dispensed by a licensed audiologist following medical clearance by physician
    - **Hearing aids will not be covered for degenerative hearing loss**
    - **Basic Plan Excludes hearing aids**

5. All oncology genetic counseling at SMHCS will be covered at 100%

Pre-Authorizations

The objective of Pre-Authorizations is to ensure that, through a process of prior approval, the most appropriate, quality, and cost-effective delivery of medical, surgical and ancillary services will take place for all elective surgeries and diagnostic processes. Emergency Admissions will not require prior authorization, but will require authorization within 48 hours of admission. If upon review, the patient's medical condition does not warrant inpatient care, the hospital coverage could be denied.

- Obtain pre-authorization for the following services:
  - Hospitalizations
  - Outpatient surgeries and invasive procedures (**Including endoscopies, sigmoidoscopies, bronchoscopies, EGD's and ERCP's, and Cardiac Cath and office procedures and diagnostics over $1000 except for Dermatology procedures and allergy serums.**

    In addition these following codes require authorizations: 90000-99199 and 99500-99602.
    - Mental health services
    - PET scans(any type)
    - Durable medical equipment over $500 and prosthetic devices
    - Referrals to out of network providers and facilities
    - EAP referral for authorization
    - Genetic Testing
    - J codes over $500.00 except steroids

    - **Any service to be rendered in the office and is over $1000.00 will require an authorization.**
  - Abdominoplasty
  - Arthroscopy (any type)
  - Back Surgery (i.e., Laminectomy, Diskectomy, Fusion)
  - Breast Surgery
  - Carpal Tunnel
  - Cardiac Rehabilitation (more than 8 weeks)
  - Cholecysectomy
  - Gastric Bypass/Gastroplasty
  - Growth Hormone Therapy
  - Hernia
  - Home Health Care
  - Hysterectomy
  - Jaw Surgery (i.e., TMJ, LaForte Osteotomies)
  - Laparoscopy
  - Lipectomy
  - Lysis of Adhesions
  - Nasal Surgery (i.e., Septoplasty, Rhinoplasty, SMR)

- PET Scans (any type)
- Substance Abuse Treatment
- Tonsillectomy/Adenoidectomy
- Weight Loss Surgery

Gulf Coast Health Plans have set procedures for physicians to follow when pre-authorization is needed for certain types of care. The procedure works like this:

1. The physician requesting the medical service that requires a pre-authorization is responsible to obtain it. Prior to requesting the pre-authorization, the PCP, if required by plan design must have made a referral for the service in question.

2. To obtain a pre-authorization, complete the Authorization Form online at www.gulfcoastmemberservices.org. The authorization will be reviewed by Medical Management Team within 72 hours and an email will be sent to you to review the action.

3. If the service is authorized, the provider performs the service and sends a claim form with the authorization code to WEB TPA.

4. Failure to follow the above-specified notification procedures will result in no benefits payable for the hospitalization and related expenses. The provider has a right to appeal this process by providing clinical documentation to the Medical Management Department and if this retro-review is found to be medically necessary the maximum benefit provided will be 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the Out-of-Pocket Medical Maximum for Members in the Basic and Comprehensive Plans.

Behavioral and Nervous Care Referrals and Pre-Authorization Process

Gulf Coast Health Plans coordinate with Employee Assistance Program Sarasota. The procedure works like this:

1. GCHP member seeks services through the EAP either by contacting the EAP directly at 941-917-1240.

2. The EAP provider decides whether to treat the patient or refer to a specialist.

In the Comprehensive and Basic plans the following will apply:
If you are already engaged in a therapeutic relationship arranged through EAP your benefits will extend to those counselors for your continued care.

All future referrals to see a counselor outside of EAP or Bayside will also require EAP authorization to confirm they are in-network.

Emergency Department Referral and Pre-Authorization Process

Gulf Coast Health Plans has procedures for emergency department authorizations and referrals. The procedure works like this:

1. The GCHP member experiences a potential emergency situation.

2. To determine if the situation is a true emergency, the "prudent layperson" rule is applied. That rule states that a true emergency is a condition characterized by acute symptoms, including severe pain, such that a prudent person with average knowledge of health and medicine could expect his or her health, or the health of an unborn child in the case of a pregnant woman, to be in serious jeopardy without immediate medical attention. The condition should pose an immediate threat to life or limb.

    2.1. The member goes to the Emergency Care Center or calls 911.

    3. If the patient does not consider he or she meets the prudent layperson definition, he or she may call the Primary Care Physician to discuss the situation.

    3.1. If the condition is determined to be an emergency, the patient will go to the Emergency Care Center or call 911. If not, the patient may be directed to the Urgent Care Center or Physician's Office for care.

    3.2. The Emergency Care Center provides treatment.

    3.3. The Emergency Care Center provides feedback to the Primary Care Physician and submits a claim to WEB TPA.

4. If the Primary Care Physician determines the patient does not have an emergency but needs follow-up care, a Primary Care Physician visit or Urgent Care Center visit will be scheduled and, if required by plan design, necessary referrals and authorizations will be obtained.
5. Any patient seen in the Emergency Department for non-emergent services will be required to cover the expense of the visit regardless of who referred them. Gulf Coast Health Plans do not cover non-emergent care in the Emergency Department.

Gulf Coast Health Plans Medical Management Program

Healthcare costs are increasing on what seems like a moment to moment basis. The desire of humans to consume medications and undergo medical evaluation at times seems insatiable. A good deal of the increased expenses are medically appropriate and lead to better long term health. Unfortunately, not all medical interventions are clinically indicated or delivered in the most efficient manner. Thus the dilemma – how do we encourage appropriate care and limit unnecessary care? How do we appropriately influence decisions as they are being made? Can we actually deliver high-quality cost-efficient care?

The Gulf Coast Medical Management program provides the best opportunity to achieve these goals. The solution starts with case management physicians and nurses who are well versed in best practice guidelines and who are reviewing care decisions as they are being planned. With full access to the medical and pharmacy record, and a local relationship with physicians and patients, this team approach provides a concurrent review process to help ensure that care is delivered at the right time, in the right location, with the best possible clinical outcome.

We have designed a comprehensive medical management system that incorporates the best of what WebTPA and Navitus Health Systems have to offer with the medical management services provided by Gulf Coast Medical Management Team. Our medical management team will evaluate and facilitate all patient care. We will review all emergency room visits for clinical appropriateness and help patients after their ER visit to obtain the appropriate follow-up care. For those patients requiring inpatient care, we will review their care on a daily basis and work with physicians and families to facilitate appropriate care and post-discharge plans. In addition, our pharmacy case managers will work with Navitus Health Systems and patients to help maximize benefits and outcomes.

In addition to the new services outlined above, we have added other programs as part of this comprehensive approach.

- GCHP Medical Director
- Disease Management
- Physician Appeal Review
- Integrated Case Management
- Health Plan Design and Development
- Healthcare Guideline and Best Practice Parameters

These medical management programs will likely have the greatest impact when combined with the new plan design changes in the Gulf Coast Health Plans. We

are proud to offer this comprehensive medical management process to our clients. We believe that this integrated approach provides Sarasota Memorial Health Care Systems with the best opportunity to ensure that employees are receiving high quality and cost effective medical care.

REIMBURSEMENT

Distribution

Fee Schedule
GCHP physicians will be reimbursed according to a pre-established fee schedule as follows:

- Fee for service reimbursement - 120% of 2006 Medicare allowable.

Claims

Submitting Claims
All claims must be submitted on standard HCFA 1500 or UB-92 forms and mailed to:

WEB TPA
P.O. Box 539508
Grand Prairie, TX 75053

Claims Inquiries
The status of a claim may be determined by calling 941-917-8004 or outside the local area 866-260-0305.

Required Claims Data
All claims are processed for payment within 45 days of receipt, provided that the claims are complete. The required data for complete claims follows:

- Member information, including name, age, date of birth, and identification number.
- Correct CPT Code modifier with the current CPT code. If applicable, indicate professional fee, technical fee, assistant surgeon, multiple procedures or global billing.
- The date and place of service for each service rendered.
- The signature of the provider who rendered service.
- The referring physician's name if applicable.
- If the doctor is covering for another physician, please highlight that information on the claim form.
- The provider group or individual to whom the remittance should be mailed.
- For anesthesiologist, please include the actual minutes for the service and use the

anesthesia CPT codes.

- HCPCS codes must be filled in correctly or payment may be denied.
- ICD-9 Diagnostic Codes.
- Information on other insurance coverage.
- Job related, auto or accident information when available.
- Authorization number, if applicable.
- Prescription from provider for physical therapy, occupational therapy, speech therapy, massage therapy or DME.
- If the member is still in the pre-existing period of the plan, their may be additional information requested from both the member and the provider.

Physician Payment Appeal Process

Payment Appeal

If payment for medical services is denied, you may appeal the decision by requesting a claim review. Send your request for review to WebTPA's P.O. Box marked, "Request for Review" to the attention "Appeals Department." Detail on appeals process, Denied Medical Appeal Process. Starting on page 48 for further details.

No Balance Billing

Balance billing is prohibited. Providers are responsible to collect the co-payment from the member at the time of service. In the event that a co-payment was not collected at the time of service, providers may bill for the co-payment amount ONLY.

Non Covered Services

In the event that a physician provides non-covered services to a GCHP member, the physician may bill the GCHP member directly for the non covered services ONLY after the member has been informed and acknowledged in writing that such services are not covered services.

PROVIDER RELATIONS

Provider Grievance

Any provider may request an appeal concerning credentialing, professional non-compliance or any other contractual obligations with GCHP. All grievances must be submitted in writing to SMH PHO Office at 1991 Main Street, Suite 147, Sarasota, FL 34236. PHO staff will review the grievance and resolve the issue. In case the PHO staff can't resolve the issue, it will be referred to the PHO Board of Directors.

The Provider Relations Department is available to answer any questions or provide additional information regarding the grievance process by calling 917-6627.

Notification of Changes

GCHP requires any changes in provider status be reported on the SMH PHO website at www.smhpho.org. Changes must be reported 90 days before the change, in writing. The types of changes that require advance notification include:

- **Tax Identification Number**
- Name
- Address
- Phone Number
- Office Hours
- New partners or associates. A new physician must complete a SMH PHO application online at www.smhpho.org and be approved by the Credentials Committee and the SMH/PHO Board prior to treating GCHP members.
- Closing practice to new members

Immediate notification is required if there are changes in any of the following:

- Licensure
- Certification
- Hospital privileges

Termination

Any participating SMH PHO Member physician may terminate his/her participation in the Gulf Coast Health Plans annually on October 1 upon 90 days prior written notice. Any such terminating physician may remain in the PHO.

Participating GCHP Providers who are not SMH PHO members have or will sign a GCHP Managed Care Agreement. This agreement allows either party to terminate without cause upon 90 days prior written notice to the other party.

Closing of Practice to New Members

Participating providers must follow these steps when closing their practice to new GCHP members:

- Give GCHP a 90-day written notice before closing their practice to new members.
- Keep their practice open to GCHP members who were patients before the closing date.
- Give GCHP written notice before reopening their practice, including a specified effective date.

MEMBER SERVICES

Member Responsibilities

- If not already established as a patient, schedule an initial visit with his or her Primary Care Physician within 90 days of enrolling in GCHP.

- Call his or her Primary Care Physician or the 24/7 Nurse Care Line before an emergency room visit, unless the member has a life- or limb-threatening injury or illness.

- Verify that all referrals, if required by plan design, from his or her Primary Care Physician are to in-network providers before receiving services.

- Verify that all laboratory studies, radiologic studies, and other services are provided at a GCHP network facility

- Verify that pre-authorizations for all services that require pre-authorization have been obtained before receiving services.

- Carry and present his or her GCHP ID card before receiving services.

- Use generic prescriptions whenever available.

- Use the mail order program for all maintenance prescriptions.

- If required by plan design, always contact his or her Primary Care Physician before receiving other health services.

- Call 917-8004 for any questions (1-866-260-0305 outside the local calling area).

Primary Care Physician Selection and Changes

When eligible employees enroll in GCHP, they receive a provider directory from which they may choose a PCP for each covered person within the member's family. The PCP may be a family practitioner, general practitioner, internist or pediatrician.

Unless already established as a patient, each member should visit his or her PCP within 90 days of enrolling. The purpose of this initial visit is to provide an opportunity for the PCP to become acquainted with each new patient.

Each member and his or her covered dependents choose a PCP to:

- Advise them on ways to stay healthy
- Work with them to understand the wellness care they need
- Diagnose and treat illness or injury
- Coordinate referrals to network specialists
- Arrange hospital stays and other specialty treatment.

Members are advised to keep in mind the advantage to having a PCP who gets to know them and their medical history, and coordinates all of their health care needs.

Changing Primary Care Physicians

A member may change his or her PCP up to 12 times per year by contacting Human Resources. The member's new choice will go into effect immediately. Once the change is made, the member receives a new identification card showing the new PCPs name.

Schedule of Medical Benefits

Benefit	**Comprehensive Plan**	**Basic Plan**	**Extended Plan**	
	In Network	**In Network**	**In Network**	**Out of Network**
Deductible* – Individual/Family – SMHCS Facility	$0/$0	$250/$1,500	$0/$0	
Deductible* – Individual/Family – Non-SMHCS facility	N/A	N/A	$1,500/ $4,500	$2,500/ $8,500

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Out-of Network Hospital Deductible* (In addition to the above deductible) – Individual/Family	N/A	$250/$1,500	SMH N/A In-Net(not SMH) $15,00/$4,500 Out of Net $2,500/$8,500 plus additional hospital deductible of $1,000.	
Children out of the 2 county area deductible* # (First Health Network must be used for In-Network benefits)	$1,000	$1,000		
* The deductible applies to the Plan Year; as of the beginning of each Plan Year, the deductible limit will be reset for all Covered Employees and Dependents # Out of area children must use the First Health Network to receive coverage at the In Network levels after satisfying deductible.				
Co-insurance SMHCS	85/15	80/20 (Subject to deductible)	85/15 SMH	
Co-insurance Non-SMHCS	N/A	N/A	60/40 (Subject to deductible)	40/60 (Subject to deductible)
Co-insurance Out-of Area Children	80/20 (Subject to deductible)	80/20 (Subject to deductible)		
Maximum Medical Out of Pocket (Co-insurance limits) – Individual/Family	$1,500/$4,500 (does not include deductibles, co-pay)	$2,500/$7,500 (does not include deductibles, co-pay)	$6,350/ $12,700 (includes deductibles, co-pay)	Unlimited
Maximum Medical Out of Pocket (Essential Health Benefits, Med and Rx combined) – Individual/Family	$6,600/$13,200 Includes Deductibles and Co-Pays	$6,600/$13,200 Includes Deductibles and Co-Pays		Unlimited
Provider Office Visits				
PCP Office Visit	Initial plan yr visit free, then $25Co-pay	Initial plan yr visit free, then $25Co-pay	Initial plan yr visit free, then $25Co-pay	$25 Co-pay (Subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Cologuardfor all physicians ***Allowed every 3 years at age 45 or older***	100%	100%		
Specialist Office Visit	$50 Co-pay PCP referral required after 2 Specialist (same type) visits per Plan Year. 5 visits per year to Dermatologist without referral. No referral needed for Podiatrist or OB/GYN.	$50 Co-pay PCP referral required for each Specialist visit. 5 visits per Plan Year to Dermatologist without referral. No referral needed for Podiatrist or OB/GYN.	$50 Co-pay	$50 Co-pay (Subject to deductible)
Holistic Care (Chiropractic (excludes massage therapy), Acupuncture, Herbal Medicine) (Combined benefit)	$50 15 visits or $600 limit per Plan Year, whichever is less	No Coverage	$50 15 visits or $600 limit per Plan Year, whichever is less	40/60 (Subject to deductible) 15 visits or $600 limit per Plan Year, whichever is less
Maternity				
Pre/post natal care and Hospital Services processed accordingly	$50 Co-pay/Initial Visit 85/15	$50 Co-pay/Initial Visit 80/20	$50 Co-pay/Initial Visit 85/15 (SMHCS) 60/40 (In-network-non SMHCS) (Subject to deductible)	40/60 (Subject to deductible) Initial Visit

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Hospital	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Breastfeeding support, supplies and counseling, manual or electric breast pumps purchased or rented	100% Usual and Customary Charge (typical U&C maximums are $250)	100% Usual and Customary Charge (typical U&C maximums are $250)	100% Usual and Customary Charge (typical U&C maximums are $250)	100% Usual and Customary Charge (typical U&C maximums are $250)
Facilities & Services				
Urgent Care Facility (Facility and Physician combined).	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room)	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room)	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room)	
Emergency Room Emergency Only	$200 Co-pay, Co-pay waived if admitted	$200 Co-pay, Co-pay waived if admitted	$200 Co-pay, Co-pay waived if admitted	
Genetic Testing (As provided in item #14 of Covered Medical Expenses)	$500 Co-pay	$500 Co-pay	$500 Co-pay (SMHCS only)	Not covered
Hospital – Inpatient (Additional $1,500 Co-pay for Weight Loss/Bariatric Surgery)	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Physician Charges – atient	85/15	80/20 (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS facilities) (Subject to deductible)	40/60 (Subject to deductible)
Outpatient Surgery	85/15 (SMHCS only) however: Endoscopy $250 copay Sleep lab $250 copay	80/20 (SMHCS only) (Subject to deductible) however: Endoscopy $250 copay Sleep lab $250 copay	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Physician Charges – Outpatient Surgery	85/15	80/20 (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Skilled Nursing Facility Maximum 90 days per year, if not at SMHCS Facilities.	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Preadmission Testing	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
2nd Opinion	60/40	Not Covered	60/40	40/60 (Subject to deductible)
Contraception/Family Planning				
Tubal Ligation/ Vasectomy	100%	100%	100% (SMHCS)	40/60 (Subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Birth Control Pills	Covered as a Prescription Drug	Covered as a Prescription Drug	Covered as a Prescription Drug	
IUD, Diaphragm, cervical caps	100% of FDA approved contraceptive methods that are considered Preventive Services	100% of FDA approved contraceptive methods that are considered Preventive Services	100% of FDA approved contraceptive methods that are considered Preventive Services	Not Covered
Tubal Ligation Reversal/Vasectomy Reversal	Not Covered	Not Covered	Not Covered	
Infertility Treatment, Artificial Insemination, Surrogate Mother, In-Vitro Fertilization, etc.	Not Covered	Not Covered	Not Covered	
Well Care – Child				
Newborn Well Care (inpatient)	Preventive Services covered at 100%; other services covered at 85/15 (SMHCS only)	Preventive Services covered at 100%; other services covered at 80/20 (SMHCS only) (Subject to deductible)	Preventive Services covered at 100%; other services covered at 85/15 (SMHCS) Preventive Services covered at 100%; other services covered at 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

Benefit	**Comprehensive Plan**	**Basic Plan**	**Extended Plan**	
	In Network	**In Network**	**In Network**	**Out of Network**
Well Child Care – periodic examinations at the following intervals of age: *2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, annually ages 3 – 17*	Preventive Services covered at 100%; other services covered at 85/15	Preventive Services covered at 100%; other services covered at 80/20 (Subject to deductible)	Preventive Services covered at 100%; other services covered at 85/15 Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	Not Covered
Well Care – Adult	Preventive Services covered at 100%; other services covered at 85/15	Preventive Services covered at 100%; other services covered at 80/20	Preventive Services covered at 100%; other services covered at 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	Not Covered
Routine Physical	Preventive Services covered at 100%; other services covered 85/15	Preventive Services covered at 100%; other services covered 80/20 (subject to deductible)	Preventive Services covered at 100%; other services covered 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	40/60 (subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Annual Well Woman/Pap Smear	Preventive Services covered at 100%; other services covered 85/15	Preventive Services covered at 100%; other services covered 80/20 (subject to deductible)	Preventive Services covered at 100%; other services covered 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	40/60 (subject to deductible)
Mammogram	Preventive Services covered at 100%; other services covered 85/15	Preventive Services covered at 100%; other services covered 80/20 (subject to deductible)	Preventive Services covered at 100%; other services covered 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	40/60 (subject to deductible)
Wellness & Educational Programs				
SMHCS Coumadin Clinic	100%	100%	100%	Not Covered
SMHCS Heart Failure Clinic	100%	100%	100%	Not Covered
SMHCS Diabetes Treatment Program	100%	100%	100%	Not Covered
Diagnostic Labs				

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
CT Scans/MRI/Diagnos-tic X-rays & Labs (Pre-authorization needed if a surgical procedure is involved)	85/15 (SMHCS only) Copays to other services: MRI $100 copay CT Scan $100 copay	80/20 (SMHCS only) (Subject to deductible) MRI $100 copay CT Scan $100 copay	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Physician charge to read labs/x-rays	85/15	80/20 (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS facilities) (Subject to deductible)	40/60 (Subject to deductible)
Other				
Ambulance (Ground & Air)	85/15	85/15	85/15	85/15
Allergy Serums & Injections	85/15	80/20 (Subject to deductible)	60/40 (Subject to deductible)	40/60 (Subject to deductible)
TMJ - Diagnostic procedures and surgical procedures to treat conditions caused by a congenital or developmental deformity, disease or Injury	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS facilities) (Subject to deductible)	40/60 (Subject to deductible)
TMJ – (1) Non-diagnostic and non-surgical procedures (2) Diagnostic and surgical procedures for conditions that are not caused by a congenital or developmental deformity, disease or Injury	85/15 (SMHCS only) $1,000 lifetime maximum	Not Covered	85/15 (SMHCS) 60/40 (In-network, non-SMHCS facilities) (Subject to deductible) $2,500 lifetime maximum	40/60 (Subject to deductible) $2,500 lifetime maximum

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Durable Medical Equipment	80/20 **Pre-Cert needed, if over $500**	Not Covered	60/40 (In-network) (Subject to deductible) **Pre-Cert needed, if over $500**	40/60 (Subject to deductible) **Pre-Cert needed, if over $500**
Home Health	85/15 (SMHCS) 60 visits per year	$25 Co-pay 30 visits per year (In lieu of hospitalization, requires Medical Management Approval)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible) 60 visits per year	40/60 (Subject to deductible) 60 visits per year
Hospice	100% 60 day lifetime maximum	100% 60 day lifetime maximum	100% 60 day lifetime maximum	40/60 (Subject to deductible) 60 day lifetime maximum
Physical Therapy/Speech Therapy/Massage Therapy/Occupational Therapy (Therapy limited to a combined maximum of 30 visits per year, with the exception of post joint replacement therapy, with prior authorization of Medical Management)	$25 Co-pay	$25 Co-pay 30 visits per year (Only if hospitalization would otherwise be required; requires Medical Management Approval)	$25 Co-pay	$25 Co-pay
Behavioral Health/Substance Abuse (GCPNS = Gulf Coast Provider Network Select)				
After the second visit, non-emergency behavioral health and/or substance abuse treatment must be pre-authorized with a GCPNS provider by EAP. With a change in level of care a new authorization is required.				

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Mental – Inpatient	85/15	85/15	85/15 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Mental – Outpatient Pine Tree Counseling Center located at: 1515 S. Osprey Avenue, Suite C-12 Sarasota, Florida Corner of Floyd Street and Osprey Avenue	EAP – Up to 6 counseling sessions per year 100% Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS[1] $50 Co-pay for psychiatrist in GCPNS[1]only No annual limit on number of visits	EAP – Up to 6 counseling sessions per year 100%, Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS[1] $50 Co-pay for psychiatrist in GCPNS[1] only No annual limit on number of visits	EAP – Up to 6 counseling sessions per year 100%, Co-pay waived at Pine Tree Counseling Center at EAP Sarasota 50/50 (In-network, non-SMHCS providers) (Subject to deductible) No annual limit on number of visits	40/60 (Subject to deductible)
Mental/Nervous – Outpatient/ Partial Day Facility Care	85/15 Co-pay waived if following Inpatient Stay at SMHCS Bayside	80/20 Co-pay waived if following Inpatient Stay at SMHCS Bayside	85/15 Co-pay waived if following Inpatient Stay at SMHCS Bayside 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

[1] Gulf Coast Provider Network Select

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Substance Abuse – Inpatient/ Detoxification	85/15	Not Covered	85/15 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Substance Abuse – Outpatient	Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS[1] $50 Co-pay for psychiatrist in GCPNS[1] only No annual limit on number of visits	Not Covered	Co-pay waived at Pine Tree Counseling Center at EAP Sarasota 50/50 (In-network, non-SMHCS) (Subject to deductible) No annual limit on number of visits	40/60 (Subject to deductible)
Substance Abuse - Partial Day Facility Care	85/15 Co-pay waived if following In-Patient Stay at SMHCS Bayside	Not Covered	85/15 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

[1] Gulf Coast Provider Network Select

Pre-Authorization Requirements

General Information

All non-emergency procedures greater than $1,000 require Pre-Authorization and must be done at an SMHCS facility if clinically appropriate.

You are responsible to ensure that you or your provider obtains pre-authorization for all:

- Hospitalizations
- Outpatient surgeries and invasive procedures (INCLUDING endoscopies, colonoscopies, sigmoidoscopies, bronchoscopes, EGD's, ERCP, Cardiac Cath, Observation Services over 23 hrs., and office procedures and diagnostics over $1,000 except for Dermatology procedures)
- PET scans
- Mental health services

Failure to obtain pre-authorization for the above services will result in reduced benefits. **To obtain pre-authorizations, you must work with the provider to place authorization at www.gulfcoastmemberservices.org. For mental health or substance abuse pre-authorizations, see Mental Health Pre-authorization section below.**

Hospitalizations

A Participant, a member of his or her family, or his Physician must notify WEBTPA prior to any non-emergency hospitalization. In the event of an emergency hospitalization, the Participant, a member of his or her family or his Physician must notify WEBTPA within forty-eight (48) hours or on the first business day following admission. **For maternity admissions, the attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.**

Upon notification, WEBTPA will review the Participant's condition and proposed treatment plan and will work with the attending Physician to plan the hospitalization in advance. A Participant's confinement is subject to concurrent review to ensure that the Participant has a clear need to remain hospitalized and to document any complications requiring a longer confinement than expected.

Penalty for Non-Compliance

Failure to follow the above-specified notification procedures will result in no benefits payable for the hospitalization and related expenses. The provider has a right to appeal this process by providing clinical documentation to the Medical Management Department and if this retro-review is found to be medically necessary the maximum benefit provided will be 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the Out-of-Pocket Medical Maximum for Members in the Basic and Comprehensive Plans.

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact **WEBTPA at 877-697-2299** to make certain that the Hospital or attending Physician has initiated the necessary processes.

Also, prior authorization **is not** a guarantee of coverage. The **Medical Management Program** is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions.

Outpatient and Diagnostic Procedures Requiring Pre-Authorization

Prior to undergoing any outpatient surgery, invasive procedure, a Covered Person or his attending Physician must request prior authorization from **Gulf Coast Medical Management at www.gulfcoastmemberservices.org. The following lists examples of procedures that must have pre-authorizations. This list is not all inclusive and if you are having any procedure performed that is not listed below that would be considered to be outpatient surgery, you should call WEBTPA to have it pre-authorized.**

- Abdominoplasty
- Arthroscopy (any type)
- Back Surgery (i.e., Laminectomy, Diskectomy, Fusion)
- Breast Surgery
- Carpal Tunnel
- Cardiac Rehabilitation (more than 8 weeks)
- Cholecysectomy
- Growth Hormone Therapy
- Hernia
- Home Health Care
- Hysterectomy
- Jaw Surgery (i.e., TMJ, LaForte Osteotomies)
- Laparoscopy
- Lysis of Adhesions
- Nasal Surgery (i.e., Septoplasty, Rhinoplasty, SMR)
- Office J codes, except steroid
- PET Scans (any type)
- Substance Abuse Treatment
- Tonsillectomy/Adenoidectomy
- Weight Loss Surgery
- J codes over $500.00

Integrated Case Management

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing Facility;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

The Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Mental Health Pre-Authorization

EAP is Sarasota Memorial's starting point for behavioral health and substance abuse treatments under the Comprehensive, Basic, and Extended Medical Plans. Prior to seeking non-emergency mental health or substance abuse treatment, Members are encouraged to contact EAP for authorization. Contacting EAP may benefit you with referrals to reputable treatment professionals, and earlier coordination between treatment professionals and the Plan may help that treatment professonal devise a treatment plan

that complies with applicable guidelines and avoid delays in Plan payments or reimbursements. Network providers can be located at www.gulfcoastprovider.net.

The Plan requires pre-authorization from EAP for behavioral health and substance abuse hospitalization in order to receive full benefits. **To obtain pre-authorizations, choose a provider at www.gulfcoastmemberservices.org and contact EAP Sarasota at 941-917-1240.**

In addition,

Basic Plan Members must have authorization from EAP to see a mental health provider for behavioral health (substance abuse treatment is not covered under the Basic Plan).

Comprehensive Plan Members must have authorization from EAP after 2 visits per plan year to a see a mental health provider for behavioral health or substance abuse.

Extended Plan Members do not need authorization from EAP to see an outpatient mental health provider for behavioral health or substance abuse. However, authorization is needed for inpatient or partial day care treatment.

Failure to obtain authorization for behavioral health and/or substance abuse treatment will result in denial of payment by SMHCS and the Member will be held responsible for payment.

EAP Sarasota
1515 South Osprey Avenue
Suite C-12
Sarasota, FL 34239
941-917-1240
800-425-7764

In the event of an emergency, Members should seek treatment and notify EAP within 48 hours or as soon as possible.

GCHP Medical Plan Benefits

Please note the Extended Plan is a PPO product with in and out of network benefits and utilizes Gulf Coast Provider Network. Basic and Comprehensive Plans utilizes Gulf Coast Select Network and requires referrals as explained in this manual.

COMPREHENSIVE AND EXTENDED MEDICAL PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Exclusions list.

For all Medical Benefits shown in the Schedule of Benefits or Medical Plan Covered Services sections of the Summary Plan Description, a charge for the following is not covered:

1. **Abortion.** Charges for elective induced abortions, except for in the cases of rape, incest or maternal endangerment.

2. **Alcohol or Substance Impairment.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of alcohol or other substances causing impairment. Expenses will be covered for Injured Covered Persons other than the person using alcohol or substances causing impairment. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

3. **Biofeedback.**

4. **Breast or penile implants.** Coverage for breast or penile implants except for reconstructive surgery following mastectomy.

5. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

6. **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, tattoos or body piercings or removals of such items (including complications from either the applying or removing of such items), or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

7. **Custodial care.** Services or supplies of a custodial care or domiciliary nature such as those normally provided at health resorts, rest homes, nursing homes, health spas, and convalescent centers. Also, services that are primarily

educational in nature or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice care as specified).

8. **Dental.** Services, supplies, care or treatment of dental or oral charges. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the SMHCS network. Dental extractions are not covered unless approved by the Medical Directors and member is active participant in Chronic Disease Case Management.

9. **Educational or vocational testing.** Services for educational or vocational testing or training.

10. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

11. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

12. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the SMHCS network.

13. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

14. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

15. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

16. **Gene Therapy.** Care, treatment, or supplies for gene therapy or genetic testing and fetal treatment except to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description or per Health Plan Medical Directors.

17. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

18. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Medical Plan Covered Services section of the Summary Plan Description.

19. **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of , but not limited to, hazardous hobbies or activities are skydiving, auto or motor cross racing, motorcycle riding without a helmet, boat racing, hang gliding, parasailing, or bungee jumping.

20. **Hearing related evaluations or treatments.** Charges for services or supplies in connection with hearing aids or exams for their fitting, including but not limited to, cochlear implants or any surgical procedure for hearing unless approved by Medical Directors and member is active participant in Chronic Disease Case Management.

21. **Hypnotherapy.** Charges for service or supplies in connection with hypnotherapy or hypnotism or any type of goal-oriented or behavior modification therapy, such as to quit smoking or lose weight.

22. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

23. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

24. **Infertility.** Charges or supplies for artificial insemination; in-vitro fertilization procedures or drugs, GIFT (Gamete IntraFallopian Transfer) procedures, studies, or drugs related to the treatment of infertility.

25. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

26. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

27. **Emergency treatment for non-emergent conditions.** Emergency care and treatment billed by a Hospital or Facility for non-emergent conditions.

28. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

29. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

30. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

31. **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded.

32. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

33. **Occupational Therapy.** Charges for occupational therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

34. **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

35. **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

36. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

37. **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or the device is no longer functional.

38. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

39. **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

40. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

41. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

42. **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

43. **Speech Therapy.** Charges for speech therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

44. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

45. **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under Standard Preventive Care, including smoking deterrent products, but not including electronic cigarettes. Tobacco cessation care and treatment is otherwise excluded unless Medically Necessary due to severe active lung illness such as emphysema or asthma.

46. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge. Also excludes charges for, but not limited to, convenience items related to travel that would not be necessary in similar situations within your own home, such as travel-size cpap or oxygen machines.

47. **Vision Therapy.** Charges for vision therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description or approved by Medical Directors and member is active participant in Chronic Disease Case Management.

48. **War or Bioterrorism.** Any loss that is due to a declared or undeclared act of war or bioterrorist prevention, such as but not limited to, immunizations, medications, supplies or other related services.

49. **Weight Loss Surgery.** Weight loss surgery, unless pre-approved by Medical Directors.

BASIC MEDICAL PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Exclusions list.

For all Medical Benefits shown in the Schedule of Benefits or Medical Plan Covered Services sections of the Summary Plan Description, a charge for the following is not covered:

1. **Abortion.** Charges for elective induced abortions, except for in the cases of rape, incest or maternal endangerment.

2. **Alcohol or Substance Impairment.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of alcohol or other substances causing impairment. Expenses will be covered for Injured Covered Persons other than the person using alcohol or substances causing impairment. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

3. **Biofeedback.**

4. **Breast or penile implants.** Coverage for breast or penile implants except for reconstructive surgery following mastectomy.

5. **Breast reduction or mammoplasty.**

6. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

7. **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, tattoos or body piercings or removals of such items (including complications from either the applying or removing of such items), or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

8. **Custodial care.** Services or supplies of a custodial care or domiciliary nature such as those normally provided at health resorts, rest homes, nursing homes, health spas, and convalescent centers. Also, services that are primarily educational in nature or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice care as specified).

9. **Dental.** Services, supplies, care or treatment of dental or oral charges. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the SMHCS network. Dental extractions are not covered unless approved by the Medical Directors and member is active participant in Chronic Disease Case Management.

10. **Educational or vocational testing**. Services for educational or vocational testing or training.

11. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

12. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

13. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the SMHCS network.

14. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

15. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

16. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

17. **Gene Therapy.** Care, treatment, or supplies for gene therapy or genetic testing and fetal treatment except to the extent specifically set forth in the Medical Plan

Covered Services section of the Summary Plan Description or per Health Plan Medical Directors.

18. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

19. **Growth Hormones.**

20. **Gynecomastia.** Surgical care or treatment for gynecomastia.

21. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Medical Plan Covered Services section of the Summary Plan Description.

22. **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of , but not limited to, hazardous hobbies or activities are skydiving, auto or motor cross racing, motorcycle riding without a helmet, boat racing, hang gliding, parasailing, or bungee jumping.

23. **Hearing related evaluations or treatments.** Charges for services or supplies in connection with hearing aids or exams for their fitting, including but not limited to, cochlear implants or any surgical procedure for hearing unless approved by Medical Directors and member is active participant in Chronic Disease Case Management.

24. **Holistic or homeopathic medicine.**

25. **Hypnotherapy.** Charges for service or supplies in connection with hypnotherapy or hypnotism or any type of goal-oriented or behavior modification therapy, such as to quit smoking or lose weight.

26. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

27. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

28. **Infertility.** Charges or supplies for artificial insemination; in-vitro fertilization procedures or drugs, GIFT (Gamete IntraFallopian Transfer) procedures, studies, or drugs related to the treatment of infertility.

29. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

30. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

31. **Emergency treatment for non-emergent conditions.** Emergency care and treatment billed by a Hospital or Facility for non-emergent conditions.

32. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

33. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

34. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

35. **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded.

36. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

37. **Occupational Therapy.** Charges for occupational therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

38. **Pain treatment.** Charges or supplies for pain treatment other than oral medications.

39. **Pectus excavatum repair.**

40. **Penile dysfunction.** Care, supplies or treatment for penile dysfunction.

41. **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

42. **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

43. **Plasmapheresis.**

44. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

45. **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or the device is no longer functional.

46. **Rhinoplasty/Rhytidectomy.**

47. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

48. **Sclerotherapy or surgery for varicose veins.**

49. **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

50. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

51. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

52. **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

53. **Sleep studies.**

54. **Speech Therapy.** Charges for speech therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

55. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

56. **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under Standard Preventive Care, including smoking deterrent products, but not including electronic cigarettes. Tobacco cessation care and treatment is otherwise excluded unless Medically Necessary due to severe active lung illness such as emphysema or asthma.

57. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge. Also excludes charges for, but not limited to, convenience items related to travel that would not be necessary in similar situations within your own home, such as travel-size cpap or oxygen machines.

58. **Uvulopalatopharyngoplasty.** Care and treatment for uvulopalatopharyngoplasty including laser assisted procedures.

59. **Travel related care for international travel.**

60. **Vision Therapy.** Charges for vision therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description or approved by Medical Directors and member is active participant in Chronic Disease Case Management.

61. **War or Bioterrorism.** Any loss that is due to a declared or undeclared act of war or bioterrorist prevention, such as but not limited to, immunizations, medications, supplies or other related services.

62. **Weight Loss Surgery**.

INSTRUCTIONS FOR SUBMITTING MEDICAL CLAIMS

Customarily, claims will be submitted by the provider of care. In the rare instance that you submit the claim, be sure the bills submitted include all of the following:

1. **Employee's name, health plan Member ID, and home address**
2. **If claim is made for a dependent, name and age**
3. **Employer's name and group number**
4. **Name and address of the Physician or Hospital**
5. **Physician's diagnosis**
6. **Itemization of charges**
7. **Date the Injury or illness began**

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed.

All payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted. In the event of the Covered Person's death, direct payment will continue to be made to the provider.

Please direct all claims and any questions regarding claims to:

WEBTPA
PO Box 99906
Grapevine, TX 76099-9706

Inside the Sarasota Area: (941) 917-7991
Outside the Sarasota Area: (877) 697-2299

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Third Party Administrator or the Employee will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of the Summary Plan Description.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from

the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.

Time Limit for Submitting Claims
All claims must be submitted within 1 year from the date charges are incurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered or supplies are actually received.

If it was not reasonably possible to submit the claim in the time required, the claim will not be reduced or denied solely for this reason, if the claim is submitted as soon as reasonably possible. The claim must be submitted no later than one year from the date of loss unless the Covered Person was legally incapacitated.

Right to Investigate Claims
The Plan Sponsor acting on its behalf retains the right to request any medical information from any provider of service it deems necessary to properly process a claim.

A Physician designated by the Plan Sponsor will have the right and opportunity to examine, at its expense, any person whose illness or Injury is the basis of any claim, when and as often as reasonably required and, in the event of death, to make an autopsy, unless prohibited by law.

DENIED MEDICAL CLAIMS APPEAL PROCESS

Pre-certification/Pre-authorization Denial Appeal Process
Enrollees are responsible for ensuring that specified services are pre-certified by WEBTPA. When a Provider or Enrollee requests pre-certification for a service, it is either approved or denied. Pre-certification for a service may be denied due to:

- **Not medically necessary;**
- **Not a covered benefit.**
- **Services not provided by an in-network provider or at an approved Facility**

Written notification of the denial for pre-certification for a requested service will be sent to the medical provider requesting the service. If a request for pre-certification is denied, in whole or in part, the Covered Person or Provider may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- **Review the Summary Plan Description and other papers affecting the denial (except information which a Physician does not wish made known to the claimant);**
- **Argue against the denial in writing; and**
- **Have a representative act on behalf of the Covered Person in the appeal.**

The decision on review shall be in writing and shall be made within 15 days of the receipt of the request for review. If your claim is urgent, you may request an expedited review. In that case, a decision will be made within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision.

If the pre-certification is denied upon review the decision must include the following:

- **The specific reasons for denial;**
- **The decision must be written in a manner understandable to the Covered Person; and**
- **The written denial will contain reference to the pertinent Plan provisions or medical protocols upon which the decision was based.**

Appeals due to the denial of a pre-certification should be addressed in writing to:

Sarasota Memorial Hospital
Attn: Gulf Coast Medical Management Medical Review
1700 S. Tamiami Trail

Sarasota, FL 34239

Correspondence should include:
- **Primary insured's name and health plan Member ID;**
- **Patient's name and relationship to primary insured;**
- **Provider's name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

Post-Service Claim Denial and Claim Denial Appeal Process

1. Level One Appeal

In the event a claim is denied, the Covered Person will be advised of the following:
- **The reason for the denial;**
- **Specific reference to Plan provisions on which the denial was based;**
- **Any additional material or information needed for further review of the claim;**
- **An explanation of the review procedure.**

If a claim is denied, in whole or in part, the Covered Person may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:
- **Review the Summary Plan Description and other papers affecting the claim (except information which a Physician does not wish made known to the claimant);**
- **Argue against the denial in writing; and**
- **Have a representative act on behalf of the Covered Person in the appeal.**

The decision on review shall be in writing and shall be made within 30 days of the receipt of the request for review. Claim denial Level One appeal requests should be addressed in writing to:

WEBTPA
Attn: Appeal Department
PO Box 99906
Grapevine, TX 76099-9706

Correspondence should include:
- **Primary insured's name and health plan Member ID;**
- **Patient's name and relationship to primary insured;**
- **Provider's name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

If the claim is denied upon review, the decision must include the following:

- **The specific reason or reasons for the adverse determination**
- **Reference to the specific Plan provisions on which the determination was based.**
- **A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.**
- **A description of the Plan's review procedures and the time limits applicable to such procedures.**
- **A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.**
- **If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.**
- **If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.**

2. Level Two Appeal

The Covered Person may appeal directly in writing to the Plan Sponsor for a Level Two review within 60 days after a claim denial has been reviewed and upheld by the Third Party Administrator. Claim denial Level Two appeal requests to the Plan Sponsor should be addressed in writing to:

Sarasota Memorial Health Care System
Attn: Benefits Department
1852 Hillview Street
Sarasota, FL 34239

Correspondence should include:

- **Primary insured’s name and health plan Member ID;**
- **Patient’s name and relationship to primary insured;**
- **Provider’s name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

The claims information provided will be submitted without any identifying data to a committee appointed by the Plan Sponsor. A written response to the Employee and/or Covered Person will be provided within 30 days of the receipt of the written claims appeal.

3. Level Three Appeal
If a claim is denied by the Plan Sponsor, in whole or in part, the Covered Person may appeal for a final external review with an Independent Review Organization within four months after the date of receipt of a notice of a denial under the Level two appeal. Claim denial Level Three appeal requests should be addressed in writing to:

WEBTPA
Attn: Appeals Department--Level Three Appeal
PO Box 99906
Grapevine, TX 76099-9706

Correspondence should include:
- **Primary insured's name and health plan Member ID;**
- **Patient's name and relationship to primary insured;**
- **Provider's name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

Within five business days following the date of receipt of the level three appeal request, WEBTPA will complete a preliminary review of the request to determine whether the claimant is eligible for the level three appeal. Within one business day after completion of the preliminary review, the Plan will notify the Covered Person whether the claim is eligible for review or if more information is needed to make the request complete. The Covered Person will have up to the end of the initial four month period or within the 48 hour period following the receipt of the notification, whichever is later, to send any additional information requested.

The Plan will assign an accredited independent review organization (IRO) to conduct the external review. The IRO will provide written notice of the final external review decision within 45 days after receipt of the request for external review to the claimant and the Plan. Upon receipt of a notice of a final external review decision reversing the second level appeal, the Plan will immediately provide coverage or payment for the claim.

Expedited External Review. The Plan will allow a Covered Person to request an expedited level 3 appeal if the denial of an appeal involves a medical condition for which the timeframe for completion of a second level or third level appeal would seriously jeopardize the life or health of the

claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or if the second level adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

If it is determined that the claim is eligible for review, the IRO will provide notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

Prescription Benefits

Prescription Benefit Limitations

There are three different prescription plans: **Comprehensive RX, Basic RX** and **Extended RX.** Each has an annual limit on the portion of pharmacy costs paid by SMHCS. A pharmacy case manager is available to help Participants in these Plans stay within the limits of the maximum expenses allowed. The limit will increase by an additional $1,000 for Plan Members who work with a pharmacy case manager and their Physicians to consider appropriate medication substitutions. You may contact the pharmacy case manager at www.gulfcoastmemberservices.org or (941) 917-1473 for more details or assistance with this program. After the increased annual limit has been reached, Plan Participants are responsible for an additional $1,000 of prescription expenses, after which the Plan covers the remaining prescription costs with a 50% co-insurance for Participants in the Comprehensive RX and Basic RX Plans. Please note that the 50% co-insurance coverage that begins after the coverage gap is not capped by a per-prescription maximum. After the Extended RX Plan annual limit has been reached and the Participant continues to work with the pharmacy case manager, the Plan will cover the remaining prescription costs with a 60% co-insurance and the Employee would be responsible for 40%. If the Employee also works with the Chronic Disease Case Manager, the Plan will cover the remaining prescription costs at 80%. If the Employee does not work with the Pharmacy Case Manager and/or Chronic Disease Case Manager, the employee would be responsible for a 50% co-insurance.

Mail Order Program for Maintenance Drugs

(up to a 90-day supply)

The Mail Order Program is available for brand and generic maintenance medications to be delivered to participants' door. Mail order service is recommended only for maintenance medications, rather than medications that will only be needed on a short-term basis (e.g. antibiotics for an acute illness). Maintenance medications are typically used to treat chronic, long-term conditions.

90-Day Medication Supply Retail Program

Prescriptions for maintenance medications may also be filled at a participating retail pharmacy in the Navitus Health Solutions network (www.Navitus.com).

Some examples of maintenance medications include:

- Anti-Arthritics
- Anti-inflammatory agents
- Colchicine agents
- Purine inhibitors
- Urlocosuric agents
- Anti-Asthmatics
- Xanthines
- Anti-Coagulants
- Oral anti-coagulants coumaria type
- Antidepressants
- Anti-Glaucomatous Agents
- Mydriatics
- Miotics & other pressure reducers
- Anti-Mania
- Anti-Narcolepsy/Anti-Hyperkinesis Agents
- Anti-Parkinson
- Anti-Seizure
- Barbiturates
- Anti-Tubercular Agents and antibiotics
- Cardiovascular
- Adrenergic inhibitors
- ldosterone antagonists
- Hypotensive agents
- Inotropic drugs
- Cardiac Drugs
- Coronary vasocilators
- Digitalis Glycosides
- Anti-Arrhythmic
- Beta-adrengic blocking agents
- Calcium channel blockers
- Peripheral vasodilators
- Diabetic Therapy including insulin, syringes, test strips and lancets
- Oral hypoglycemic agents
- Sulfonylurea type
- Diuretics
- Thiazide diuretics & related agents
- Potassium sparing diuretics
- Carbonic anhydrous inhibitors
- Hormones
- Estrogenic agents
- Progestoroneal agents
- Oral Contraceptives
- Potassium Replacement
- Thyroid Supplements
- Thyroid hormones
- Anti-thyroid preparations
- Ulcer Medications
- Proton Pump Inhibitors

Prescription Plan Definitions

Generic Drugs A drug that is no longer limited to manufacture by a single producer due to expiration of patent protection. By law, generic drugs must meet the Food & Drug Administration's guidelines for purity, strength and safety and must produce the same effect in the body and have the same active ingredients as brand name drugs.

Formulary Drugs "Preferred" brand-name drugs selected based on their ability to meet patient needs at a lower cost.

Brand Name Drugs Drugs for which there is no generic substitute.

Generic Substitution

Unless otherwise noted by the Physician, each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. When a Generic Prescription Drug is available but a non-generic drug is dispensed *for any reason*, the covered person must pay the generic co-payment plus the difference between the generic and the non-generic price. Prescription Drugs without a generic equivalent are subject to the listed brand co-insurance.

Step Therapy

To effectively manage both single-source and multi-source brands, step therapy requires that a cost effective generic alternative is tried first before targeted single source brand

medications. Mandatory rules steer Members to lower cost alternatives. See more details at www.gulfcoastmemberservices.org under Pharmacy Case Management.

Covered Expenses

- Insulin; and insulin needles/syringes, chemstrips and lancets by prescription only;
- Compound medications, excluding bulk chemicals, in which at least one ingredient is a Prescription Legend Drug;
- Other drugs or medicines (other than those listed in the "Limitations" section below that can be legally dispensed only upon the written prescription of a Physician).
- Growth Hormones, Retin-A, and amphetamines are covered only with prior authorization from Medical Management.
- Family planning drugs or medicines that are FDA approved contraceptive methods and are Preventive Services/Care, including the following:
  - Oral contraceptives:
    - Formulary generic and some formulary brands without a generic alternative oral contraceptives covered at no cost
    - Formulary brand oral contraceptives covered at applicable co-pay and/or deductible, step therapy applies
  - Spermicides: over the counter covered at no cost with a prescription
  - Injections:
    - Formulary generic and some formulary brands without a generic alternative covered at no cost
    - Formulary brand covered at applicable co-pay and/or deductible, step therapy applies
  - Patch:
    - Formulary generic and some formulary brands without a generic alternative covered at no cost
    - Formulary brand covered at applicable co-pay and/or deductible; step therapy applies
  - Vaginal ring:
    - Formulary generic and some formulary brands without a generic alternative covered at no cost
    - Formulary brand covered at applicable co-pay and/or deductible; step therapy applies

Prescription Pre-Authorizations

Specialty Drugs

Navitus Health Solutions must pre-authorize prescriptions for specialty medications with your Physician prior to filling them. Navitus SpecialtyRx is a specialty pharmacy program offered through a partnership with Walgreens Specialty Pharmacy that helps manage high-cost and injectable drugs with a focus on patient care. Call Navitus SpecialtyRx toll-free at 1-800-218-1488.

Schedule Of Prescription Benefits

Limitations	***Comprehensive Plan***	***Basic Plan***	***Extended Plan***
Base Benefit *(Net Cost to SMHCS)*	*$3,000*	*$2,000*	*$7,000*
Additional Benefit Amount of Coverage if Pharmacy Case Management is Utilized	*$1,000*	*$1,000*	*$1,000*
Coverage Gap Per Participant (After base benefit and additional benefit has been reached)	*$1,000*	*$1,000*	*$1,000*
Umbrella Coverage Co-insurance *(Begins after coverage gap has been met)*	*50/50* *(No per script maximum)*	*50/50* *(No per script maximum)*	*50/50* *With a Pharmacy Case Manager: 60/40.* *With a Pharmacy Case Manager and Chronic Disease Case Manager: 80/20 with maximum $300 per prescription.*
Mandatory Generic (and certain lower-cost preferred brand) Substitution	Yes	Yes	Yes

Limitations	***Comprehensive Plan***	***Basic Plan***	***Extended Plan***
Mandatory Mail Order on Maintenance Drugs	No	No	No
Retail Benefits (30 day supply)			
Tier 1 Preferred generics and some lower cost brand products	$9	$9	$9
Tier 2 Preferred brand products and some high cost non-preferred generics	60/40 ($25 minimum per script, $75 maximum per script)	60/40 ($25 minimum per script, $75 maximum per script)	60/40 ($25 minimum per script, $100 maximum per script)
Tier 3 Non-preferred products (may include some high cost non-preferred generics)	40/60 ($35 minimum per script, $75 maximum per script)	40/60 ($35 minimum per script, $75 maximum per script)	40/60 ($35 minimum per script, $100 maximum per script)
Tier 4 Specialty Drugs	$100 **Specialty drugs may require participation in a specialty drug program**	$100	$100
Compound Drugs	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply
Retail Benefits (90 day supply)			
Tier 1 Preferred generics and some lower cost brand products	$25	$25	$25

Limitations	***Comprehensive Plan***	***Basic Plan***	***Extended Plan***
Tier 2– Preferred brand products and some high cost non-preferred generics	60/40 ($50 minimum per script; $100 maximum per script)	60/40 ($50 minimum per script; $100 maximum per script)	60/40 ($50 minimum per script; $100 maximum per script)
Tier 3 Non-preferred products (may include some high cost non-preferred generics)	40/60 ($75 minimum per script; $100 maximum per script)	40/60 ($75 minimum per script; $100 maximum per script)	40/60 ($75 minimum per script; $125 maximum per script)
Tier 4 Specialty Drugs	Not Available	Not Available	Not Available
Mail Order Benefits (90 day supply)			
Tier 1 Preferred generics and some lower cost brand products	$20	$20	$20
Tier 2 Preferred brand products and some high cost non-preferred generics	60/40 ($50 minimum per script, $75 maximum per script)	60/40 ($50 minimum per script, $75 maximum per script)	60/40 ($50 minimum per script, $100 maximum per script)
Tier 3 Non-preferred products (may include some high cost non-preferred generics)	40/60 ($75 maximum per script)	40/60 ($75 maximum per script)	40/60 ($100 maximum per script)
Tier 4 Specialty Drugs	Not Available	Not Available	Not Available
90 day supply—applies to both retail and mail order	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the

Limitations	*Comprehensive Plan*	*Basic Plan*	*Extended Plan*
	alternatives including scripts that are medical necessity (see ~~Generic~~ Step Therapy paragraph on previous page).	available lower cost alternatives including scripts that are medical necessity (see ~~Generic~~ Step Therapy paragraph on previous page).	available lower cost alternatives including scripts that are medical necessity (see ~~Generic~~ Step Therapy paragraph on previous page).
Family Planning - FDA approved contraceptive methods that meet the definition of Preventive Services/Care	Covered at 100%	Covered at 100%	Covered at 100%

PRESCRIPTION PLAN EXCLUSIONS

Note: All exclusions related to Medical Plans are shown in the "Basic Medical Plan Exclusions" or the "Comprehensive and Extended Medical Plan Exclusions" lists.

For all Prescriptions shown in the Schedule of Prescription Benefits or Prescription Benefits sections of the Summary Plan Description, in addition to the General Limitations of this Plan, no payment will be made under any portion of this Plan for expenses incurred for:

- Non-FDA approved drugs, dosage forms, strengths or indications/uses; or
- Drugs or medicines that are not for Medically Necessary care;
- Over-the-counter (OTC) drugs and drugs with OTC equivalents, other than insulin;
- Non-prescription drugs unless recommended by the Physician, reviewed by the Pharmacy Case Manager and with a Physician Prescription;
- Charges for drugs, medicines, or supplies which do not require a prescription for purchase, including but not limited to vitamins, mineral supplements, and fluoride drugs;
- Prescriptions covered under Worker's Compensation;
- Charges for the administration or injection of any drug;
- Therapeutic devices or appliances, including support garments, and other non-medicinal substances, regardless of intended use;
- Medication which is to be taken by or administered to a Covered Person, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals to the extent such medications are already covered under the Medical Plan;
- Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
- Replacements for lost or stolen prescriptions;
- Fertility drugs;
- Special Diets;
- Vitamins (other than prenatal) and nutritional supplements;
- Immunization agents, biological sera, blood or blood plasma;
- Drugs labeled "Caution-limited by federal law to investigational use," or Experimental drugs, even though a charge is made to the Covered Person.
- Steroids for body building;
- CII, CIII, Benzodiazepine, and Hypnotics delivered or administered by the prescriber;
- CII, CIII, Benzodiazepine, and Hypnotics prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family;
- Any prescription directing pre-natal administration or use (in-utero treatment);
- Drugs or medicines for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage;

- Drugs or medicines paid for or furnished by the US government or one of its agencies (except as required under Medicaid provisions of federal law);
- Drugs or medicines provided as a result of sickness or Injury due to war or an act of war or to voluntary participation in criminal activities.
- Injectables other than Insulin, Anticoagulants, Epi-pen, and specialty medications
- Compound drugs that include bulk chemicals

Payment of Prescription Drug Benefits
If you purchase your prescriptions from a Network Pharmacy, you should present your medical/RX ID card to the pharmacist with your prescription when your prescription is filled or refilled.

If you buy your prescription drugs from a non-Network pharmacy, you should:

- Pay the pharmacist the entire cost of the prescription;
- Obtain a prescription claim form from SMHCS or Navitus;
- Complete your portion of the claim;
- Mail the completed form and receipts to this address:

  Navitus Health Solutions, LLC
  P.O. Box 999
  Appleton, WI 54912-0999
  OR
  Fax
  (920)735-5315 / Toll Free (855)668-8550

- The covered benefit amount will be paid directly to you from Navitus.
- Note that if you use a non-Network pharmacy, your benefit will be reimbursed at the Network pharmacy negotiated rate less any applicable co-payments. The Participant must pay the difference between the negotiated rate and the actual cost plus the appropriate co-payment.

Mail Order Drug Program
To receive prescriptions through the mail order program, submit the original prescription with a mail order claim form and payment of the appropriate co-payment amount. If you do not know the amount of your co-payment, call NoviXus at 1-888-240-2211. NoviXus may also be accessed via the internet at www.novixus.com to access updated claims information, order refills, view drug information, or ask questions. You may also call the Pharmacy Case Manager at 941-917-1473.

Pharmacy Case Management
Information on the benefits available through this free program is available at www.gulfcoastmemberservices.org or by calling the Pharmacy Case Manager at 941-917-1473.

DENIED PHARMACY CLAIMS APPEAL PROCESS

Pre-authorization Denial Appeal Process
Enrollees are responsible for ensuring that specified prescriptions are pre-authorized through Navitus Health Solutions, LLC.. When a Provider or Enrollee requests pre-authorization for a prescription, it is either approved or denied. Pre-authorization for a prescription may be denied due to:

- **Not medically necessary**
- **Not a covered drug**
- **Drug not approved for the diagnosis provided**

Written notification of the denial for pre-authorization for a requested drug will be sent to the medical provider requesting the prescription by Navitus. If a request for pre-authorization is denied, the Covered Person or Provider may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- **Review the Summary Plan Description and other papers affecting the denial (except information which a Physician does not wish made known to the claimant);**
- **Argue against the denial in writing; and**
- **Have the prescribing MD or member act on behalf of the Covered Person in the appeal.**

The decision on review shall be in writing and shall be made within 15 days of the receipt of the request for review. If your claim is urgent, you may request an expedited review. In that case, a decision will be made within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision.

If the pre-authorization is denied upon review the decision must include the following:

- **The specific reasons for denial;**
- **The decision must be written in a manner understandable to the Covered Person; and**
- **The written denial will contain reference to the pertinent Plan provisions or medical protocols upon which the decision was based.**

Appeals due to the denial of a pre-authorization should be addressed in writing and mailed or faxed to:

Sarasota Memorial Hospital
Attn: Pharmacy Case Manager
1700 S. Tamiami Trail
Sarasota, FL 34239
FAX: 941-917-2669

Correspondence should include:

- **Primary insured's name and health plan Member ID;**
- **Patient's name and relationship to primary insured;**
- **Provider's name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

Prescription Claim Denial and Claim Denial Appeal Process

1. Level One Appeal

In the event a prescription is denied, the Covered Person will be advised of the following:

- **The reason for the denial;**
- **Specific reference to Plan provisions on which the denial was based;**
- **Any additional material or information needed for further review of the claim;**
- **An explanation of the review procedure.**

If a prescription is denied, the Covered Person may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- **Review the Summary Plan Description and other papers affecting the claim (except information which a Physician does not wish made known to the claimant);**
- **Argue against the denial in writing; and**
- **Have a representative act on behalf of the Covered Person in the appeal.**

The decision on review shall be in writing and shall be made within 30 days of the receipt of the request for review. Claim denial Level One appeal requests should be addressed in writing and mailed or faxed to:

Sarasota Memorial Hospital
Attn: Pharmacy Case Manager
1700 S. Tamiami Trail
Sarasota, FL 34239
Fax: 941-917-2669

Correspondence should include:

- **Primary insured's name and health plan Member ID;**
- **Patient's name and relationship to primary insured;**
- **Provider's name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

If the claim is denied upon review, the decision must include the following:

- **The specific reason or reasons for the adverse determination**
- **Reference to the specific Plan provisions on which the determination was based.**
- **A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.**
- **A description of the Plan's review procedures and the time limits applicable to such procedures.**
- **A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.**
- **If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.**
- **If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.**

2. Level Two Appeal

The Covered Person may appeal directly in writing to the Plan Sponsor for a Level Two review within 60 days after a claim denial has been reviewed and upheld by the Pharmacy Case Manager. Prescription denial Level Two appeal requests to the Plan Sponsor should be addressed in writing to:

Sarasota Memorial Health Care System
Attn: Benefits Department
1852 Hillview Street, Ste. 203
Sarasota, FL 34239

Correspondence should include:

- **Primary insured’s name and health plan Member ID;**
- **Patient’s name and relationship to primary insured;**
- **Provider’s name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

The claims information provided will be submitted without any identifying data to a committee appointed by the Plan Sponsor. A written response to the Employee and/or Covered Person will be provided within 30 days of the receipt of the written claims appeal.

3. Level Three Appeal

If a prescription is denied by the Plan Sponsor, the Covered Person may appeal for a final external review with an Independent Review Organization (IRO) within four months after the date of receipt of a notice of a denial under the Level two appeal. Claim denial Level Three appeal requests should be addressed in writing to:

Sarasota Memorial Health Care System
Attn: Benefits Department – 3rd level appeal
1852 Hillview Street, Ste. 203
Sarasota, FL 34239

Correspondence should include:

- **Primary insured's name and health plan Member ID;**
- **Patient's name and relationship to primary insured;**
- **Provider's name;**
- **Any additional information Participant feels would assist in reconsideration;**
- **Contact information, including daytime telephone number.**

Within five business days following the date of receipt of the level three appeal request, SMH will complete a preliminary review of the request to determine whether the claimant is eligible for the level three appeal. Within one business day after completion of the preliminary review, the Plan will notify the Covered Person whether the claim is eligible for review or if more information is needed to make the request complete. The Covered Person will have up to the end of the initial four month period or within the 48 hour period following the receipt of the notification, whichever is later, to send any additional information requested.

The Plan will assign an accredited independent review organization (IRO) to conduct the external review. The IRO will provide written notice of the final external review decision within 45 days after receipt of the request for external review to the claimant and the Plan. Upon receipt of a notice of a final external review decision reversing the second level appeal, the Plan will immediately provide coverage or payment for the claim.

Expedited External Review. The Plan will allow a Covered Person to request an expedited level 3 appeal if the denial of an appeal involves a medical condition for which the timeframe for completion of a second level

or third level appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or if the second level adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

If it is determined that the claim is eligible for review, the IRO will provide notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.