SimplyBlue

All Copay 18753

Schedule of Benefits

This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found. Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amount **you pay**.

Your Benefit Period.....**01/01 - 12/31**

FINANCIAL FEATURES	YOU PAY
Deductibles (DED) per Benefit Period – Embedded Individual Deductible	$3,200
Family Deductible	$6,400
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	0%
Out-of-Pocket Maximums per Benefit Period – Embedded Individual Out-of-Pocket Maximum	$9,450
Family Out-of-Pocket Maximum	$18,900

What **applies** to the out-of-pocket maximum?

- All Copays (including Pharmacy)
- Coinsurance (including Pharmacy)
- DED (including Pharmacy)

What **does not apply** to out-of-pocket maximums?

- Non-covered charges
- Benefit penalties

MEDICAL BENEFITS

You should always verify a Provider's participation status before you receive Health Care Services. To verify a Provider's specialty or participation status, you may contact our local office or access the most recent Provider directory on our website at www.floridablue.com.

Unless indicated otherwise, Copays listed in the charts that follow, apply per visit.

PREVENTIVE SERVICES	YOU PAY
Adult Wellness Services (at all locations)	$0
Child Wellness Services (at all locations)	$0
Mammograms	$0
Routine Colonoscopies	$0

OFFICE SERVICES	YOU PAY
Office Visits rendered by Primary Care Providers	$35
Specialist Physicians and other health care professionals licensed to perform such Services	$70
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) **rendered by** Primary Care Providers	**$35**
Specialist Physicians and other health care professionals licensed to perform such Services	$70
All other Diagnostic Services (e.g., X-rays) Primary Care Providers	**$35**
Specialist Physicians and other health care professionals licensed to perform such Services	$70
Allergy Injections rendered by Primary Care Providers	$10
Specialist Physicians and other health care professionals licensed to perform such Services	$10

OFFICE SERVICES	YOU PAY
Maternity Copay applies to initial visit only Primary Care Providers	**$35**
Specialist Physicians and other health care professionals licensed to perform such Services	$70
Outpatient Therapies and Spinal Manipulation rendered by Primary Care Providers	$35
Specialist Physicians and other health care professionals licensed to perform such Services	$70

VIRTUAL HEALTH	YOU PAY
Virtual Visits General Medicine and Urgent Care rendered by a designated Virtual Care Provider	$0
Specialized Care rendered by a designated Virtual Care Provider	$75
Behavioral Health rendered by a designated Virtual Care Provider	$0

Please visit https://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

MEDICAL PHARMACY	YOU PAY
Medication**	
Low Tier Medications	10%
Standard Tier Medications	20%
Maximum Out-of-Pocket per person per Month***	
Low Tier Medications	$100
Standard Tier Medications	$200

Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Medical Pharmacy does not include immunizations, allergy

injections or Services covered through a pharmacy program. Please refer to your Benefit Booklet for a description of Medical Pharmacy.

*** The Low Tier Medication Maximum Out-of-Pocket and the Standard Tier Medication Maximum Out-of-Pocket are separate, and as such, accumulate separately. Therefore, amounts incurred for Low Tier Medications shall be applied only to the Low Tier Medication Maximum Out-of-Pocket and the Standard Tier Medication amounts incurred shall be applied only to the Standard Tier Maximum Out-of-Pocket.

OUTPATIENT DIAGNOSTIC SERVICES	YOU PAY
Independent Clinical Lab	$50
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$350
All other diagnostic Services (e.g., X-rays)	$200
Outpatient Hospital Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$1,000
All other diagnostic Services (e.g., X-rays)	$1,000

EMERGENCY AND URGENT CARE SERVICES	YOU PAY
Ambulance Services	DED + 0%
Convenient Care Center	$35
Emergency Room Visits Facility (In-Network and Out-of-Network)	$650
Physicians and other health care professionals licensed to perform such Services	$125
Urgent Care Center	$80

Note: If you are admitted to a Hospital as an inpatient at the time of an emergency room visit to the same facility the Cost Share applicable to inpatient Hospital will apply instead of the emergency room Cost Share.

HOSPITAL AND SURGICAL SERVICES	YOU PAY
Ambulatory Surgical Center Facility	$500
Physicians and other health care professionals licensed to perform such Services	$125
Inpatient Hospital Facility	DED + $1,000
Physicians and other health care professionals licensed to perform such Services	$125
Outpatient Hospital Facility	$1,000
Physicians and other health care professionals licensed to perform such Services	$125
Outpatient Therapies	$1,000

BEHAVIORAL HEALTH SERVICES	YOU PAY
Inpatient Facility Services rendered at Hospital, Psychiatric or Substance Abuse Facility	$0
Outpatient Facility Services rendered at Emergency Room	$0
Hospital, Psychiatric or Substance Abuse Facility	$0
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Provider's Office	$0
Specialist Office	$0
Hospital, Psychiatric or Substance Abuse Facility or Emergency Room	$0
All other locations	$0

Note: If you are admitted to a Hospital as an inpatient at the time of an emergency room visit to the same facility the Cost Share applicable to inpatient Hospital will apply instead of the emergency room Cost Share.

OTHER SERVICES	YOU PAY
Birth Center	DED + 0%
Dialysis Center	DED + 0%
Durable Medical Equipment Motorized wheelchairs	DED + 0%
All other Durable Medical Equipment	$0
Enteral Formula	DED + 0%
Home Health Care	$0
Outpatient Hab/Rehab Facility	$75
Prosthetic and Orthotic Devices	$0
Second Medical Opinion In-Network Provider	$75
Out-of-Network Provider	40%
Skilled Nursing Facility	DED + 0%

BENEFIT MAXIMUMS

All benefit maximums apply per person and are based on your Benefit Period.

Home Health Care Visits..... 60

Inpatient Habilitative Days..... 30

Inpatient Rehabilitative Days 30

Outpatient Habilitative Therapies Visits 35

Outpatient Rehabilitative Therapies and Spinal Manipulation Visits 35

Note: Spinal Manipulations are limited to 35 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation maximum.

Skilled Nursing Facility Days 60

Benefit Maximum Carryover

If you or your Covered Dependent were covered under a prior group policy form issued to the Group by Florida Blue, Florida Blue HMO or Truli for Health and changed to this plan under the same Group, amounts applied to your Benefit Period maximums under the prior Florida Blue, Florida Blue HMO or Truli for Health plan will be applied toward your Benefit Period maximums under this plan.

PRESCRIPTION DRUG PROGRAM

ValueScript Rx Pharmacy Program

For a list of In-Network Pharmacies, you may contact our local office or access the most recent Provider directory on our website at www.floridablue.com.

COST SHARE TIER	Preferred Pharmacy (for each One-Month Supply*)	Standard Pharmacy (for each One-Month Supply*)	Mail Order Pharmacy (up to a Three-Month Supply)
Tier 1: Preventive Prescription Drugs and Supplies	$0	$10	$0
Tier 2: Condition Care Generic Prescription Drugs and Supplies	$4	$14	$10
Tier 3: Low Cost Generic Prescription Drugs and Supplies	$25	$35	$63
Tier 4: Condition Care Brand Name Prescription Drugs and Supplies	$30	$50	$75
Tier 5: High Cost Generic Prescription Drugs and Supplies and Preferred Brand Name Prescription Drugs and Supplies	$55	$65	$138
Tier 6: Specialty** Generic and Brand Name Prescription Drugs and Non-Preferred Prescription Drugs and Supplies	DED + 50%	DED + 50%	DED + 50%
Oral Chemotherapy Medications* **			
Non-Specialty Prescription Drugs	$10	$10	$25
Specialty Prescription Drugs	$10	$10	Not Covered

Other Important Information affecting the amount you will pay:

* You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) from a retail Pharmacy, if the Prescription is written for a Three-Month Supply.

** Specialty Drugs are only covered when purchased from the Specialty Pharmacy and only up to a One-Month Supply. Some Specialty Drugs may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits. Specialty Drugs are not covered when purchased from the Mail Order Pharmacy.

*** Please refer to the Oral Chemotherapy Drug List contained in the Medication Guide.

PEDIATRIC VISION BENEFITS

Pediatric Vision Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

COVERED SERVICE	YOU PAY

Eye exam one every 12 months $0

- including dilation (when professionally indicated)

Spectacle Lenses one pair every 12 months $0

- Clear plastic single vision, lined bifocal, trifocal or lenticular lenses (any Rx)
- Oversize lenses
- Scratch-resistant coating
- Standard progressive lenses
- Plastic photosensitive lenses
- Polycarbonate lenses (for monocular patients and patients with prescriptions +/- 6.00 diopters or greater)
- Tinting of plastic lenses
- Ultraviolet coating

Frames one every 12 months from the Pediatric Frame Selection* $0

* If you choose a frame that is not in the Pediatric Frame Selection, you will be responsible for the difference in cost between the price of the frame selected and those available in the Pediatric Frame Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.

Contact Lenses (instead of eye glasses) once every 12 months from the Pediatric Contact Lens Selection** including the evaluation, fitting and follow-up care $0

** If you do not select contact lenses from the Pediatric Contact Lens Selection you will be responsible for the difference in cost between the contact lenses selected and those available in the Pediatric Contact Lens Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.

Medically Necessary Contact Lenses (prior authorization is required) $0

- Including the evaluation, fitting and follow-up care

PEDIATRIC DENTAL BENEFITS

Pediatric Dental Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

Coverage includes Preventive, Basic and Major Dental care; we have listed some examples of the types of Services that fall under each category, but it is important you review the Benefit Booklet for detailed information, frequency limits and exclusions.

COVERED SERVICE	YOU PAY

Preventive Services (examples listed below) $0

- Oral exams, cleanings and fluoride treatments
- Sealants
- Space maintainers
- X-rays (bitewing)

Basic Services (examples listed below) $0

- Anesthesia
- Emergency treatment (Palliative care)
- Extractions
- Fillings
- Minor Endodontics (pulpal therapy)
- Minor Periodontics (deep cleaning)
- Minor Prosthodontics (repair/relining)

Major Services (examples listed below) $0

- Major Endodontics (root canal treatment)
- Medically Necessary Implants (prior authorization is required)
- Major Periodontics (surgical)
- Major Prosthodontics (dentures, crowns)
- Medically Necessary Orthodontia (prior authorization is required)

Simply**Blue**

Benefit Booklet for Small Groups

Florida Blue

HMO

This Benefit Booklet contains a deductible provision

SBL.SG.BB 0617

Simply**Blue**

Benefit Booklet for Small Groups

Jon Urbanek
Chief Executive Officer

For Customer Service Assistance: 800-FLA-BLUE

Florida Blue

HMO

4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

SBL.SG.BB 0617

TABLE OF CONTENTS

HOW TO USE YOUR BENEFIT BOOKLET

This is your Benefit Booklet ("Booklet"). You should read it carefully before you need Health Care Services. It contains valuable information about:

- your SimplyBlue benefits;
- what is covered;
- what is not covered;
- coverage and payment rules;
- how and when to file a claim and under what circumstances we will pay;
- what you will have to pay as your share; and
- other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how we will coordinate benefits with other policies or plans; our subrogation rights; and our right of reimbursement.

Refer to the Schedule of Benefits to determine how much you have to pay for particular Health Care Services.

When reading your Booklet, please remember:

1. You should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered. Sometimes it may be necessary to change the standard language in this Booklet. If changes are needed, we will create an Endorsement to this Booklet, which will either be inserted after the section that it modifies, or at the end of the Booklet. Be sure to always check for these additional documents before making benefit decisions.
2. The headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
3. References to "you" or "your" throughout refer to you as the Covered Employee and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Covered Employee or solely to your Covered Dependents will be noted as such.
4. References to "we", "us", "our" and "Florida Blue HMO" throughout refer to Health Options, Inc.
5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the DEFINITIONS section or within the particular section where it is used.

Where do I find information on…	**…go to:**
What is **covered?**	The **WHAT IS COVERED?** section.
What is **not covered?**	The **WHAT IS NOT COVERED?** section, along with the **WHAT IS COVERED**? section.
What is **covered** under my **retail pharmacy plan?**	The **PRESCRIPTION DRUG PROGRAM** section
How do I know what **Providers** I can use, and how the Providers I use will affect my **Cost Share** amount?	The **HEALTH CARE PROVIDER OPTIONS** section and the **COVERAGE ACCESS RULES** section, along with the current **Provider Directory**.
How much do I pay for Health Care Services?	The **YOUR SHARE OF HEALTH CARE EXPENSES** section along with the **Schedule of Benefits**.
What happens if **I receive a surprise bill?**	The **Surprise Billing** subsection in the **YOUR SHARE OF HEALTH CARE EXPENSES** section
How do I access Services when I'm **out-of-state?**	The **BLUECARD PROGRAM** section and the **AWAY FROM HOME CARE** section.
How do I **add or remove a Dependent?**	The **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section and the **TERMINATION OF COVERAGE** section.
What if I am covered under **SimplyBlue** and **another health plan?**	The **COORDINATION OF BENEFITS** section.
What happens when **my coverage ends?**	The **TERMINATION OF COVERAGE** section, along with the **CONTINUING COVERAGE** section.
What do the **terms used** throughout this Booklet **mean?**	The **DEFINITIONS** section.
Who do I call if I have **questions or complaints?**	Call our **customer service** department at **800-FLA-BLUE** (this phone number can also be found on your **ID Card**).

WHAT IS COVERED?

Introduction

This section describes the Health Care Services that are covered under this Booklet. All benefits for Covered Services are subject to: (1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, (2) the applicable Allowed Amount, (3) any limitations and exclusions, as well as any other provisions contained in this Booklet including any Endorsements that are part of your Booklet, and (4) our Medical Necessity guidelines and Coverage Access Rules then in effect (see the MEDICAL NECESSITY and COVERAGE ACCESS RULES sections).

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included with the benefit description in this section. There are other exclusions and limitations listed in the WHAT IS NOT COVERED? section and, in some cases, in separate Endorsements that are part of this Booklet. More than one limitation or exclusion may apply to a specific Service or a particular situation.

We will provide coverage for the Health Care Services listed in this section only if they are:

1. authorized in advance by us, if prior coverage authorization is required (see the COVERAGE ACCESS RULES section);
2. within the Covered Services Categories in this section;
3. rendered, prescribed or ordered by an **In-Network Provider** except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition;
4. actually rendered to you (not just recommended) by an appropriately licensed health care Provider who is recognized by us for payment;
5. billed to us on a claim form or itemized statement that lists the procedures and Services rendered to you. Claims and statements should include procedure codes, diagnosis codes and other information we require to process the claim;
6. Medically Necessary, as defined in this Booklet and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;
7. provided in accordance with our COVERAGE ACCESS RULES section;
8. rendered while your coverage is in force; and
9. not specifically or generally limited or excluded under this Booklet.

We will determine whether Services are Covered Services under this Booklet after you have obtained them and we have received a claim for them. In some cases we may decide if Services are Covered Services under this Booklet before they are rendered to you. For example, we may determine if a transplant would be a Covered Service under this Booklet before you have the transplant.

We are not obligated to determine if a Service that has not been provided to you will be covered unless we have designated that the Service must be authorized in advance in the COVERAGE ACCESS RULES section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

In determining if Health Care Services are Covered Services under this Booklet, no written or verbal representation by any employee or agent of Florida Blue HMO or by any other person shall waive or modify the terms of this Booklet and, therefore, neither you, the Group, nor any health care Provider or other person should rely on any such written or verbal representation.

Covered Services Categories

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum may be covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based on the type and number of doses.

Ambulance Services

Ground Ambulance

Ground Ambulance Services for Emergency Medical Conditions and limited non-emergency ground transport may be covered only when:

1. For Emergency Medical Conditions – it is Medically Necessary to transport you from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
    a. from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;
    b. to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;
    c. to the nearest more cost-effective acute care facility as determined solely by us; or
    d. from an acute facility to the nearest cost-effective sub-acute setting.

Note: Non-emergency Ambulance transportation meets the definition of Medical Necessity only when the patient's Condition requires treatment at another facility and when another mode of transportation, whether by Ambulance or otherwise (regardless of whether covered by us or not) would endanger the patient's medical Condition. If another mode of transportation could be used safely and effectively, regardless of time, or mode (e.g. air, ground, water) then Ambulance transportation is not Medically Necessary.

Air and Water Ambulance

Air and water Ambulance coverage is specifically limited to transport due to an Emergency Medical Condition when the patient's destination is an acute care Hospital, and:

1. the pick-up point is not accessible by ground Ambulance, or
2. speed in excess of the ground vehicle is critical for your health or safety.

Air and water Ambulance transport for non-emergency transport is excluded unless it is specifically approved by us in advance of the transport.

Exclusion

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
    a. the crew renders aid until a helicopter can be sent;
    b. the patient refuses care or transport; or
    c. only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
    a. patient wants to be at a certain Hospital or facility for personal/preference reasons;
    b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment) or after being discharged from inpatient care; or
    c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
6. Air and water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Ambulatory Surgical Center

Services rendered at an Ambulatory Surgical Center may be covered and include:

1. use of operating and recovery rooms;
2. respiratory therapy, such as oxygen;
3. Drugs and medicines administered at the Ambulatory Surgical Center (except for take-home Drugs);

4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as EKG;
10. chemotherapy treatment for proven malignant disease; and
11. other Medically Necessary Services.

Anesthesia Administration Services

Anesthesia administered by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. When the CRNA is actively directed by a Physician other than the Physician who performed the surgery, the Allowed Amount for Covered Services will include both the CRNA and the Physician's charges and will be based on the lower-directed Services Allowed Amount according to our payment program then in effect for such Covered Services.

Exclusion

Coverage does not include anesthesia Services by an operating Physician, his or her partner or associate.

Behavioral Health Services

Mental Health Services

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a Physician, Psychologist or Mental Health Professional for the treatment of a Mental and Nervous Disorder may be covered. Covered Services may include:

1. Physician office visits;
2. Intensive Outpatient Treatment (rendered in a facility), as defined in this Booklet;
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of an In-Network Physician; and
4. Residential Treatment Services, as defined in this Booklet.

Exclusion

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;

3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability, except for Services that meet the definition of Medical Necessity for the Condition;
4. Services for educational purposes, except for Services that meet the definition of Medical Necessity for the Condition;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation, except for Services that meet the definition of Medical Necessity for the Condition;
8. Services to test aptitude, ability, intelligence or interest;
9. Services required to maintain employment;
10. Services for cognitive remediation; and
11. inpatient stays for Custodial Care, convalescent care, change of environment or any other Service primarily for your convenience or that of your family members or the Provider.

Substance Dependency Treatment Services

When there is a sudden drop in consumption after prolonged heavy use of a substance a person may experience withdrawal, often causing both physiologic and cognitive symptoms. The symptoms of withdrawal vary greatly, ranging from minimal changes to potentially life threatening states. Detoxification Services can be rendered in different types of locations, depending on the severity of the withdrawal symptoms.

Care and treatment for Substance Dependency includes the following:

1. Inpatient and outpatient Health Care Services rendered by a Physician, Psychologist or Mental Health Professional in a program accredited by The Joint Commission or approved by the state of Florida for Detoxification or Substance Dependency.
2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency.

We may provide you with information on resources available to you for non-medical ancillary services like vocational rehabilitation or employment counseling, when we are able to. We don't pay for any Services that are provided to you by any of these resources; they are to be provided solely at your expense.

Exclusion

Long term Services for alcoholism or drug addiction, including specialized inpatient units or inpatient stays that are primarily intended as a change of environment.

Breast Reconstructive Surgery

Breast Reconstructive Surgery and implanted prostheses incident to Mastectomy are Covered Services. Surgery must be provided in a manner chosen by you and your Physician and be consistent with prevailing medical standards.

Child Cleft Lip and Cleft Palate Treatment

Health Care Services prescribed by your Physician including medical, dental, Speech Therapy, audiology, and nutrition Services for treatment of a child under the age of 18 who has cleft lip or cleft palate may be covered. In order to be covered, Services must be prescribed by a Provider who must certify in writing, that the Services are Medically Necessary. Speech Therapy is subject to the limits in your Schedule of Benefits for Outpatient Therapies and Spinal Manipulation Services.

Clinical Trials

Clinical trials are research studies in which Physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial.

If you are eligible to participate in an Approved Clinical Trial, routine patient care for Services furnished in connection with your participation in the Approved Clinical Trial may be covered when:

1. an In-Network Provider has indicated such trial is appropriate for you, or
2. you provide us with medical and scientific information establishing that your participation in such trial is appropriate.

Routine patient care includes all Medically Necessary Services that would otherwise be covered under this Booklet, such as doctor visits, lab tests, x-rays and scans and Hospital stays related to treatment of your Condition and is subject to the applicable Cost Share(s) on the Schedule of Benefits.

Even though benefits may be available under this Booklet for routine patient care related to an Approved Clinical Trial you may not be eligible for inclusion in these trials or there may not be any trials available to treat your Condition at the time you want to be included in a clinical trial.

Exclusion

1. Costs that are generally covered by the clinical trial, including, but not limited to:
    a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
    b. The investigational item, device or Service itself.
    c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
2. Services related to an Approved Clinical Trial received outside of the United States.

Concurrent Physician Care

Concurrent care means care that is rendered to you by more than one Physician on the same date or during the same inpatient stay. Concurrent Physician care Services are only covered when documentation shows that:

1. the additional Physician actively participates in your treatment;
2. the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and

3. the Physicians have different specialties or have the same specialty with different subspecialties.

Consultations

Consultations provided by a Physician may be covered if your attending Physician requests the consultation and the consulting Physician prepares a written report.

Dental Services

Some types of dental Services are general dental Services; while most other dental Services are covered under the Pediatric Dental Benefit. The only reason you need to know this, is that some Services may have a different Cost Share, depending on whether the Services are covered as general dental Services or your Pediatric Dental Benefits.

General dental Services are limited to the following:

1. Care and stabilization Services for the treatment of damage to Sound Natural Teeth rendered within 62 days of an Accidental Dental Injury.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care, including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care rendered to you in a Hospital or Ambulatory Surgical Center if:
    a. a Covered Dependent is under eight years of age and the dentist and the Covered Dependent's Physician determine that:
        1) dental treatment is necessary due to a dental Condition that is significantly complex; or
        2) the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
    b. you or your Covered Dependent has one or more medical Conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Exclusion

Dental Services other than described in the Pediatric Dental Benefits section rendered more than 62 days after the date of an Accidental Dental Injury even if the Services could not have been rendered within 62 days.

Pediatric Dental Benefits

Pediatric Dental Benefits, as used in this Booklet, means Covered Services, as described below, for Covered Persons age 19 and under. Pediatric Dental Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

Pediatric Dental Benefits are covered under this section **only** if they are:

1. not specifically or generally limited or excluded; and
2. authorized for coverage by us, if prior coverage authorization is required.

Note: The BLUECARD PROGRAM and AWAY FROM HOME CARE sections do not apply to these Services.

Preventive Services:

1. Oral exams, cleaning and fluoride treatments – once every six months.
2. Sealants – once per permanent tooth every 36 months.
3. Space maintainers to replace prematurely lost teeth.
4. X-rays (bitewing – two films) – once every six months.

Basic Services:

1. Anesthesia – general anesthesia and intravenous sedation is covered only when rendered in connection with a covered surgical procedure.
2. Endodontics – Minor (such as pulpal therapy).
3. Extractions (removal of teeth).
4. Palliative care (treatment to relieve pain or to keep a dental injury or condition (such as an abscess) from getting worse):
    a. Coverage for Services rendered outside the Service Area is limited to palliative care and is only covered up to $100 in urgent situations when you:
        1) are more than 100 miles away from an In-Network Dentist; and
        2) did not and could not reasonably expect the need for Services before you left the Service Area.
    b. You may have to pay for the Services up front and then file a claim with us for reimbursement. Claims must be filed within 90 days of the date of Service.
5. Periodontics – Minor (such as deep cleaning).
6. Prosthodontics – Minor (such as repair and relining of bridges, crowns and dentures).
7. Fillings (limited to amalgam for posterior teeth and resin (composite) only for anterior teeth).

Major Services:

1. Endodontics – Major (such as root canal treatment).
2. Periodontics – Surgical (such as gingivectomy).
3. Prosthodontics – Major (such as crowns and dentures, crowns are limited to one per tooth every 60 months and dentures are limited to one denture every 60 months).

Implants and orthodontia may be covered, when Medically Necessary, and with prior coverage authorization.

Duplication of Dental Coverage

You cannot receive coverage under the Dental Services category for a Covered Service under both the general dental benefits and the Pediatric Dental Benefits. Dental Services covered under general dental

benefits will not be covered under the Pediatric Dental Benefits and Dental Services covered under Pediatric Dental Benefits will not be covered under the general dental benefits.

Dental Exclusions applicable to all Dental Categories including general dental and Pediatric Dental Benefits.

1. Any dental Services not listed in this category as covered.
2. Cosmetic procedures, including, but not limited to veneer restorations, tooth whitening, and non-Medically Necessary orthodontia.
3. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
4. Charges for nitrous oxide.
5. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth reconstruction, restoration of tooth structure lost from attrition and restoration for crooked teeth.
6. Any additional treatment required because you don't follow instructions, or do not cooperate with the Dentist.
7. General anesthesia and intravenous sedation administered solely for patient management or comfort.
8. Services related to hereditary or developmental defects or cosmetic reasons, including but not limited to, cleft palate (except as covered under Child Cleft Lip and Cleft Palate Treatment category), upper or lower jaw defects, lack of development of enamel, discoloration of the teeth, and congenitally missing teeth.
9. Services other than as described in the Pediatric Dental Benefits category including, but not limited to: care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays.

Diabetes Treatment Services

Services related to the treatment and management of diabetes may be covered when the treating Physician or a Physician who specializes in the treatment of diabetes certifies that such Services are Medically Necessary and include the following:

1. outpatient self-management training and educational Services when provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology;
2. nutrition counseling provided by a licensed dietitian;
3. equipment and supplies to treat diabetes, such as insulin pumps and tubing; and

   Note: Blood glucose meters, lancets and test strips are covered under your pharmacy benefit (see the PRESCRIPTION DRUG PROGRAM section).

4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Value-Based Diabetes Program

Managing a chronic condition, like diabetes, can be difficult. However, studies show you can help control your symptoms by making lifestyle changes and by following your doctor's advice. You can also delay, or even prevent, many of the complications of the disease.

Through the value-based diabetes program, certain diabetes treatment Services are covered at no cost to you when you use In-Network Providers. Your Cost Share will be waived for the following diabetes treatment Services, up to the maximum amount listed. Please note, the limits listed in the chart below apply only to the number of Services covered at no cost and do not limit the number of Services covered on your plan.

Type of Service	**Limitations**
Diabetic retinal exam	1 exam per year at $0*
Podiatrist exam	1 exam per year at $0*
Insulin pump	$0 Cost Share may be limited to preferred brands/models** **Note:** Insulin pump supplies, such as tubing and infusion sets are subject to the amount listed in your Schedule of Benefits
Diabetic training	All outpatient self-management training and educational Services are covered at $0 Cost Share when rendered by a certified Diabetes Educator or a board certified Physician specializing in endocrinology
Lab tests	• HbA1c – 4 per year at $0* • lipid panel – 4 per year at $0* • urinalysis – 4 per year at $0*

* Medically Necessary Services rendered beyond the maximums listed above are subject to the Cost Share amounts listed on your Schedule of Benefits and any applicable benefit limitations in this Booklet.

** Insulin pumps require prior authorization. If, at the time the prior authorization is obtained, the $0 Cost Share is limited to certain brands or models, this information will be made available at the time of the prior authorization.

Diagnostic Services

Diagnostic Services may be covered and include the following:

1. radiology and ultrasound;
2. advanced imaging Services such as nuclear medicine, CT/CAT Scans, MRAs, MRIs and PET Scans;
3. laboratory and pathology Services;

4. Services involving bones or joints of the jaw, such as Services to treat temporomandibular joint (TMJ) dysfunction, or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
5. approved machine testing such as electrocardiogram (EKG), electroencephalograph (EEG), and other electronic diagnostic medical procedures; and
6. genetic testing for the purpose of explaining current signs and symptoms of a possible hereditary disease and/or for other purposes in accordance with our Medical Necessity criteria then in effect.

Exclusion

Oversight of a medical laboratory by a Physician or other health care Provider, as described in the WHAT IS NOT COVERED? section.

Dialysis Services

Coverage includes equipment, training and medical supplies, when rendered at any location by a Provider licensed to perform dialysis, including a Dialysis Center.

Durable Medical Equipment

Durable Medical Equipment may be covered when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, and is limited to the most cost-effective equipment, as determined by us. Replacement of Durable Medical Equipment due to growth of a child or significant change in functional status, and repair of equipment you own or are buying are also Covered Services.

Examples of Durable Medical Equipment include: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Payment Rules for Durable Medical Equipment

Benefits for Durable Medical Equipment will be based on the lowest of the following:

1. the purchase price;
2. the lease/purchase price;
3. the rental rate; or
4. our Allowed Amount. Our Allowed Amount for rental equipment will not exceed the total purchase price.

Note: Remember that your Cost Share is applied as claims are received and paid by us. This is important because if you are leasing to purchase Durable Medical Equipment, your Cost Share will apply throughout the lease period and continue until the equipment has been completely paid for.

For example, you may lease to purchase a piece of equipment in November after you have met your Deductible for that year, but if the lease continues into the next year, or if the purchase is made in the next year, we will not make any more payments until you have met your Deductible again.

Exclusion

Durable Medical Equipment that is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such

as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment just because it is old or used.

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services for treatment of an Emergency Medical Condition are covered In-Network and Out-of-Network without the need for any prior authorization from us.

You must notify us as soon as possible, concerning the receipt of Emergency Services and/or any admission which results from an Emergency Medical Condition.

Exclusion

Follow-up care must be rendered by an In-Network PCP or In-Network Specialist. If you are told you need follow-up care after your emergency room visit, be sure to contact your PCP or an In-Network Specialist first. Any follow-up care you receive that is rendered by a Provider other than your PCP or an In-Network Specialist may not be covered.

Urgent Care Services

For non-critical but urgent care needs, you may be able to reduce your out-of-pocket expenses and, in many cases, your wait time for care by using an Urgent Care Center. All Urgent Care Centers maintain extended weekday and weekend hours. Urgent Care Centers treat non-emergency conditions such as:

- Animal bites
- Cuts, scrapes and minor wounds
- Minor burns
- Minor eye irritations or infections
- Rash, poison ivy
- Sprains, strains, dislocations and minor fractures

Enteral Formulas

Prescription and non-prescription enteral formulas for home use are covered when prescribed by a Physician and when Medically Necessary, in accordance with our Medical Necessity criteria then in effect.

Eye Care and Vision Services

Some types of eye care and vision Services are covered under the medical benefits; some are covered under your Pediatric Vision Benefits. The only reason you need to know this is that some Services may have a different Cost Share depending on whether the Services are covered under your medical benefits or your Pediatric Vision Benefits. Exclusions that apply to all Services are listed under the section titled General Eye Care and Vision Exclusions.

Eye care and vision Services covered under the **medical benefits** are limited to the following:

1. Physician Services, soft lenses or sclera shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician Services to treat an injury to or disease of the eyes.

Pediatric Vision Benefits

Pediatric Vision Benefits, as used in this Booklet, means Covered Services, as described below, for Covered Persons age 19 and under. Pediatric Vision Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

Pediatric Vision Benefits are covered under this section **only** if they are

1. not specifically or generally limited or excluded; and
2. authorized for coverage by us, if prior authorization is required.

Note: The BLUECARD PROGRAM and AWAY FROM HOME CARE sections do not apply to these Services.

Pediatric Vision Benefits are limited to the following:

1. Eye exam including dilation (when professionally indicated), once every 12 months.
2. Spectacle lenses, one pair every 12 months, including:
    a. clear plastic single-vision lenses;
    b. lined bi-focal, trifocal or lenticular lenses;
    c. polycarbonate lenses;
    d. standard progressive lenses;
    e. plastic photosensitive lenses;
    f. oversize lenses;
    g. scratch resistant coating;
    h. tinting of plastic lenses; and
    i. ultraviolet coating.
3. Frames covered under this Booklet are limited to the Pediatric Frame Selection. The network provider will show you the selection of frames covered under this Booklet. If you select a frame that is not included in the Pediatric Frame Selection covered under this Booklet, you are responsible for the difference in cost between the network provider reimbursement amount for covered frames from the Pediatric Frame Selection and the retail price of the frame you selected. Any amount paid to the Provider for the difference in cost of a Non-Selection Frame will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum.
4. Elective contact lenses covered under this Booklet are limited to the Pediatric Contact Lens Selection and includes the evaluation, contact lens fitting and follow-up. The network provider will inform you of the contact lens selection covered under this Booklet. If you select a contact lens that is not part of the Pediatric Contact Lens Selection covered under this Booklet, you are responsible for the difference in cost between the network provider reimbursement amount for covered contact lenses available from the Pediatric Contact Lens Selection and the retail price of the contact lenses you selected. Any amount paid to the Provider for the difference in cost of a Non-Selection Contact Lens will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum.

5. Contact lenses (with prior authorization), when glasses cannot correct your vision properly, includes materials; evaluation; fitting; and follow-up care.

Duplication of Vision Coverage

You cannot receive coverage under the Eye Care and Vision Services category for a Covered Service under both the medical and Pediatric Vision Benefits. Eye care and vision Services covered under medical benefits will not be covered under the Pediatric Vision Benefits, and vision Services covered under Pediatric Vision Benefits will not be covered under medical benefits.

General Eye Care and Vision Exclusions

1. Health Care Services to diagnose or treat vision problems for Covered Persons that are not a direct consequence of trauma or prior eye surgery, except as covered under Pediatric Vision Benefits;
2. vision examinations other than as described in the Pediatric Vision Benefits category;
3. eye exercises or visual training; and
4. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.

Family Planning

Family planning Services include:

1. family planning counseling and Services, such as counseling and information on birth control; sex education, including prevention of venereal disease; and fitting of diaphragms;
2. contraceptive medication by injection provided and administered by a Physician;
3. intra-uterine devices indicated as covered in the Preventive Services Guide located on our website at www.floridablue.com/healthresources, coverage includes insertion and removal; and
4. surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services may be covered under the Preventive Services category and will be paid in accordance with that category. Please refer to that category for more information.

Contraceptive medications, devices and appliances, other than as noted above may be covered under your pharmacy benefit. Refer to the PRESCRIPTION DRUG PROGRAM section for more information.

Exclusion

Elective abortions and the reversal of surgical sterilization procedures are not covered.

Home Health Care

Home Health Care Services may be covered when all the following criteria are met:

1. you are unable to leave your home without considerable effort and assistance because you are bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;
2. the Home Health Care Services rendered have been prescribed by a Physician;

3. the Home Health Care Services are provided by or through a Home Health Agency within the Service Area; and
4. you are meeting or achieving the desired treatment goals as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse and/or home health aide Services; (part-time is defined as less than eight hours per day and less than 40 hours a week and an intermittent visit will not exceed two hours per day);
2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and provided under the supervision of a Registered Nurse;
3. medical social Services;
4. nutritional guidance;
5. respiratory or inhalation therapy, such as oxygen; and
6. Physical Therapy, by a Physical Therapist, Occupational Therapy, by an Occupational Therapist, and Speech Therapy, by a Speech Therapist.

Exclusion

1. homemaker or domestic maid services;
2. sitter or companion services;
3. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
4. Speech Therapy provided for diagnosis of developmental delay;
5. Custodial Care;
6. Food, housing and home-delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is:

1. approved by your Physician; and
2. certified to us in writing by your Physician that your life expectancy is 12 months or less.

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;

2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary or inhalation therapy, such as oxygen;
6. Drugs and medicines administered by the Hospital (except for take-home Drugs);
7. intravenous solutions;
8. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as an EKG;
13. chemotherapy and radiation treatment for proven malignant disease;
14. Physical, Speech, Occupational and Cardiac Therapies;
15. transplants as set forth in the Transplants Services category; and
16. other Medically Necessary Services.

Exclusion

1. All expenses for Hospital Services (including the Hospital charges, Physician charges and any other charges related to an inpatient stay) are excluded when Services could have been rendered without admitting you to the Hospital.
2. gowns and slippers;
3. shampoo, toothpaste, body lotions and hygiene packets;
4. take-home drugs;
5. telephone and television;
6. guest meals or gourmet menus; and
7. admission kits.

Inpatient Habilitatative and Rehabilitative Services

Inpatient Habilitative Services

Inpatient Habilitative Services are limited to inpatient feeding programs when children are ready to wean from tube feeding and/or the failure to progress after intensive outpatient programs. Covered inpatient Habilitative Services are subject to the maximum number of days indicated in the Schedule of Benefits, when all of the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive habilitative program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect; and
4. Habilitative Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Inpatient Rehabilitative Services

Inpatient Rehabilitative Services may be covered, subject to the maximum number of days indicated in the Schedule of Benefits, when all of the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect;
4. you must be able to actively participate in at least two of the following therapies: Cardiac Therapy, Physical Therapy, pulmonary therapy or Speech Therapy and be able to tolerate at least three hours per day of Rehabilitative Services for at least five days a week t; and
5. Rehabilitative Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Exclusion

All inpatient Rehabilitative Services for Pain Management and respiratory ventilator management Services are excluded.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate regulatory agencies for diagnostic purposes or breast cancer screening may be Covered Services.

In accordance with the Florida Statute 641.31095, coverage is available under the following circumstances:

1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
2. A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's Physician's recommendation.
3. A mammogram every year for any woman who is 50 years of age or older.
4. One or more mammograms a year, based upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.

Mastectomy Services

Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas) and outpatient post-surgical follow-up care for Mastectomy Services may be covered when rendered by a Provider in accordance with prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center or your home as determined by you and your Physician.

Maternity Services

Health Care Services provided to you by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife are Covered Services and include:

Physician or Midwife Services provided to you for routine pregnancy, delivery, miscarriage or pregnancy complications. If your plan includes a Copayment for office Services, you will usually only have one Copayment, due on the first visit, for all prenatal care, the delivery and your follow-up visits to your obstetrician or Midwife. This Copayment applies only to Physician or Midwife Services relating to the pregnancy; any visits you have due to illness not related to the pregnancy may require a separate per-visit Copayment.

Hospital or Birth Center Services for labor and delivery of the baby. This includes a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment and room and board for the mother and routine nursery care. Your Cost Share for these Services is listed on your Schedule of Benefits and is in addition to your Cost Share for the obstetrician or Midwife. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply.

Routine nursery care for the newborn child during the covered portion of the mother’s maternity stay is included under this benefit. However, when an infant requires non-routine treatment during or after the mother’s stay, the newborn is considered a patient in his or her own right and will be covered separately only if the newborn is properly enrolled. The newborn’s Hospital admission in this case is subject to separate Cost Share amounts.

Note: A plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, this does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case a plan can only require that a Provider obtain authorization for prescribing an inpatient Hospital stay that exceeds 48 hours (or 96 hours).

Medical Pharmacy

Prescription Drugs that are provided in a Physician’s office may have a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug but does not include the cost for the Services of the person who administers the Prescription Drug to you. Allergy injections and immunizations are not part of the Medical Pharmacy benefit.

You or your Physician must contact us to request coverage for a Prescription Drug covered under this category before administering it to you by following the process for prior coverage authorization process

outlined in the Medication Guide. Prescription Drugs covered under this category may be subject to the utilization review programs described in the PRESECRIPTION DRUG PROGRAM section.

Your plan may also include a maximum amount that you have to pay out-of-pocket for Medical Pharmacy Prescription Drugs you receive each month. If your plan includes a Medical Pharmacy out-of-pocket maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

Please refer to your Schedule of Benefits for the additional Cost Share amount and/or monthly maximum out-of-pocket applicable to Medical Pharmacy for your plan.

Newborn Care

A newborn child who is properly enrolled may be covered from the moment of birth for injury or illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment

An assessment of the newborn child is covered when the Services are rendered at a Hospital, attending Physician's office, Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife. Covered Services include physical assessment of the child and any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Newborn Ambulance Services

Ambulance Services may be covered when necessary to transport the newborn child to and from the nearest appropriate facility that is appropriately staffed and equipped to treat the child's Condition, as determined by us and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child.

Nutrition Counseling

Nutrition counseling by a licensed Dietitian as described in the Diabetes Treatment Services category or as part of the treatment of a Mental and Nervous Disorder or Substance Dependency Condition or Services that meet the definition of Medical Necessity for treatment of a Condition.

Orthotic Devices

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets may be covered when prescribed by a Physician and designed and fitted by an Orthotist.

Benefits may be provided for necessary replacement of an Orthotic Device you own when due to irreparable damage, wear, a change in your Condition, or when necessary due to growth of a child.

Payment for splints for the treatment of temporomandibular joint (TMJ) dysfunction is limited to one splint in a six-month period unless a more frequent replacement is determined by us to be Medically Necessary. Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device which meets your medical needs as determined by us.

Exclusion

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers,

ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) when Medically Necessary, in accordance with our Medical Necessity criteria then in effect.

2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding, such as dynamic orthotic cranioplasty or molding helmets; except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis.
3. Expenses for devices necessary to exercise train or participate in sports, such as custom-made knee braces.

Osteoporosis Services

Screening, diagnosis and treatment of osteoporosis may be covered for high-risk individuals, including, but not limited to individuals who:

1. are estrogen-deficient and at clinical risk for osteoporosis;
2. have vertebral abnormalities;
3. are receiving long-term glucocorticoid (steroid) therapy;
4. have primary hyperparathyroidism; or
5. have a family history of osteoporosis.

Outpatient Habilitative and Rehabilitative Services

1. Outpatient Habilitative Services

   The outpatient therapies listed below may be Covered Services when provided as Habilitative Services and ordered by a Physician or other health care professional licensed to perform such Services. These are the only outpatient habilitative therapies covered under this Booklet. Some therapies may also be covered in other health care settings; see the Home Health Care, Hospital, Inpatient Habilitative and Rehabilitative and Skilled Nursing Facility categories in this section. Your Schedule of Benefits sets forth the maximum number of visits that we will pay for any combination of the outpatient therapies, provided as Habilitative Services listed in this category.

   - **Occupational Therapy** Services provided by a Physician or Occupational Therapist to keep, learn or improve skills and functioning for Daily Living.
   - **Speech Therapy** Services rendered by a Physician, Speech Therapist, or licensed audiologist to keep, learn or improve skills and functioning for Daily Living.
   - **Physical Therapy** Services provided by a Physician or Physical Therapist to keep, learn or improve skills and functioning for Daily Living.

     Coverage Access Rules for Physical Therapy

     Coverage for Physical Therapy Services s limited to no more than four 15-minute treatments per day for Physical Therapy treatment, not to exceed the Outpatient Habilitative Therapies benefit maximum listed on your Schedule of Benefits.

Exclusion

Cardiac Therapy, Massage Therapy and spinal manipulation Services are not covered as Habilitative Services.

2. Outpatient Rehabilitative Therapies

a. **Outpatient Therapies**

The outpatient therapies listed below may be Covered Services when provided as Rehabilitative Services and ordered by a Physician or other health care professional licensed to perform such Services. These are the only outpatient rehabilitative therapies covered under this Booklet.Some therapies may also be covered in other health care settings; see the Home Health Care, Hospital Services, Inpatient Habilitative and Rehabilitative and Skilled Nursing Facility categories in this section.

Your Schedule of Benefits sets forth the maximum number of visits that we will cover for any combination of the outpatient therapies and spinal manipulation Services, provided as Rehabilitative Services, listed in this category. For example, even if you have only received two of your spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy visit maximum with other Services.

- **Cardiac Therapy** Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.
- **Occupational Therapy** Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition.
- **Speech Therapy** Services rendered by a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition.
- **Physical Therapy** Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition.
- **Massage Therapy** Services provided by a Physician, Massage Therapist, or Physical Therapist are covered when the Massage Therapy is prescribed as being Medically Necessary for the treatment of an acute illness or injury (rehabilitative) by a Physician licensed per Florida Statutes Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry). The Physician's Prescription must specify the number of treatments.

  Coverage Access Rules for Massage and Physical Therapy

  1. Coverage for Massage Therapy Services is limited to no more than four 15-minute Massage treatments per day, not to exceed the Outpatient Rehabilitative Therapies and Spinal Manipulations benefit maximum listed in your Schedule of Benefits.

2. Coverage for a combination of Massage and Physical Therapy Services rendered on the same day is limited to no more than four 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Rehabilitative Therapies and Spinal Manipulations benefit maximum listed on your Schedule of Benefits.
3. Coverage for Physical Therapy Services rendered on the same day as spinal manipulation is limited to one Physical Therapy treatment per day not to exceed 15 minutes in length.

Exclusion

Application or use of the following or similar techniques or items for the purpose of aiding in the provision of a Massage including, but not limited to: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; and/or contrast baths are not covered.

b. **Spinal Manipulation**

Spinal manipulation Services rendered by Physicians for manipulation of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray may be covered.

Coverage Access Rules for Spinal Manipulation

It is important that you understand the difference between a spinal manipulation and a visit in order to understand how the benefit limits work. During a visit, more than one Service can be rendered and billed. Spinal manipulation is a treatment modality or method and more than one spinal manipulation can occur and be billed during a single visit to a Provider. There are limits under this coverage for the number of spinal manipulations and also for the number of visits we will cover during a Benefit Period.

1. Coverage for spinal manipulation is limited to the number of spinal manipulations listed in your Schedule of Benefits each Benefit Period **or** the maximum number of visits listed in your Schedule of Benefits, whichever occurs first.
2. Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one Physical Therapy treatment per day, not to exceed 15 minutes in length.

Oxygen

Coverage includes oxygen and the use of equipment for its administration.

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility.

Exclusion

Expenses for Health Care Services rendered by telephone (except as indicated as covered under the Preventive Services category) or failure to keep a scheduled appointment.

Preventive Services

Preventive Services may be covered for both adults and children based on prevailing medical standards and recommendations which are explained further below. Some examples of preventive Services include (but are not limited to) periodic routine health exams, routine gynecological exams, immunizations and related preventive Services such as Prostate Specific Antigen (PSA), routine mammograms and pap smears.

In order to be covered as a preventive Service, Services shall be provided in accordance with prevailing medical standards:

1. consistent with evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) established under the Public Health Service Act;
2. consistent with immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph number one as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

More detailed information, such as medical management programs or limitations, on Services that are covered under the Preventive Services category is available in the Preventive Services Guide located on our website at www.floridablue/healthresources.com. Drugs or Supplies covered as Preventive Services are described in the Medication Guide. In order to be covered as a Preventive Service under this section, the Service must be provided as described in the Preventive Services Guide or, for Drugs and Supplies, in the Medication Guide.

Note: From time to time medical standards that are based on the recommendations of the entities listed in numbers 1 through 4 above are changed. Services may be added to the recommendations and sometimes may be removed. It is important to understand that your coverage for these preventive Services is based on what is in effect on your Effective Date. If any of the recommendations or guidelines change after your Effective Date, your coverage will not change until your Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

For example, if the USPSTF adds a new recommendation for a preventive Service that we do not cover and you are already covered under this Booklet; that new Service will not be a Covered Service under this category right away. The coverage for a new Service will start on your Group's Anniversary Date one year after the new recommendation goes into effect.

Exclusion

Routine vision and hearing examinations and screenings are not covered as Preventive Services, except as required under paragraph numbers one and/or three above.

Prosthetic Devices

The following Prosthetic Devices are covered when prescribed by a Physician and designed and fitted by a Prosthetist:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and Prosthetic Devices incident to a Mastectomy;
2. appliances needed to effectively use artificial limbs or corrective braces; and
3. penile prosthesis.

Covered Prosthetic Devices (except cardiac pacemakers, and Prosthetic Devices incident to Mastectomy) are limited to the first permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition. Coverage for Prosthetic Devices is based on the most cost-effective Prosthetic Device which meets your medical needs as determined by us.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessary due to growth of a child.

Exclusion

1. Expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs); and
2. Expenses for cosmetic enhancements to artificial limbs.

Second Medical Opinion

You are entitled to a second medical opinion when:

1. you do not agree with the opinion of your treating Physician or us regarding the reasonableness or necessity of a surgical procedure or treatment of a serious injury or illness; or
2. you feel you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated.

You may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion, but will need to ask your PCP or an In-Network Specialist to get an authorization from us before you receive the Services. However, you should know that your Cost Share amount for Services rendered by an In-Network Provider (usually a set Copayment) for a second medical opinion will be lower than those rendered by an Out-of-Network Provider. When you use an Out-of-Network Provider for a second medical opinion, your Cost Share will be a percentage of our Allowed Amount, which may be less than the Out-of-Network Provider charges for such Services. In this case, in addition to your percentage of the Allowed Amount, you will also have to pay any charges billed by an Out-of-Network Provider in excess of the Allowed Amount.

All tests in connection with rendering the second medical opinion, including tests ordered by an Out-of-Network Physician, must be Medically Necessary and must be performed by In-Network Providers.

We may deny coverage for a second medical opinion if you seek more than three in any Benefit Period if we deem the second medical opinion costs are evidence that you are unreasonably over-utilizing the

second medical opinion privileges. Our decision, after review of documentation from the second medical opinion you obtained, will be controlling as to our obligation to pay for such treatment.

Self-Administered Prescription Drugs

Self-Administered Prescription Drugs are generally covered under the pharmacy benefit (PRESCRIPTION DRUG PROGRAM section). However, there are times when these Drugs would be covered under the medical benefits, for example when you are an inpatient in a Hospital or Skilled Nursing Facility or when rendered to you by a Provider for immediate stabilization, such as anaphylaxis. Also see the following Covered Service Categories: Ambulatory Surgical Centers, Hospital Services and Skilled Nursing Facilities.

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when you are an inpatient in a Skilled Nursing Facility:

1. room and board;
2. respiratory, pulmonary or inhalation therapy, such as oxygen;
3. Drugs and medicines administered while an inpatient (except take-home Drugs);
4. intravenous solutions;
5. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as an EKG;
9. chemotherapy and radiation treatment for proven malignant disease;
10. Physical, Speech and Occupational Therapies; and
11. other Medically Necessary Services.

Exclusion

Expenses for an inpatient admission to a Skilled Nursing Facility for Custodial Care, convalescent care, or any other Service primarily for your convenience or that of your family members or the Provider are not covered.

Surgical Procedures

Surgical procedures rendered by a Physician, including surgical assistant Services rendered by a Physician, Registered Nurse First Assistant (RNFA) or a Physician Assistant acting as a surgical assistant when such assistance is Medically Necessary, include the following:

1. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
2. oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;

3. surgical procedures involving bones or joints of the jaw such as temporomandibular joint (TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and
4. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and
5. Gender Reassignment surgery and Services, including breast augmentation and reduction mammoplasty, related to gender dysphoria or gender transition.

   Note: Gender Reassignment surgery must be authorized in advance, by us, in order to be covered.

Exclusion

The following Services, which are considered cosmetic in nature, are not covered when used to improve the gender-specific appearance of an individual. Examples of Services which are considered cosmetic include, but are not limited to:

a. reduction thyroid chondroplasty;
b. liposuction;
c. rhinoplasty;
d. facial bone reconstruction;
e. face lift;
f. blepharoplasty;
g. voice modification surgery;
h. hair removal/hairplasty; and
i. breast augmentation and reduction mammoplasty, except as specifically indicated as a Covered Service elsewhere in this Booklet.

Payment Rules for Surgical Procedures

1. When multiple surgical procedures are performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session, our payment will be based on 50 percent of the Allowed Amount for any secondary surgical procedure performed and is subject to the Cost Share amount (if any) indicated in your Schedule of Benefits. This guideline applies to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An “incidental surgical procedure” includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure, which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (there is no payment for the removal of the normal appendix in the example).

3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount for the surgical procedure.

Transplant Services

Transplant Services, limited to the procedures listed below, are covered when authorized in advance by us and performed at a facility acceptable to us. Coverage is subject to the conditions and limitations described below. Transplant includes pre-transplant, transplant and post-discharge Services and treatment of any complications after transplantation.

1. Bone Marrow Transplant, as defined herein and specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung transplant.

You may call the customer service phone number on your ID Card to determine which Bone Marrow Transplants are covered under this Booklet.

Lodging and Transportation

Expenses for lodging (hotel, motel, apartment or house rentals) and transportation (air, rail, bus, mileage and/or taxi) for a transplant recipient and companion may be covered when:

1. the transplant recipient is a Covered Person at the time Services are rendered;
2. the transplant is a Covered Service at the time Services are rendered and is designated by us as eligible for lodging and transportation assistance. Please note that only certain types of transplants are eligible for lodging and transportation assistance; the fact that a transplant is a Covered Service under this Booklet, does not mean such transplant is eligible for lodging and transportation assistance;
3. Covered Services are performed at a Designated Transplant Facility;

4. lodging and transportation arrangements to and from the Designated Transplant Facility are coordinated through us;
5. the transplant, including pre-transplant evaluation, has been approved by us in advance; and
6. the facility where the transplant will be performed is 50 miles or more away from the recipient's home, unless a shorter distance is Medically Necessary, as determined by us.

The lodging and transportation benefit is limited to $10,000 per Transplant Travel Benefit Period.

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized by us **before** they are provided.
4. Transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect;
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility, except as indicated under the Lodging and Transportation heading above.
11. Expenses related to evaluation for registration at more than one transplant center (dual listing).
12. Travel expenses that are not authorized by us in advance and those associated with:
    a. transplants that are not covered under this Booklet;
    b. evaluation for registration at more than one transplant center (dual listing); or
    c. costs considered taxable income under IRS regulations.

Virtual Visits

Your plan covers Virtual Visits between you and a Virtual Care Provider when rendered consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered. Not all

Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Coverage includes Virtual Visits between you and an In-Network Provider who offers Virtual Visits at the time the Services are rendered. The Cost Shares for Virtual Care Provider Services are listed in your Schedule of Benefits.

Exclusion

1. Expenses for failure to keep a scheduled Virtual Visit.
2. Virtual Visits rendered by any Provider other than a Virtual Care Provider, as defined in the DEFINITIONS section.

PRESCRIPTION DRUG PROGRAM

Introduction

Coverage for Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at an In-Network Pharmacy is provided through the ValueScript Rx Pharmacy Program described in this section. Some Health Care Services are available in a Pharmacy and in a medical office or facility, however we will only pay for them under one benefit (medical or pharmacy). For this reason some items are excluded under this section, but covered under the medical benefits. In these cases, we will tell you what section to go to for more information.

A Formulary list is included in the ValueScript Rx Medication Guide (referred to as "Medication Guide" hereafter), where you will find a listing of Generic Prescription Drugs and Brand Name Prescription Drugs. Generic Prescription Drugs not included on the Formulary List are covered unless specifically listed in the Limitations and Exclusions subsection. In order to be covered under this Pharmacy Program, Brand Name Prescription Drugs must be included on the Formulary List. You may be able to reduce your out-of-pocket expenses by choosing Generic Prescription Drugs.

To verify if a Pharmacy is an In-Network Pharmacy, or to view the Medication Guide, you may access the Pharmacy Program Provider Directory or Medication Guide at www.floridablue.com or call the customer service phone number on your ID Card.

Covered Drugs and Supplies

A Prescription Drug, Covered OTC Drug or Self-Administered Injectable Prescription Drug is covered under this section **only** if it is:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
2. dispensed by a Pharmacist at an In-Network Pharmacy;
3. Medically Necessary, as defined in this Booklet and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;
4. in the case of a Brand Name Prescription Drug, included on the Formulary List in the Medication Guide;
5. in the case of a Self-Administered Injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a Covered Self-Administered Injectable Prescription Drug;
6. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide;
7. a Prescription Drug contained in an anaphylactic kit;
8. authorized for coverage by us, if prior coverage authorization is required, as indicated with a special symbol in the Medication Guide, then in effect;

9. not specifically or generally limited or excluded herein;
10. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs;
11. reviewed by our Pharmacy and Therapeutics Committee; and
12. within the Coverage and Benefit Guidelines category listed in this section.

A Supply is covered under this section **only** if it is:

1. a Covered Prescription Supply;
2. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license;
3. Medically Necessary; and
4. not specifically or generally limited or excluded herein.

Cost Share Tiers

All Drugs and Supplies covered under this section are assigned to a Cost Share tier. The Cost Share tiers that apply to your plan are described below:

Tier 1: Preventive Prescription Drugs and Supplies

Tier 2: Condition Care Generic Prescription Drugs and Supplies

Tier 3: Low Cost Generic Prescription Drugs and Supplies

Tier 4: Condition Care Brand Name Prescription Drugs and Supplies

Tier 5: High Cost Generic, Preferred Brand Name Prescription Drugs and Supplies

Tier 6: Specialty Generic and Brand Name Prescription Drugs and Non-Preferred Prescription Drugs and Supplies

Within the above tiers, Cost Share amounts are lower when Covered Drugs and Supplies are purchased from a Preferred Pharmacy.

Condition Care Rx Program

Certain medications used in the treatment of chronic Conditions, may be available to you at a lower Cost Share. These Drugs and Supplies are included in the Medication Guide. If your plan includes a reduced Cost Share for these Drugs and Supplies, the Cost Share will be indicated in the Schedule of Benefits.

Preventive Medications

Certain medications may be available at no Cost Share when purchased from a Preferred Pharmacy or the Mail Order Pharmacy, if they are considered a Preventive Service as outlined in the WHAT IS COVERED? section. Please see the Medication Guide for a list of these medications.

Coverage and Benefit Guidelines

The benefits under this Pharmacy Program have special benefit and payment rules in addition to rules that are specific to particular Covered Services listed in this Booklet.

Contraceptive Coverage

Prescription diaphragms, oral contraceptives and contraceptive patches are covered under this Pharmacy Program subject to the limitations and exclusions listed in this section.

Generic Prescription oral contraceptives (including generic emergency contraceptives) and diaphragms indicated as covered in the Medication Guide, are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Preferred Pharmacy or the Mail Order Pharmacy. Contraceptives purchased from Standard Pharmacies are subject to the applicable Cost Share on your Schedule of Benefits.

Exceptions may be considered for Brand Name oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an "Exception Request Form" from your Physician.

You can obtain an Exception Request Form on our website at www.floridablue.com or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

Note: Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants, such as Norplant and IUD inserted for any purpose are not covered under this section. Some contraceptive methods are covered under the medical benefits, see the WHAT IS COVERED? section for more information.

Covered Over-the-Counter (OTC) Drugs

Certain OTC Drugs, listed in the Medication Guide, may be covered when you get a Prescription for the OTC Drug from your Physician. Only OTC Drugs that are listed in the Medication Guide are covered.

Diabetic Coverage

Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this section.

Insulin is **only** covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting insulin are covered only when prescribed in conjunction with insulin.

The following Supplies and equipment used in the treatment of diabetes are covered under the Pharmacy Program: blood glucose testing strips and tablets, lancets, blood glucose meters, acetone test tablets and syringes and needles.

Note: Other Supplies used in the treatment of diabetes are covered under the medical benefits, see the WHAT IS COVERED? section for more information.

Mineral Supplements, Fluoride or Vitamins

Unless noted below, the following Drugs are covered **only** when state or federal law requires a Prescription and when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license:

1. prenatal vitamins;
2. oral single-product fluoride (non-vitamin supplementation);

3. sustained release niacin;
4. folic acid;
5. oral hematinic agents;
6. dihydrotachysterol; or
7. calcitriol.

Note: The Drugs in this category may be available at no Cost Share if they are considered a Preventive Service as outlined in the WHAT IS COVERED? section, when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and obtained from a Preferred Pharmacy or the Mail Order Pharmacy.

Exclusion

Prescription vitamin or mineral supplements not listed above, non-prescription mineral supplements and non-prescription vitamins are not covered.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the Cost Share for Intravenous (IV) Chemotherapy Infusions when provided by an In-Network Provider.

Specialty Pharmacy Split Fill Option

Some types of medication may be difficult to tolerate for patients who are new to certain forms of treatment, such as oral oncology medication. To reduce waste and help avoid cost for medications that will go unused, the Specialty Pharmacy may split the first fill for certain medications identified in the Medication Guide. The Cost Share would also be split between the two fills.

Exception Process

If a Drug is not covered on the Formulary you may request an exception to gain access to the Drug. For additional details on how to request an exception please see the Medication Guide. You can obtain an Exception Request Form on our website at www.floridablue.com.

Limitations and Exclusions

Limitations

Coverage and benefits for Covered Prescription Drugs and Supplies and Covered OTC Drugs are subject to the following limitations in addition to all other provisions and exclusions in this Booklet.

1. We will not cover more than the Maximum supply, as set forth in the Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs.
2. Prescription refills beyond the time limit specified by state and/or federal law are not covered.
3. Certain Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.

4. Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. We reserve the right to cover the Biosimilar Prescription Drug as an alternative to coverage of the referenced Brand Name Prescription Drug.

Exclusions

1. Drugs that are covered and payable under the WHAT IS COVERED? section, such as Prescription Drugs which are dispensed and billed by a Hospital.
2. Except as covered in the Covered Drugs and Supplies subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription even when a written Prescription is provided (Drugs which do not require a Prescription), except for insulin, emergency contraceptives and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage of this Booklet.
6. Therapeutic devices, appliances, medical or other Supplies and equipment, such as air and water purifiers, support garments, creams, gels, oils and waxes, regardless of the intended use (except for Covered Prescription Supplies).
7. Drugs and Supplies that are:
    a. in excess of the limitations specified in this section or on the Schedule of Benefits;
    b. furnished to you without cost;
    c. Experimental or Investigational;
    d. indicated or used for the treatment of infertility;
    e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine or Renova;
    f. prescribed by a Pharmacist, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
    g. used for smoking cessation (except as indicated as covered under the Preventive Services category of the WHAT IS COVERED? section);
    h. listed in the Homeopathic Pharmacopoeia;
    i. not Medically Necessary;
    j. indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject;
    k. purchased from any source (including a Pharmacy) outside of the United States;
    l. prescribed by any health care professional not licensed in any state or territory of the United States of America, such as Puerto Rico, U.S. Virgin Islands or Guam; and

m. Brand Name Prescription Drugs, Supplies and OTC Drugs not listed in the Medication Guide.

8. Non-Formulary Drugs, unless approved through the exception process described in this section.
9. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines subsection.
10. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.
11. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs and Supplies subsection.
12. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for such treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of your particular cancer that have not been approved for any indication are also excluded.
13. Drugs that have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce.
14. Drugs that are compounded, even when one or more active ingredients are Covered Prescription Drugs under this section;
15. Drugs and Supplies purchased from an Out-of-Network Pharmacy, except for Emergency Services or when authorized in advance by us.
16. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:
    a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;
    b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by the American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or
    c. we, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.
17. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by the:
    a. American Medical Association;
    b. National Heart Lung and Blood Institute;

c. American Cancer Society;

d. American Heart Association;

e. National Institutes of Health;

f. American Gastroenterological Association; or

g. Agency for Health Care Policy and Research;

unless we, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.

18. Any amount you are required to pay under the Pharmacy Program as indicated on the Schedule of Benefits.
19. Any benefit penalty reductions.
20. Drugs or Supplies you prescribe to yourself or that are prescribed by any person related to you by blood or marriage.
21. Food or medical food products, whether prescribed or not.
22. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a. the Drug is a Repackaged Drug;

    b. the Drug is no longer marketed;

    c. the Drug has been shown to have excessive adverse effects and/or safer alternatives;

    d. the Drug or an effective alternative is available Over-the-Counter (OTC);

    e. the Drug has a preferred formulary alternative;

    f. the Drug has a widely available/distributed AB rated generic equivalent formulation;

    g. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or

    h. the number of members affected by the change.

    Refer to the Medication Guide to determine if a particular Prescription Drug is excluded under this Pharmacy Program.

23. New Prescription Drugs.
24. We may not apply manufacturer or Provider cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

Payment Rules

The amount you must pay for Covered Prescription Drugs and Supplies or Covered OTC Drugs may vary depending on:

1. the participation status of the Pharmacy where purchased (i.e., In-Network Pharmacy versus Out-of-Network Pharmacy);

2. the terms of the Pharmacy's agreement with us or our Pharmacy Benefit Mangaer;
3. whether you have satisfied any Deductible and the amount of Copayment or Coinsurance set forth in the Schedule of Benefits;
4. the assigned Cost Share tier;
5. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and
6. If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
    a. the Cost Share amount that applies to the Brand Name Prescription Drug you received as indicated in your Schedule of Benefits; **and**
    b. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug you received.

    Note: The difference in cost described in b. above is a benefit penalty and therefore does not help to satisfy your Deductible or Out-of-Pocket Maximums.

Pharmacy Participation Status

For purposes of this section, there are two types of Pharmacies: In-Network Pharmacies and Out-of-Network Pharmacies.

In-Network Pharmacies

In-Network Pharmacies have agreed not to charge, or collect from, you, more than the amount set forth in the Schedule of Benefits for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug.

To verify if a Pharmacy is an In-Network Pharmacy, you may refer to the provider directory then in effect at www.floridablue.com or you may call the customer service phone number on your ID Card.

Prior to purchase, you must pay your Cost Share amount as listed in the Schedule of Benefits and present your ID Card and the Pharmacy must be able to verify that you are, in fact, covered by us.

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by an In-Network Pharmacy are less than the required Copayment, the amount you pay will depend on the agreement then in effect between the Pharmacy and us or our Pharmacy Benefit Manager, and will be one of the following:

1. The usual and customary charge of such Pharmacy as if it were not an In-Network Pharmacy;
2. The charge under the Pharmacy's agreement with us or our Pharmacy Benefit Manager; or
3. The Copayment, if less than the usual and customary charge of such Pharmacy.

Preferred Pharmacy

Preferred Pharmacies are a subset of In-Network Pharmacies and are designated, solely by us, as the Pharmacies where you can purchase Covered Prescription Drugs and Supplies for a lower Cost Share under this Pharmacy Program.

Specialty Pharmacy

Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions, are typically more difficult to maintain, administer and monitor when compared to traditional Drugs. Specialty Drugs may require frequent dosage adjustments, special storage and handling and may not be readily available at local Pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require.

These Specialty Drugs can only be purchased from a Specialty Pharmacy. Specialty Pharmacies are a subset of In-Network Pharmacies and are designated solely by us, as the Pharmacies where you can purchase Specialty Drugs under this Pharmacy Program. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for Specialty Drugs, even if such Pharmacy is an In-Network Pharmacy for other Covered Prescription Drugs under this Pharmacy Program.

For additional details on how to obtain Covered Prescription Specialty Drugs from a Specialty Pharmacy, refer to the Medication Guide.

Mail Order Pharmacy

For details on how to order Covered Prescription Drugs and Supplies and Covered OTC Drugs from the Mail Order Pharmacy, refer to the Mail Order Pharmacy Brochure or the Medication Guide.

Note: Specialty Drugs are not available through the Mail Order Pharmacy.

Out-of-Network Pharmacies

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from an Out-of-Network Pharmacy is covered under this Pharmacy Program **only** for Emergency Services or when authorized by us.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from an Out-of-Network Pharmacy for Emergency Services or when authorized by us, you may have to pay the full cost of the Drug at the time of purchase.

In order to be reimbursed for Covered Prescription Drugs and Supplies or Covered OTC Drugs purchased from an Out-of-Network Pharmacy, you must submit an itemized paid receipt to us at the address on your ID Card.

Pharmacy Utilization Review Programs

Our pharmacy utilization review programs are intended to help educate and encourage the responsible use of Drugs and Supplies. Please review the following information so that you know what you may need to do in order to get the medication you need, without delays at the Pharmacy, and at a lower Cost Share.

Prescription Drugs covered by this plan are subject to misuse, waste and/or abuse utilization review by us, your Provider and/or your In-Network Pharmacy. The outcome of this review may include:

- Limiting coverage of the applicable Drug(s) to one prescribing Provider and/or one In-Network Pharmacy.
- Limiting the quantity, dosage or Day Supply.
- Allowing only a partial fill or denial of coverage for such Drug(s).

We may, in our sole discretion, require that Prescriptions from your Provider for select Prescription Drugs and Supplies or OTC Drugs be reviewed under our pharmacy utilization review programs then in effect, in order for them to be covered. Under these programs, there may be limitations or conditions on coverage for select Prescription Drugs and Supplies and OTC Drugs, depending on the quantity, frequency, or type of Drug or Supply your Provider prescribed.

Note: If coverage is not available through these programs, or is limited, this does not mean that you cannot get the Drug or Supply from the Pharmacy; it only means that we will not cover or pay for the Drug or Supply. You are always free to purchase the Drug or Supply at your sole expense.

Our pharmacy utilization review programs include the following:

Responsible Steps Program

Many medical Conditions have several Drug treatment options that have been approved by the FDA, which means there may be a lower cost Drug that will effectively treat your Condition. Under the responsible steps program, certain Prescription Drugs and OTC Drugs may not be covered unless you have first tried one or more designated Drugs identified in the Medication Guide.

Your Physician must contact us to request coverage for a Prescription Drug that is part of the responsible steps program prior to prescribing the Drug. In order to be covered, we must receive written documentation from your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Coverage Protocol Exemption

Information on how to request a coverage protocol exemption or to appeal a denial of a request for exemption can be found on our website at https://www.floridablue.com/docview/coverage-protocol-exemption-request/.

Responsible Quantity Program

Safety limits apply to certain Drugs based on the Drug maker and FDA's guidelines. For example, your Physician may prescribe 12 tablets for a One-Month Supply and the prescribed Drug may have a 9-tablet limit for a One-Month Supply. Under this program, any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide may not be covered. If your Physician prescribes more than the Maximum quantity listed in the Medication Guide, you can either pay for the additional amount yourself or ask your Physician to request an authorization from us.

Prior Coverage Authorization Program

Certain Prescription Drugs and Supplies and OTC Drugs require prior authorization from us in order to be covered. **If you do not obtain an authorization when one is required we will deny coverage.** Prescription Drugs and Supplies and OTC Drugs that require prior authorization are marked in the Medication Guide with a special symbol.

If your Provider prescribes a medication for you that requires prior authorization, ask him or her to get an authorization for you before you go to pick it up. When the prior authorization decision has been made, we will let you and your Provider know.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your policy, or

2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

Information on our pharmacy utilization review programs is published in the Medication Guide. Your Pharmacist may also tell you if a Prescription Drug or OTC Drug requires prior coverage authorization.

Ultimate Responsibility for Medical Decisions

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the terms of this Booklet. Ultimately the final decision as to whether the Prescription Drug, Supply or OTC Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us in authorizing coverage are made only to determine whether coverage or benefits are available under this Pharmacy Program and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug, Supply or OTC Drug, must be made solely by you and your treating Physician in accordance with the patient/Physician relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug, Supply or OTC Drug is needed, appropriate, or desirable, even though such Prescription Drug, Supply or OTC Drug may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if we have indicated that we will not pay for such Prescription Drug, Supply or OTC Drug.

WHAT IS NOT COVERED?

Introduction

The following exclusions are in addition to any that are specified in the WHAT IS COVERED? and PRESCRIPTION DRUG PROGRAM sections, including any Endorsement that is a part of this Booklet. **If you do not follow our Coverage Access Rules, any Services you receive will not be covered.** For further information, please refer to the COVERAGE ACCESS RULES section.

We will not pay for any of the Services, treatments, or supplies described in this section, even when recommended or prescribed by a Physician or it is the only available treatment for your Condition.

Exclusions

Abortions, that are elective.

Ambulance Services, including but not limited to:

1. Services for situations that are not Medically Necessary because they do not require Ambulance transportation.
2. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
3. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
   a. the crew renders aid until a helicopter can be sent;
   b. the patient refuses care or transport; or
   c. only basic first aid is rendered.
4. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
5. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
6. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
   a. patient wants to be at a certain Hospital or facility for personal/preference reasons;
   b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment) or after being discharged from inpatient care; or
   c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
7. Air and water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Anesthesia administration Services rendered by an operating Physician who performed the surgery, his or her partner or associate.

Autopsy or postmortem examination Services, unless specifically requested by us.

Behavioral Health Services except as indicated in the WHAT IS COVERED? section, including:

1. Mental health Services which are (a) rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder; (b) for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability; (c) beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability, except for Services that meet the definition of Medical Necessity for the Condition; (d) for educational purposes, except for Services that meet the definition of Medical Necessity for the Condition; (e) for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder; (f) for pre-marital counseling; (g) for court ordered care or testing, or required as a condition of parole or probation, except for Services that meet the definition of Medical Necessity for the Condition; (h) to test aptitude, ability, intelligence or interest; (i) required to maintain employment; (j) for cognitive remediation, and (k) inpatient stays for Custodial Care, convalescent care, change of environment or any other Service primarily for your convenience or that of your family members or the Provider.
2. Substance dependency care and treatment Services that are long-term Services for alcoholism or drug addiction, including specialized inpatient units or inpatient stays that are primarily intended as a change of environment.

Clinical Trial expenses including:

1. Costs that are generally covered by the clinical trial, including, but not limited to:
    a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
    b. The investigational item, device or Service itself.
    c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
2. Services related to an Approved Clinical Trial received outside of the United States.
3. Services related to an Approved Clinical Trial that are not authorized by us in advance.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; prayer and mental healing; Massage except as listed in the WHAT IS COVERED? section; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, Swedish massage, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Cosmetic Services including any Service to improve the appearance or self-perception of an individual, including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling, such as Minoxidil, Rogaine, Retin-A, and hair implants/transplants or Services used to improve the gender specific appearance of individual including, but not limited to breast augmentation and reduction mammoplasty, except as specifically indicated as a Covered Service elsewhere in this Booklet, reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery and hair removal/hairplasty.

Cost Share amounts you are required to pay even when a Provider waives the Cost Share.

Custodial Care as defined in the DEFINITIONS section of this Booklet.

Dental Services except as indicated in the WHAT IS COVERED? section, including:

1. Dental Services, other than as described in the Pediatric Dental Benefits category, rendered more than 62 days after the date of an Accidental Dental Injury even if the Services could not have been rendered within 62 days.
2. Any dental Service not listed in the WHAT IS COVERED? section as covered.
3. Any dental Service listed under Pediatric Dental Benefits that is rendered by a Provider who is not an In-Network Provider, except for Emergency Services.
4. Cosmetic procedures, including, but not limited to veneer restorations, tooth whitening, and non-Medically Necessary orthodontia.
5. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
6. Charges for nitrous oxide.
7. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth reconstruction, restoration of tooth structure lost from attrition and restoration for crooked teeth.
8. Any additional treatment required because you do not follow instructions, or do not cooperate with the Dentist.
9. General anesthesia and intravenous sedation administered solely for patient management or comfort.
10. Services related to hereditary or developmental defects or cosmetic reasons, including but not limited to, cleft palate (except as covered under Child Cleft Lip and Cleft Palate Treatment category of the WHAT IS COVERED? section), upper or lower jaw defects, lack of development of enamel, discoloration of the teeth, and congenitally missing teeth.
11. Services other than as described in the Pediatric Dental Benefits category, including, but not limited to: care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays.

Drugs

1. Drugs prescribed for uses other than the United States Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. Drugs dispensed to, or purchased by you from a Pharmacy except as covered under the PRESCRIPTION DRUG PROGRAM section. This exclusion does not apply to Drugs dispensed to you when:
   a. you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
   b. you are in the outpatient department of a Hospital;
   c. dispensed to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required); or
   d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs..
3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, Over-the-Counter Drugs, products, or health foods.
4. Any Drug which is indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject.
5. Any Self-Administered Prescription Drug except when indicated as covered in the WHAT IS COVERED? or PRESCRIPTION DRUG PROGRAM sections of this Booklet.
6. Any Drug, which requires prior coverage authorization when prior coverage authorization is not obtained.
7. Blood or blood products used to treat hemophilia, except when provided to you for:
   a. emergency stabilization;
   b. during a covered inpatient stay; or
   c. when proximately related to a surgical procedure.
8. The exceptions to the exclusion for Drugs purchased or dispensed by a Pharmacy described in exclusion two above, do not apply to hemophilia Drugs excluded under this subparagraph.
8. New Prescription Drug(s), as defined in the DEFINITIONS section
9. Convenience Kits as defined in the DEFINITIONS section.

10. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment just because it is old or used.

Experimental or Investigational Services except as otherwise covered under the Bone Marrow Transplant provision described in the Transplant Services category of the WHAT IS COVERED? section.

Eye Care and Vision Services except as indicated in the WHAT IS COVERED? section, including:

1. Health Care Services to diagnose or treat vision problems for a Covered Person, that are not a direct consequence of trauma or prior eye surgery, other than as described in the Pediatric Vision Benefits category;
2. vision examinations other than as described in the Pediatric Vision Benefits category in the WHAT IS COVERED? section;
3. eye exercises, visual training or visual therapy;
4. eye glasses and contact lenses and their fitting except initial glasses or contact lenses following cataract surgery, other than as described in the Pediatric Vision Benefits category in the WHAT IS COVERED? section.
5. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.
6. any vision Service, treatment or materials not specifically listed as a Covered Service;
7. Services and materials not meeting accepted standards of optometric practice;
8. Services and materials resulting from your failure to comply with professionally prescribed treatment;
9. state or territorial taxes on vision Services performed;
10. special lens designs or coatings except as indicated in the WHAT IS COVERED? section;
11. replacement of lost or stolen eyewear;
12. non-prescription (Plano) eyewear;
13. two pairs of eyeglasses in lieu of bifocals;
14. Services not performed by licensed personnel;
15. Prosthetic Devices and Services except as indicated in the WHAT IS COVERED? section; and
16. insurance for contact lenses.

Follow-up Care related to an emergency room visit must be rendered by an In-Network PCP or In-Network Specialist. If you are told you need follow-up care after your emergency room visit, be sure to contact your PCP or an In-Network Specialist first. Any follow-up care you receive that is rendered by a Provider other than your PCP or an In-Network Specialist may not be covered.

Food and Food Products whether prescribed or not, except as covered in the Enteral Formulas category of the WHAT IS COVERED? section.

Foot Care (routine) including any Service or Supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, trimming of toenails, corns, or calluses, unless determined by us to be Medically Necessary.

General Exclusions include, but are not limited to:

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates.
2. Any Health Care Service not within the Covered Services Categories described in the WHAT IS COVERED? or PRESCRIPTION DRUG PROGRAM sections or any Endorsement that is part of this Booklet, unless such Services are specifically required to be covered by applicable law.
3. Any Health Care Service you render to yourself or those rendered by a Physician or other health care Provider related to you by blood or marriage.
4. Any Health Care Service that is not Medically Necessary as defined in this Booklet and determined by us. The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service.
5. Any Health Care Service rendered at no charge.
6. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage.
7. Any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a. war or an act of war, whether declared or not;
    b. your participation in, or commission of, any act punishable by law as a felony whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical Condition;
    c. your engaging in an illegal occupation, except for an injury resulting from an act of domestic violence or a medical Condition;
    d. Services received at military or government facilities to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or
    e. Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard.

8. Services that are not patient-specific, as determined solely by us, such as office infection control charges.
9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Booklet.
10. Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
11. Any Health Care Service rendered outside the Service Area, except Emergency Services for treatment of an Emergency Medical Condition, unless such Services are approved by us in advance.
12. Expenses for completion of any form and /or medical information and for copies of your records, or charts including any costs associated with forwarding or mailing copies of your records or charts.

Genetic Screening including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition, except as provided under the Diagnostic Testing and Preventive Services categories of the WHAT IS COVERED? section.

Hearing Services including routine hearing exams and screenings, except as provided under the Preventive Services category of the WHAT IS COVERED? section, and hearing aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries and repair costs.

Home Health Care Services that (1) are rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility; (2) are rendered in a nursing home, or intermediate care facility; or (3) is Speech Therapy provided for diagnosis of developmental delay.

Hospital Expenses including the Hospital charges, Physician charges and any other charges related to an inpatient stay are not covered when Services could have been rendered without admitting you to the Hospital.

Immunizations except those covered under the Preventive Services category of the WHAT IS COVERED? section or the PRESCRIPTION DRUG PROGRAM section.

Infertility Treatment including Services beyond what is necessary to determine the cause or reason for infertility and Services rendered to assist in achieving pregnancy are excluded. These Services include, but are not limited to:

1. Services provided to treat infertility;
2. reversal of voluntary surgical sterilization procedures;
3. all infertility treatment medications;
4. assisted reproductive therapy including, but not limited to, Artificial Insemination (AI); In VItiro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); and any Services associated with these procedures; and
5. all Services associated with the donation or purchase of sperm.

Inpatient Habilitative Services, except inpatient feeding programs when children are ready to wean from tube feedings and/or the failure to progress after intensive outpatient programs as described in the WHAT IS COVERED? section.

Inpatient Rehabilitative Services except as described in the WHAT IS COVERED? section, including all inpatient Rehabilitative Services for Pain Management and respiratory ventilator management Services.

Massage Techniques such as application or use of the following or similar techniques or items for the purpose of aiding in the provision of Massage including, but not limited to: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; and/or contrast baths.

Missed Appointment including any costs you incur for not going to a scheduled appointment, regardless of the reason for missing the appointment.

Motor Vehicle Accident Injuries and Services you incur due to an accident involving any motor vehicle for which no-fault insurance is available.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Orthotic Devices except as indicated in the WHAT IS COVERED? section, including:

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) when Medically Necessary, in accordance with our Medical Necessity criteria then in effect.
2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding, such as dynamic orthotic cranioplasty or molding helmets; except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis.
3. Expenses for devices necessary to exercise, train or participate in sports, e.g. custom-made knee braces.

Oversight of a medical laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion, shall include, but is not limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. the calibration of laboratory machines or testing of laboratory equipment;
3. the preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and
4. laboratory equipment or laboratory personnel for any reason.

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to your treatment, including, but not limited to:

1. homemaker or domestic maid services;
2. sitter or companion services;

3. food, housing and home-delivered meals;
4. beauty and barber services;
5. personal hygiene supplies such as shampoo, toothpaste, body lotions and hygiene packets;
6. clothing, including support hose;
7. radio and television;
8. guest meals and accommodations;
9. telephone charges;
10. take-home supplies or Drugs;
11. travel expenses (other than Medically Necessary Ambulance Services);
12. motel/hotel accommodations;
13. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
14. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
15. heating pads, hot water bottles, or ice packs;
16. physical fitness equipment;
17. hand rails and grab bars; and
18. Massage except as set forth in the WHAT IS COVERED? section.

Private Duty Nursing Care rendered at any location.

Prosthetic Devices except as indicated in the WHAT IS COVERED? section, including:

1. expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs); and
2. expenses for cosmetic enhancements to artificial limbs.

Services to Treat Complications of Non-Covered Services, including any Service(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this policy or another Florida Blue/Florida Blue HMO policy. It also applies if the non-covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this policy even if the Service(s) were covered under the prior carrier or self-funded plan.

Skilled Nursing Facilities expenses for an inpatient admission to a Skilled Nursing Facility for Custodial Care, convalescent care, or any other Service primarily for your convenience or that of your family members or the Provider.

Smoking Cessation Programs used for smoking cessation, except as indicated as covered under the Preventive Services category of the WHAT IS COVERED? section.

Sports-Related Devices and Services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

Telephone Consultations except as provided under the Preventive Services category of the WHAT IS COVERED? section.

Training and Educational Programs or materials, including, but not limited to programs or materials for Pain Management and vocational rehabilitation, except as provided under the Diabetes Treatment Services category of the WHAT IS COVERED? section.

Transplant Services except as indicated in the WHAT IS COVERED? section, including:

1. Transplant procedures not included in the Transplant Services category of the WHAT IS COVERED? section, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized by us **before** they are provided.
4. Transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility, except as indicated under the Lodging and Transportation heading of the Transplant Services catergory in the WHAT IS COVERED? section.
11. Expenses related to evaluation for registration at more than one transplant center (dual listing).
12. Travel expenses that are not authorized by us in advance and those associated with:
    a. transplants that are not covered under this Booklet;
    b. evaluation for registration at more than one transplant center (dual listing); or

c. costs considered taxable income under IRS regulations.

Travel or vacation expenses even if prescribed or ordered by a Provider.

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits under this Booklet.

Volunteer Services or Services which would normally be provided free of charge.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, except as indicated as covered under the Preventive Services category of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs, exercise or other equipment, gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this booklet or another Florida Blue/Florida Blue HMO policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Policy even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a. a licensed outdoor youth program, and/or
    b. a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Work-Related Health Care Services to treat a work related Condition to the extent you are covered; or required to be covered by Workers' Compensation law. Any Service to diagnose or treat any Condition resulting from or in connection with your job or employment will be excluded, except for Medically Necessary Services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

MEDICAL NECESSITY

In order for Health Care Services to be covered under this Booklet, the Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as determined by us and defined in this Booklet.

It is important to remember that any time we review Services for Medical Necessity it is solely for the purpose of determining coverage, benefits or payment under the terms of this Booklet and not for the purpose of recommending or providing medical care. When we review for Medical Necessity, we may review specific medical facts or information about you. Any such review, however, is strictly for the purpose of determining whether the Service provided or proposed meets the definition of Medical Necessity in this Booklet. In applying the definition of Medical Necessity to a specific Service, we may apply our coverage and payment guidelines then in effect.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Providers. You and your Providers are responsible for deciding what medical care you should have and when that care should be provided. We are solely responsible for determining whether expenses incurred for that medical care are covered under this Booklet. In making coverage decisions, we will not be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

The following are a few examples of hospitalization and other Services that are not Medically Necessary:

1. staying in the Hospital because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;
3. staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department or at home with Home Health Care Services); or
4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other Service primarily for the convenience of the patient or his or her family members or a Provider.

Note: Whether or not a Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Service does not mean that the Service is Medically Necessary (as determined by us and defined in this Booklet) or a Covered Service. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service. Please refer to the DEFINITIONS section for the definition of “Medically Necessary or Medical Necessity”.

YOUR SHARE OF HEALTH CARE EXPENSES

This section explains what your share of the health care expenses may be for Covered Services you receive. Since not all plans include all the different types of Cost Shares explained in this section, it is important that you look at your Schedule of Benefits to see your share of the cost for specific Covered Services.

Deductibles

A deductible is a fixed dollar amount that you must pay before we begin to pay for Covered Services. There are different types of deductibles; some that apply to most Covered Services on your plan and some that apply only to a specific type of Service. Listed below are the different types of deductibles and a brief explanation of how they work. You will need to look at your Schedule of Benefits to find out what types of deductibles (if any) apply to your plan.

Rules for applying charges to deductibles:

- we can only apply charges for claims we actually receive;
- only charges for Covered Services will be applied; and
- we will only apply the amount of charges up to our Allowed Amount.

Overall Deductible (DED)

This deductible applies to most of the Covered Services on your plan before we begin to pay for Covered Services. When we talk about this type we just call it "Deductible" and on the Schedule of Benefits "DED". Some Covered Services, such as Preventive Services, do not apply the Deductible, so be sure to look at your Schedule of Benefits. After the Deductible has been met, neither you nor your Covered Dependents (if any) will have any additional Deductible amount for the rest of that Benefit Period. The Deductible starts over every year on the first day of your Benefit Period.

There are individual and family Deductibles, both of which apply on a Benefit Period basis:

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by us. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount.

Family Deductible

If you have one or more family members on your plan, the family Deductible can be satisfied by any one Covered Person or a combination of Covered Persons depending on the type of family Deductible described below.

Embedded Deductible

If your Schedule of Benefits indicates that the Deductible is embedded, each Covered Person only needs to satisfy the individual Deductible and not the entire family Deductible, prior to us paying for Covered

Services for that Covered Person. We will not begin to pay for Covered Services for the other family members until they either satisfy the individual Deductible or until the family Deductible is met. The family Deductible is met when any combination of family members' costs for Covered Services meets the family Deductible limit. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward that person's individual Deductible.

Shared Deductible

If your Schedule of Benefits indicates that the family Deductible is Shared, the entire family Deductible must be met by any one Covered Person or a combination of any or all Covered Persons before we will begin to pay for Covered Services for any Covered Person under your plan.

Copayments

A Copayment is a fixed dollar amount you must pay when you receive certain Covered Services. Listed below are the different types of Copayments and a brief explanation of how they work. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you will pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

Copayments:

- must be paid at the time you receive the Services;
- apply before any payment will be made by us;
- apply regardless of the reason for the Service; and
- usually apply to all Services rendered during the visit, but there are exceptions to this rule, so be sure to check your Schedule of Benefits and the brief explanations below.

Office Services Copayment

An office Services Copayment applies to each office visit and applies to all Covered Services rendered during that visit, except for Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Copayment.

Inpatient Facility Services Copayment

The inpatient facility Copayment only applies to the inpatient facility (such as a Hospital) and you must pay it for each inpatient admission. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment

The outpatient facility Copayment only applies to an outpatient facility and you must pay it for each outpatient visit. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while using these facilities.

Note: Copayments for outpatient facility Services may vary depending on the type of facility chosen and the Services received. Please see your Schedule of Benefits for more information. If your plan includes a Copayment for emergency room Services and you are admitted to the Hospital as an inpatient at the

time of the emergency room visit, will pay the Cost Share that applies to inpatient facility Services, as indicated on your Schedule of Benefits.

Coinsurance

Coinsurance is a percentage of our Allowed Amount that you must pay before we will pay our portion of the Allowed Amount for Covered Services. The Coinsurance percentage is figured after all other Cost Share amounts for a given Service, such as Deductible.

Application of Multiple Cost Share Types

When a Service is subject to more than one type of Cost Share, the Schedule of Benefits will list the Cost Share types in the order in which they apply to the Service. For example, when the Schedule shows "$100 Copay then DED"; this means that the Copay is applied first and then, if you have not reached the Deductible; the Deductible is applied to the remainder of that Service, up to the Allowed Amount. If you have already met the plan Deductible; then only the Copay is applied.

Out-of-Pocket Maximums

An out-of-pocket maximum is the Benefit Period limit on Cost Share amounts that you have to pay for a given Benefit Period for Health Care Services that are Covered Services under this Booklet. After you have paid this dollar amount in Cost Share, you will have no additional Cost Share for the rest of that Benefit Period and we will pay 100 percent of our Allowed Amount for Covered Services rendered during the rest of that Benefit Period.

Individual Out-of-Pocket Maximum

If you are the only person on your plan, only the individual out-of-pocket maximum applies to you and the family out-of-pocket maximum listed on your Schedule of Benefits does not apply to you. After you have paid this dollar amount in Cost Share, you will have no additional Cost Share for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the rest of that Benefit Period.

Family Out-of-Pocket Maximum

If you have one or more family members on your plan, the family out-of-pocket maximum can be satisfied by any one Covered Person or a combination of Covered Persons depending on the type of out-of-pocket maximum described below.

Embedded Out-of-Pocket Maximum

If your Schedule of Benefits indicates that the out-of-pocket maximum is embedded, when any one Covered Person meets the individual out-of-pocket maximum, that Covered Person will have no additional Cost Share for the rest of the Benefit Period. The rest of the family must continue satisfying their out-of-pocket maximum until the family out-of-pocket maximum is met. The maximum amount that any one Covered Person in your family can contribute toward the family out-of-pocket maximum is the amount applied toward that person's individual out-of-pocket maximum.

Shared Out-of-Pocket Maximum

If your Schedule of Benefits indicates that the out-of-pocket maximum is shared, any one Covered Person or a combination of any or all Covered Persons can meet the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, neither you nor your Covered Dependents will have to pay any additional Cost Share for Covered Services for the rest of the Benefit Period.

All Cost Share amounts you pay toward the Covered Services explained in this Booklet will apply to the out-of-pocket maximum, such as Deductibles, Copayments and Coinsurance. The following charges **will not apply** to the out-of-pocket maximums and when you have reached the out-of-pocket maximum, **you will still have to pay** these charges:

- Premium amounts you must pay;
- charges for Services that are not covered; and
- any benefit penalties.

How We Will Credit Benefit Maximums

We will only credit the amounts we actually pay for Covered Services to any benefit maximums on your plan. The amounts we pay are based on our Allowed Amount for the Covered Services provided. You will need to look at your Schedule of Benefits to find out if any benefit maximums apply to your plan.

Prior Coverage Credit

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Deductible or out of pocket maximums met by you under a prior Florida Blue HMO policy maintained by the Group that is replaced with this Policy. This provision only applies if the prior coverage purchased by the Group was in effect immediately preceding the Effective Date of this Policy. This provision is only applicable for you during the initial Benefit Period of coverage under the Policy and the following rules apply:.

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage under this Policy only, charges credited by the Group's prior carrier, toward your deductible requirement, for Services rendered during the 90-day period immediately preceeding the Effective Date of this Policy, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

For the initial Benefit Period of coverage under this Policy only, charges credited by the Group's prior carrier, towards your Coinsurance maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of this Policy, will be credited to your out-of-pocket maximum under this Booklet.

Prior coverage credit toward the Deductible or out-of-pocket maximums will only be given for Health Care Services, which would have been Covered Services under this Booklet.

Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group. You and/or the Group are responsible for providing us with any information necessary for us to apply this prior coverage credit.

Special Rule for Capitated Providers

We typically pay In-Network Providers for Covered Services provided to you based upon that Providers' negotiated Allowed Amount with us. This form of payment to Providers is called "fee-for-service." In these circumstances, the amount you are responsible for paying for Covered Services will be based upon our actual Allowed Amount negotiated with the rendering Provider and will be credited toward applicable Deductibles and out-of-pocket maximums and/or used to calculate your Coinsurance.

In other circumstances under the agreements we have with In-Network Providers we may pay a set monthly amount per individual to cover the cost of providing Covered Services to you, whether or not care is actually provided during the month. This form of payment is called "capitation." In these instances, when you receive Covered Services from such a Provider, the amounts you are responsible for paying and the applicable credit toward any Deductible or out-of-pocket maximums may be, as determined by us, based upon the amounts we could have paid for such Covered Services to an In-Network Provider of the same or similar provider type licensed to provide such services but not paid on a capitation basis (based on our Allowed Amounts then in effect for such Covered Services). Similarly, in these instances, the amounts you will owe for Coinsurance may be calculated, as determined by us, utilizing the amounts we could have paid an In-Network Provider of the same or similar provider type licensed to provide such services but not paid on a capitated basis (based upon our Allowed Amounts for such Covered Services). The comparison form of payment utilized for this purpose, in the case of such a same or similar In-Network Provider, is fee-for-service payment. Further, in those circumstances where Services provided were paid on a capitation basis but such Provider may be paid fee-for-service by us for the same or similar Services for other individuals, we may utilize the fee-for-service amounts for such same or similar Services when calculating the credits toward applicable Deductibles and out-of-pocket maximums and/or use such fee-for-service amounts to calculate your Coinsurance.

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 641.54 of the Florida Statutes.

Additional Expenses You Must Pay

In addition to your share of the expenses described above, you are also responsible for:

1. charges in excess of any maximum benefit limitation listed in your Schedule of Benefits;
2. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
3. any benefit reductions/benefit penalties;
4. charges for Health Care Services which are non-Covered Services or excluded; and
5. any Premium contribution amount required by the Group.

Surprise Billing

Sometimes you may receive Covered Services from Out-of-Network Providers who will not accept our payment as payment in full. Out-of-Network Providers in the specific situations described below are prohibited from balance billing you for amounts over what we pay. Should you receive a bill for more than your Cost Share (as described below) from the Out-of-Network Provider in these situations, please send that information to us at the address on your ID card and we will attempt to work with the Out-of-Network Provider to appropriately honor their obligation to not balance bill you, if applicable.

Out-of-Network Services where I should not be balance billed

Please note, in the following specific circumstances federal and/or Florida state law prohibits Out-of-Network Providers from balance billing you for receipt of Covered Services.

- **Emergency Services for an Emergency Medical Condition** provided at an Out-of-Network facility to Stabilize you (which may include part or all of an inpatient admission from the Emergency Room of an Out-of-Network Hospital); and
- **Certain non-Emergency Services or ancillary Services** provided by an Out-of-Network Provider at an In-Network facility including but not limited to:
  - Surgery
  - Pathology
  - Hospital Services
  - Anesthesiology
  - Radiology
  - Laboratory Services

  Note: If the Out-of-Network Provider rendering the non-Emergency Services referenced above has given you the following, in advance: (a) the estimated charges for the Covered Services to be rendered; (b) notice that the Provider is an Out-of-Network Provider; and (c) notice for your approval in writing to the treatment to be rendered by the Out-of-Network Provider, then the Provider **may** be able to balance bill you and this Surprise Billing subsection will not apply.
- **Air Ambulance Services** if the Services are Covered Services under this Benefit Booklet regardless of whether or not the Services are due to an Emergency Medical Condition.

Please note that an authorization is never required for Covered Services for the treatment of an Emergency Medical Condition. Not all Air Ambulance Services are Covered Services under this Benefit Booklet. Please refer to the Ambulance Services category in the WHAT IS COVERED? section of this Benefit Booklet.

Facility, as used above means:

- hospital (as defined in section 1861 of the Social Security Act)
- hospital outpatient department
- critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act)
- an ambulatory surgical center (as defined in section 1833(i)(1)(A) of the Social Security Act)
- and for an Emergency Medical Condition only, an independent freestanding emergency medical department

How Much we will Pay Out-of-Network Providers

Generally, Florida state law prohibits Out-of-Network Providers rendering Covered Services subject to this Surprise Billing section from balance billing you. If section 641.513, Florida Statutes applies, then the Allowed Amount (i.e., the amount we base payment on) will generally be calculated in accordance with the definition within this Benefit Booklet. In certain circumstances, the Allowed Amount will be calculated for Out-of-Network Providers, including all Covered Services rendered by Out-of-Network Air Ambulance Providers, based upon the Median Contracted Rate. The term "Median Contracted Rate" as used here means, generally:

1. The rate that is the median contracted rate for all In-Network Providers for the same or similar item(s) or Service(s) for all plans offered by us:
   a) in the same insurance market (i.e., individual, small group or large group); and,
   b) provided in the same geographic region as the Covered Service provided to you.

Important Note: The above definition of "Median Contracted Rate" has been simplified here to make it easier to understand. The term "Median Contracted Rate", as defined by federal law, is complicated. We will calculate the "Median Contracted Rate" more specifically in accordance with the federal law (and regulations then in effect) known as the federal No Surprises Act (H.R. 133, P.L. 116-260).

Calculating Your Share of the Cost

If you receive Covered Services subject to this Surprise Billing subsection, your Cost Share (e.g., Deductibles and/or Coinsurance) will be calculated based upon the Allowed Amount we initially paid the Out-of-Network Provider as described above. Should we decide to pay more, or if the federal Independent Dispute Resolution Process results in us paying the Out-of-Network Provider more, your Cost Share will not change.

Any Cost Share you paid with respect to Covered Services identified in this subsection will be applied toward your In-Network Deductible and out-of-pocket maximum, if applicable. We will provide notice of payment or denial no later than 30 calendar days after receipt of the bill from the Provider.

Important Note: It is not a surprise bill when you knowingly choose to go to an Out-of-Network Provider for a planned Service or have signed a consent as noted above, in advance for the Covered Services. In such a case, you are responsible for all charges.

HEALTH CARE PROVIDER OPTIONS

Introduction

It is important that you understand how the Providers you choose to use for medical care will affect how much you have to pay for medical Services. Under this HMO plan, most Services must be rendered by In-Network Providers in order to be Covered Services. This is true even when the Services you receive are Medically Necessary (except in the case of an Emergency Services for an Emergency Medical Condition). This section explains some special rules for getting Covered Services with certain types of Providers under this Booklet.

For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

You are responsible for making sure a Provider is In-Network prior to receiving Services. To find out if a Provider is in our Provider network you can:

1. access the current SimplyBlue Provider directory at www.floridablue.com; or
2. call the customer service phone number on your ID Card.

Types of Providers

Primary Care Provider (PCP)

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP for each person covered under this Booklet. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You do not need a referral to see your PCP.

Value Choice Providers

Some Providers, designated by us, may provide Services other than maternity and Medical Pharmacy Services at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office or Independent Diagnostic Testing Centers designated as Value Choice Providers. The chart below lists the Services included and the Cost Share amounts:

Value Choice Provider Type	Services Included	Cost Share
Primary Care Provider	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$0

Value Choice Provider Type	Services Included	Cost Share
Specialist Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$20**
Dietitian / Nutritionist	Covered Services such as Diabetic Education	$0
Independent Diagnostic Testing Center	Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$20**
Urgent Care Center	Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period	$0 for first 2 visits***

* Maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

** Or the Specialist Physician office Cost Share listed on your Schedule of Benefits; whichever is lower.

*** After the first 2 visits, the urgent care Cost Share listed on your Schedule of Benefits will apply.

To find a Value Choice Provider access the most recent provider directory at www.floridablue.com and look for Providers with “Value Choice Providers” under “Programs”.

Specialist Care

If you need to visit a Specialist, you and/or your PCP may choose any In-Network Specialist.

Your PCP may consult with us regarding coverage or benefits and with the Specialist in order to coordinate your care. This provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

You do not need a referral from your PCP to see an In-Network Specialist; however, some Services require an authorization from us before Services are rendered in order to be covered. In-Network Providers are responsible for obtaining authorization from us.

Below are some special rules for certain types of Providers:

Chiropractors and Podiatrists: Upon your request, we will assign an In-Network Doctor of Chiropractic or a Doctor of Podiatry who is an In-Network Provider to you for chiropractic Services and podiatric Services, respectively. You can access the assigned Doctor of Chiropractic or Doctor of Podiatry without a referral from your PCP.

Certified Registered Nurse Anesthetist: You may access anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license upon your request as long as such Services are available, as determined by us, and are Covered Services under this Booklet.

Dermatologists: You may access an In-Network dermatologist for up to five visits each Benefit Period without authorization or referral from your PCP. Some Services, such as surgical procedures require an

authorization before the Services are rendered and if you do not have an authorization; those Services will not be covered.

Obstetric and Gynecological Providers: You may access In-Network Providers who specialize in obstetrics or gynecology for gynecological care without the need for authorization.

Osteopathic Hospitals: You may access Hospitals accredited by the American Osteopathic Association for inpatient and outpatient Services similar to Services that would be covered in an allopathic Hospital. These Services may be covered at an osteopathic Hospital when such Services are available in the Service Area even when such Hospital has not entered into a written agreement with us for such Services. The Hospital providing these Services may not charge more than their usual and customary rates minus the average discount that we have with allopathic Hospitals in the Service Area. You must contact us to get the documents necessary to comply with this provision.

Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other Covered Services may be rendered by licensed Physician Assistants, nurse practitioners or other individuals who are not Physicians.

Specialty Pharmacy: Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions are typically more difficult to maintain, administer and monitor when compared to traditional Drugs. Specialty Drugs may require frequent dosage adjustments, special storage and handling and may not be readily available at local Pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require.

You must use a Specialty Pharmacy to provide these Specialty Drugs. Please refer to the Medication Guide for a list of Specialty Pharmacies.

Services Not Available from In-Network Providers

Except as provided in the WHAT IS COVERED? section, if a Covered Service is not available through In-Network Providers, we may authorize coverage for such Services to be rendered by an Out-of-Network Provider. Services rendered by an Out-of-Network Provider must be authorized by us **before** the Services are rendered in order to be covered.

Provider Financial Incentive Disclosure

Health care decisions are the shared responsibility of you, your family, and your health care Providers. A Provider's decisions regarding Health Care Services may have a financial impact on you and/or the Provider. For example, a Provider in his or her contract with us may agree to accept financial responsibility for your Health Care Services. We encourage you to talk to your Providers about how, and to what extent, the acceptance of financial risk by the Provider may affect his or her Health Care Service decisions.

Continuity of Coverage and Care Upon Termination of a Provider Contract Under Federal Law

Federal law (42 U.S. Code § 300gg –113) provides for continuity of Services for enrollees of health plans when there is a change in the plans' Provider network resulting in a Provider no longer being In-Network

for the enrollee's benefit plan. These protections extend to individuals defined as a "Continuing Care Patient" and include patients who are undergoing a course of treatment for:

1. a serious or complex Condition,
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care,
3. a scheduled non-elective surgery including postoperative care.
4. pregnancy; or
5. a terminal illness.

Such patients will have up to 90 days of continued coverage at the In-Network Cost Share to allow for a transition of care to an In-Network Provider.

Continuity of Coverage and Care Upon Termination of a Provider Contract Under State Law

When a contract between us and an In-Network Provider (including a PCP) is terminated by us or the Provider without cause and, at the time of the In-network Provider's termination, you are actively receiving Services for a Condition, Services for that Condition shall continue even after the date of the In-Network Physician's contract termination. Services for that Condition will be covered with that Provider only until the earlier of:

1. treatment for that specific Condition is completed;
2. you select another In-Network Physician; or
3. the next open enrollment period.

This extension period will not exceed the maximum time period allowed under Florida law, and in no case will it be longer than six months after termination of the Provider's contract with us.

We will continue to provide maternity benefits under this Group Plan, regardless of the trimester in which Services were initiated, until completion of your postpartum care, if you initiated your prenatal care prior to the termination of the In-Network Provider's contract.

We are not required to cover or pay for any Services under this subsection for an individual whose coverage under the plan is not in effect at the time Services are rendered. Further, this subsection does not apply if the In-Network Provider is terminated "for cause".

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, we will not honor any of the following assignments, or attempted assignments, by you to any Provider, including, and without limitation, any of the following:

1. an assignment of the benefits due you under this Booklet;
2. an assignment of the right to receive payments due under this Booklet; or
3. an assignment of a claim for damage resulting from a breach, or an alleged breach, of any promise or obligation set forth in this Booklet, or any promise of obligation set forth in any contract, plan or policy.

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who (1) is an In-Network Provider under your Booklet; (2) is a licensed Hospital or Physician and the benefits which have been assigned are for care provided per Florida Statutes; or (3) is an Ambulance Provider that provides transportation for care from a location where an Emergency Medical Condition, as defined per Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care per Florida Statutes. A written attestation of the assignment of benefits may be required.

BLUECARD® PROGRAM

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain Health Care Services outside of Florida, the claims for these Services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

We cover only limited Services received outside of Florida. As used in this section, "Out-of-Area Covered Services" only include Emergency Services for treatment of an Emergency Medical Condition obtained outside of Florida. Any other Services will not be covered even if processed through any Inter-Plan Arrangements.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

BlueCard Program

Under the BlueCard Program, when you receive Out-of-Area Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the Out-of-Area Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Cost Share amounts.

Medical Emergency: If you experience a medical emergency while traveling outside of Florida, go to the nearest facility that can provide the type of Services needed.

When you receive Out-of-Area Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Services, if not a fixed dollar Copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Services; or
- The negotiated price that the Host Blue makes available to us.

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside of Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment for such Covered Services will be based on the applicable Allowed Amount.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico or the U.S. Virgin Islands, you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when obtaining Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for Out-of-Area Covered Services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Out-of-Area Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Out-of-Area Covered Services.

Outpatient Services

Physicians, Urgent Care Centers and other Providers of outpatient Services located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Out-of-Area Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Out-of-Area Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

COVERAGE ACCESS RULES

It is important that you become familiar with the rules for accessing health care coverage under SimplyBlue. This section explains our role and the Primary Care Provider's (PCP) role, how to access specialty care coverage, and what to do if Emergency Services are needed. It is also important for you to review all Service Area-specific Coverage Access Rules for particular types of Services and In-Network Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the Provider directory and may vary based on negotiated Provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Provider

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You are free to choose any PCP listed in our published list of PCPs whose practice is open to additional SimplyBlue patients. This choice should be made when you enroll. You must choose a PCP for all minor Covered Dependents including a newborn child or an adopted newborn child. If you do not choose a PCP when you enroll, we will assign one to you and let you know which PCP was assigned to you. The following important rules apply to your PCP relationship.

- PCPs are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs. Developing and continuing a relationship with a PCP allows the Provider to become knowledgeable about your health history.
- A PCP can help you determine the need to visit a Specialist and also help you find one based on his or her knowledge of you and your specific health care needs.
- A PCP may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist, or APRN may elect to contract with us as a Primary Care Provider.
- Care rendered by your PCP usually results in lower Cost Share for you.

The PCP you select maintains a Physician-patient relationship with you, and will be responsible for helping to coordinate medical Services for you, except as specified by the Coverage Access Rules set forth in the Provider directory, if any.

Both you and your PCP may request a change in the PCP assignment as described below:

1. You may request a transfer to another PCP whose practice is open to new SimplyBlue patients. The effective date of a transfer to the new PCP will depend upon when we receive your request. Requests may be made on our website at www.floridablue.com or by calling the number on the back of your ID card.
2. There are also times when a PCP, for good cause, may request that we assist you in choosing another PCP.

3. If your PCP terminates his or her contract with us, is unable to perform his or her duties or is on a leave of absence, we may help you choose another PCP or assign a new one for you.

Authorization Requirements

Many Services have to be authorized by us **before** the Services are rendered in order to be covered under this Booklet.

There may be times when Services are authorized, but only if received in a specific setting, such as an Ambulatory Surgical Center or Independent Diagnostic Testing Center. If the authorization includes a specific setting and you receive the Services in a different setting, such Services may be denied. For example, a procedure may be authorized only when performed in an Ambulatory Surgical Center. In this case, if you have the procedure done in a Hospital, the claim may be denied because the procedure was only authorized when performed in an Ambulatory Surgical Center.

In-Network Providers have agreed to obtain these authorizations for you; however, it is always a good idea to ask your Provider if he or she has obtained an authorization if one is required. Services that must be authorized by us in advance include, but are not limited to:

1. hospitalization, both inpatient and observation stays (except Emergency Services rendered for an Emergency Medical Condition, see the WHAT IS COVERED? section);
2. certain radiology Services, including advanced diagnostic imaging Services, such as CT scans, MRIs, MRAs and nuclear imaging;
3. Birth Center Services;
4. Services rendered in connection with Approved Clinical Trials;
5. Home Health Care;
6. certain Durable Medical Equipment;
7. Prosthetic Devices and Orthotic Devices
8. Pain Management Services;
9. surgery (at all locations);
10. Services provided by Out-of-Network Providers;
11. all Services provided in a Skilled Nursing Facility;
12. certain injections and infusion therapy;
13. certain Provider-administered Drugs (denoted with a special symbol in the Medication Guide);
14. Hospice Services;
15. certain diagnostic Services; and
16. Transplant Services, as described in the WHAT IS COVERED? section.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your policy, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Services. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

Personal Case Management Program

The personal case management program focuses primarily on members who suffer from a catastrophic illness or injury. If you meet our case management guidelines, we may, in our sole discretion, assign a personal case manager to you to help you coordinate coverage, benefits or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the personal case management program, we may offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by us on a case-by-case basis when you meet our case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing.

The fact that we may offer to pay for, or that we have paid for certain Health Care Services under the personal case management program in no way obligates us to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of our right to enforce this Booklet in strict accordance with its terms. The terms of this Booklet will continue to apply, except as specifically modified in writing by us in accordance with the personal case management program rules then in effect.

Comprehensive Clinical Assessment Program

Our Comprehensive Clinical Assessment Program ("Assessment Program") is for members with chronic illnesses or other injuries or who may or may not have seen a primary care Provider or other Provider type in the last year. If you meet our Assessment Program guidelines, we may, in our sole discretion, offer to you Services to help you access coverage, benefits or payment for Health Care Services. You may also receive lower Cost Shares than those normally owed for Covered Services rendered under this program. This program is completely voluntary for you.

Under the Assessment Program, we may elect to offer different benefits or payment for cost-effective Health Care Services. We may include things like coverage for Services at different locations that are not normally covered under this Benefit Booklet. Such locations may include Home Health visits, such as in-home assessments and e-medicine Services.

We may offer these substitute benefits or payments on a case-by-case basis if you meet the Assessment Program criteria then in effect. Also, we may ask that you or a person you designate and, if appropriate, your Physician agree to the substitute benefits or payments in writing or otherwise. The Assessment Program may be operated by us or a vendor of our choosing.

The fact that we may offer to pay for, or that we have paid for certain Health Care Services under the Assessment Program, in no way obligates us to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of our right to enforce this Benefit Booklet in strict accordance with its terms. The terms of this Benefit Booklet will continue to apply, except as specifically modified in writing by us in accordance with the Assessment Program rules then in effect.

Coverage Protocol Exemption Request

In some cases, Services under this Booklet require you to complete use of another Prescription Drug, medical procedure, or course of treatment other than the one requested by your treating Physician, before coverage will be authorized/granted. Florida Statute 641.31(46) permits you to request a protocol exemption in order to receive coverage without completing our coverage protocol for the Prescription Drug, medical procedure, or course of treatment. If we deny the coverage protocol exemption request, we will provide you with a written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure for appealing the denial. In some instances, the process for appealing a denied coverage protocol exemption request will be your formal appeal of an Adverse Benefit Determination process as outlined in the COMPLAINT AND GRIEVANCE PROCESS section of this Booklet.

Information on how to request a coverage protocol exemption or to appeal a denial of a request for exemption can be found on our website at https://www.floridablue.com/docview/coverage-protocol-exemption-request/.

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in the Group Plan, and who meets and continues to meet the eligibility requirements described in this Booklet, shall be entitled to apply for coverage with us. These eligibility rules are binding upon you and the Group. No changes in our eligibility rules will be permitted unless we have been notified of and have agreed in writing to any such change in advance. We may require acceptable documentation that an individual meets and continues to meet the eligibility requirements such as a court order naming the Covered Employee as the legal guardian or appropriate Adoption documentation described in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

Employee Eligibility

In order to be eligible to enroll as a Covered Employee, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. the employee must maintain his or her primary residence in the Service Area or be regularly employed in the Service Area;
2. be a bona fide employee;
3. the employee's job must fall within a job classification identified on the Small Employer Application;
4. complete any applicable Waiting Period identified on the Small Employer Application required by Florida Blue HMO
5. meet any additional eligibility requirements identified on the Small Employer Application or required by Florida Blue HMO.

The Covered Employee eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Group , provided such companies and the Group are under common control; and
4. other individuals as determined by us and the Group such as members of associations or labor unions.

Any expansion of the Employee eligibility class must be approved in writing by us and the Group prior to such expansion, and may be subject to different Rates.

Dependent Eligibility

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Employee's spouse under a legally valid existing marriage and who maintains his or her primary residence in the Service Area;

2. The Covered Employee's present Domestic Partner when the Covered Employee has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met and who maintains his or her primary residence in the Service Area;

3. The Covered Employee's or covered Domestic Partner's natural, newborn, Adopted, Foster or step child (or a child for whom the Covered Employee or covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan. A dependent child must maintain his or her primary residence in the Service Area only beginning with the Calendar Year following the year they reach age 26 to the end of the Calendar Year the dependent child reaches age 30;

4. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: You are solely responsible, as the Covered Employee, to establish that a child meets the eligibility rules. Eligibility will end when the child no longer meets the eligibility rules required to be an Eligible Dependent described above.

Children with Disabilities

In the case of a dependent child with an intellectual or physical disability, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 30, if the child is:

1. otherwise eligible for coverage under the Group Plan;

2. incapable of self-sustaining employment by reason of an intellectual or physical disability and

3. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 30th birthday.

This eligibility will end on the last day of the month in which the dependent child no longer meets these requirements.

Other Eligibility Rules

1. No person whose coverage with us has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll with us.

2. No person shall be refused enrollment or re-enrollment because of race, color, national origin, disability, sex, age, creed, marital status, gender, gender identityor sexual orientation (except as provided in this section).

3. The Covered Employee must notify us as soon as possible when a Covered Dependent is no longer eligible for coverage. If a Covered Dependent fails to continue to meet each of the eligibility requirements, and the Covered Employee does not provide timely notice to us, we shall have the right to:

a. retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met, and

b. recover an amount equal to the Allowed Amount for Services and/or supplies provided after such date less any Premium received for such dependent for coverage after such date.

Upon our request, the Covered Employee shall provide proof, which is acceptable to us, of a Covered Dependent's continuing eligibility for coverage.

If the Group offers an alternative health benefits plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for coverage under this Policy.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage as described in this section. Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. We will have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. You may apply for coverage by completing an Enrollment Form and submitting it to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during enrollment, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right we may have, we may terminate or Rescind your coverage.
3. We will not provide coverage or benefits to any person who would not have been eligible to enroll with us, had accurate and complete information been provided to us on a timely basis. In such cases, we may require you or a person legally responsible for you, to repay us for any payments we made on your behalf.

How to Apply for Coverage

To apply for coverage, you as the Eligible Employee must:

1. complete the Enrollment Form and submit it to the Group;
2. provide any additional information we may need to determine eligibility, at our request;
3. agree to pay your portion of the required Premium; and
4. add Eligible Dependents or delete Covered Dependents, by completing the Enrollment Form and submitting it to the Group.

Enrollment Periods

There are only certain times during the year that you can enroll for coverage, these enrollment periods are as follows:

Initial Enrollment Period: this is the period of time during which you are first eligible to enroll. It starts on the date you are first eligible and ends no less than 30 days later. This time can be when the Group first starts its Plan with us, or when an employee first becomes eligible for coverage under the Plan.

Annual Open Enrollment Period: this is the period of time (usually 30 days) when you have an opportunity to select coverage from the alternatives your Group offers in its health benefit program. This period takes place every year prior to the Anniversary Date.

Special Enrollment Period: this is a 30-day period of time immediately following a special event such as getting a new dependent or losing other coverage. During this time you may apply for coverage because of the special event. Special events are described in the Special Enrollment Period subsection of this section.

Initial Enrollment Period

1. If you are an Eligible Employee when the Group first obtains coverage with us; you must enroll (yourself and any Eligible Dependents) during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. In this case, the Effective Date of coverage for you and the dependents you enroll will be the same as the Group.
2. If you become an Eligible Employee after the Group has coverage with us (for example, newly-hired employees) you must enroll (yourself and any Eligible Dependents) before or within the Initial Enrollment Period and your Effective Date of coverage will begin on the date specified on the Small Employer Application.

Annual Open Enrollment Period

If you did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period you may apply for coverage by completing an Enrollment Form during an Annual Open Enrollment Period. Your Effective Date of coverage will be the first billing date following the Annual Open Enrollment Period.

The Eligible Employee may enroll by completing the Enrollment Form during the Annual Open Enrollment Period.

If you do not enroll or change your coverage selection during the Annual Open Enrollment Period, you must wait until the next Annual Open Enrollment Period to make any changes, unless a special event, as outlined in the Special Enrollment Period subsection of this section, occurs.

Special Enrollment Period

You may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, you must complete an Enrollment Form and submit it to the Group within the time periods noted below for each special enrollment event.

If you declined coverage when it was first offered under this Group Plan and you stated, in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment, you may apply for coverage if one of the following special enrollment events occurs and you complete an Enrollment Form and submit it to the Group within time periods indicated in the chart that follows.

Special Enrollment Events

Loss of Coverage under…	Caused by…	Enrollment Form due to Group within…
a group health plan or COBRA	• Exhaustion of COBRA or Florida Continuation • termination of employment • reduction in the number of hours you work • reaching or exceeding the lifetime maximum of all benefits under other health coverage • the employer stopped offering group health coverage • death of your spouse • divorce or legal separation • employer contributions toward such coverage are terminated	30 days of the date coverage was terminated
a Children's Health Insurance Program (CHIP) or Medicaid	• loss of eligibility for such coverage • becoming eligible for the optional state premium assistance program	60 days of the date coverage was terminated
Adding Coverage…	• your marriage • your getting a new dependent through birth, Adoption or placement in anticipation of Adoption	30 days of the date of the event

Your Effective Date of coverage will be the date of the special enrollment event. If you do not enroll or change your coverage during the Special Enrollment Period you must wait until the next Annual Open Enrollment Period.

Note: Loss of coverage for failure to pay your portion of the required Premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Employee. Below are special rules for certain Eligible Dependents.

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must complete an Enrollment Form and submit it to the Group. The Effective Date of coverage for a newborn child is usually the date of birth as long as you have enrolled the newborn child in time (as indicated below). We must be notified, in writing, when you are adding a newborn and the rules for Effective Date

and Premiums charged for the newborn may vary depending on when we receive this written notification. The chart that follows indicates these differences:

Newborn Enrollment

If we receive written notice within…	**The Effective Date of the newborn will be…**	**Premium for the newborn child…**
30 days after the date of birth	the date of birth	will **not** be charged for the **first 30 days**
31 to 60 days after the date of birth	the date of birth	will be charged from the date of birth
61 or more days* after the date of birth	the date of birth	will be charged from the date of birth

***This applies only if the Group has not had an Open Enrollment Period since the baby was born. If we receive the written notice more than 60 days after the birth of the newborn child, and your Group has had an Open Enrollment Period since the birth of the newborn, the child may not be added until the Group's next Open Enrollment Period.

Additional Rules for Adopted Newborn Children

If an Adopted newborn's Effective Date of coverage is determined to be the date of birth (based on the above chart), a written agreement to Adopt such child must have been entered into by the Covered Employee or covered Domestic Partner prior to the birth of such child, whether or not such an agreement is enforceable. We may require the Covered Employee to provide any information and/or documents which we deem necessary in order to administer this provision. If the Adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the Adopted newborn child. It is your responsibility as the Covered Employee to notify us within ten calendar days of the date that placement was to occur if the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee the newborn should be added during the Initial Enrollment Period.

Adopted/Foster Children – To enroll an Adopted child (other than a newborn child) or Foster Child, the Covered Employee must complete an Enrollment Form and submit it to the Group within 30 days after the date of placement and the Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Covered Employee or covered Domestic Partner pursuant to Florida law. If timely notice is given, no additional Premium will be charged for coverage of the Adopted or Foster Child for the duration of the notice period (the 30-day period before the child was placed in your home). We may need you to provide additional information and/or documents deemed necessary by us in order to properly administer this provision.

If you have submitted the Enrollment Form to the Group on time, as discussed above, but we are not notified timely, the child will be added as of the date of placement so long as we receive the Enrollment Form within 60 days of the placement, and any applicable Premium is paid back to the date of placement. If we are not notified within 60 days of the date of placement, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period in order for the Adopted or Foster Child to be covered.

Adopted Children

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for such Adopted child. It is your responsibility as the Covered Employee to notify us if the Adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the Adopted child.

Foster Children

If the Covered Employee's status as a foster parent is terminated, coverage will end for any Foster Child. It is your responsibility as the Covered Employee to notify us in writing that the Foster Child is no longer in your care. Upon receipt of this notification, we will terminate the coverage of the child on the date provided by the Group on the first billing date following receipt of the written notice.

Marital Status – If the Covered Employee marries after his or her Effective Date, he or she may add the spouse who is an Eligible Dependent due to a legally valid marriage. The Covered Employee must complete an Enrollment Form and submit it to the Group within 30 days of the marriage and the Effective Date of coverage for the new spouse will be the date of the marriage.

Court Order – You, as the Covered Employee may add an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided by you for a minor child under your plan. The Covered Employee must complete an Enrollment Form and submit it to the Group within 30 days of the court order and the Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order will be the date required by the court or the next billing date.

Other Provisions

Rehired Employees

If you are rehired as an employee of the Group; you are considered a newly-hired employee for purposes of this section. The provisions of the Policy, applicable to newly-hired employees and their Eligible Dependents, such as Effective Dates of coverage and Waiting Periods will apply to you.

Premium Payments

In those instances where an individual is to be added to coverage (e.g., a new Eligible Employee or a new Eligible Dependent, including a newborn or Adopted child), that individual's coverage shall be effective, as described in this section, only if we receive the additional Premium payment within 30 days of the date we notified the Group of such amount. In no event shall an individual be covered under this Policy if we do not receive the Premium payment within such time period.

TERMINATION OF COVERAGE

Covered Employee

A Covered Employee's coverage will automatically terminate at 12:01 a.m.:

1. on the date the Policy terminates;
2. on the date the Covered Employee becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the last day of the first month that the Covered Employee no longer meets any of the applicable eligibility requirements;
4. on the date the Covered Employee's coverage is terminated for cause; or
5. on the date specified by the Group.

Covered Dependent

A Covered Dependent's coverage will automatically terminate at 12:01 a.m.:

1. on the date the Covered Employee's coverage terminates for any reason;
2. on the last day of the Calendar Year that the Covered Dependent no longer meets the eligibility requirements;
3. on the date we specify that the Covered Dependent's coverage is terminated by us for cause;
4. on the date specified by the Group.

If you as the Covered Employee wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group prior to the termination date requested.

If you as the Covered Employee wish to delete your spouse from coverage, in the case of divorce for example, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Domestic Partner and/or Domestic Partner's Dependent Child

In addition to the rules listed under Covered Dependent above, a covered Domestic Partner and his or her Covered Dependent child's coverage under the Contract will end at 12:01 a.m. on the date that the Domestic Partnership ends or the date of death of the covered Domestic Partner.

Termination for Cause

If, in our opinion, any of the following events occur, we may terminate a person's coverage for cause:

1. fraud, intentional misrepresentation of material fact or omission in applying for coverage or benefits;
2. you intentionally misrepresent, omit or give false information on Enrollment Forms or other forms completed for us for the purpose of obtaining coverage under this Booklet, by you or on your behalf;
3. fraudulent misuse of the ID Card;

4. you no longer live or work in the Service Area; or
5. a Covered Dependent reaches the limiting age.

Any termination made under the provisions stated above is subject to review in accordance with the Complaint and Grievance Process described in this Booklet.

Note: Only fraudulent misstatements on the Enrollment Form may be used by us to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

Rescission of Coverage

We reserve the right to Rescind coverage under this Booklet for any individual covered under this Benefit Booklet as permitted by law.

We may only Rescind your coverage if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

We will provide at least 45 days advance written notice to the Covered Employee of our intent to Rescind coverage.

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review standards described in the CLAIMS PROCESSING section and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS sections.

Notice of Termination

It is the Group's responsibility to immediately notify you of termination of the Policy for any reason.

Our Responsibilities Upon Termination of Your Coverage

Upon termination of coverage for you or your Covered Dependents for any reason, we will have no further liability or responsibility with respect to such individual, except as otherwise specifically described in this Booklet.

CONTINUING COVERAGE

Introduction

This section describes the ways coverage can be continued after your termination date. We have divided this section into three subsections: Federal and Florida Continuation Provisions, Conversion Privilege and Extension of Benefits.

Federal and Florida Continuation Provisions

This subsection describes the federal and Florida laws that cover continuation of coverage for certain former employees of Small Employers. While both federal and Florida law provide for continuation of coverage for certain employees of Small Employers, they do not overlap. Therefore, if federal law applies to the Small Employer, state law will not and vice versa.

Whether federal or Florida law will apply to your Group will depend upon many factors, including but not limited to, the size of the Group and whether the Group is a church group or a government plan.

This subsection provides a description of both federal and Florida law continuation of coverage requirements. Contact your Group to determine which continuation law is applicable to you.

Important Note: Covered Domestic Partners and their Covered Dependents are not entitled to continuing coverage but, may be entitled to apply for one of our conversion policies as set forth in the "Conversion Privilege" subsection later in this section.

Federal Continuation of Coverage Law

A federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to your Group; if so, you may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

You must contact your Group to determine if you are entitled to COBRA continuation of coverage. Your Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify you of your rights under COBRA. If you or the Group fail to meet your obligations under COBRA and this Policy, we will not be liable for any claims incurred by you after your coverage terminates.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by the purchase of the Policy; the duty to meet such obligations remains with the Group.

The following is a summary of what you may elect, if COBRA applies to your Group and you are eligible for such coverage:

1. You may elect to continue your coverage for a period not to exceed 18 months* in the case of:
    a. termination of employment of the Covered Employee other than for gross misconduct; or
    b. reduced hours of employment of the Covered Employee.

***Note**: You and your Covered Dependents are eligible for an 11 month extension of the 18 month COBRA continuation option above (to a total of 29 months) if you are totally disabled, as defined by the Social Security Administration (SSA) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. You must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependents may elect to continue their coverage for a period not to exceed 36 months in the case of:
    a. the Covered Employee's entitlement to Medicare;
    b. divorce or legal separation from the Covered Employee;
    c. death of the Covered Employee;
    d. the employer files bankruptcy (subject to bankruptcy court approval); or
    e. a Covered Dependent who ceases to be an Eligible Dependent under the terms of the Policy.

Children born to or placed for Adoption with the Covered Employee during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

If you are eligible to continue group health insurance coverage pursuant to COBRA, the following conditions must be met:

1. The Group must notify you of your continuation of coverage rights under COBRA within 14 days of the event that creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or because a Covered Dependent child no longer meets eligibility requirements, you or your Covered Dependent must notify the Group, in writing, within 60 days of any of these events. The Group's 14-day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue the coverage within 60 days of the later of:
    a. the date that your coverage ends; or
    b. the date the notification of continuation of coverage rights is sent by the Group.
3. COBRA coverage will terminate if you become covered under any other group health plan.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the SSA that you are no longer disabled. You must inform the Group of the SSA's determination within 30 days of such determination.
6. You must meet all Premium payment requirements and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, as described in the Policy.
7. The Group must continue to provide group health coverage to its employees, in order for COBRA continuation coverage to remain available to you.

An election by a Covered Employee or Covered Dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that Covered Employee or Covered Dependent spouse, unless otherwise specified in the election form.

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Policy shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Florida Continuation of Coverage Law

The Florida Health Insurance Coverage Continuation Act, requires that a Small Employer, who does not qualify for COBRA coverage, offer you the opportunity for a temporary extension of health coverage (called "continuation of coverage") in certain instances where coverage under the Policy would otherwise end. The Group may not qualify for COBRA coverage for many reasons, including, but not limited to, the Group employs fewer than 20 employees or is a state or local government plan, or church plan.

You have certain rights and obligations under the continuation of coverage provision of the law. These rights are outlined below.

Initial Notice to Choose Continuation of Coverage:

It is your responsibility to notify the designated administrator of any event that qualifies you to continue coverage under the Policy. Please refer to the Notice Requirements in this subsection.

Types of Qualifying Events

If your Group has fewer than 20 employees, you have the right to continue coverage under the Florida continuation of coverage law if:

1. you lose group health coverage because of a reduction in your hours of employment; or
2. your employment is terminated, for reasons other than gross misconduct on your part.

The Covered Dependent spouse of the Covered Employee has the right to choose continuation of coverage if the group health coverage is lost for any of the following four reasons:

1. death of the Covered Employee;
2. termination of the Covered Employee's employment (for reasons other than gross misconduct) or a reduction in the Covered Employee's hours of employment;
3. divorce or legal separation from the Covered Employee; or
4. the Covered Employee becomes entitled to Medicare.

The Covered Dependent child of a Covered Employee has the right to continuation of coverage if group health coverage is lost for any of the following reasons:

1. death of the Covered Employee;
2. termination of the Covered Employee's employment (for reasons other than gross misconduct) or a reduction in the Covered Employee's hours of employment;
3. parents' divorce or legal separation;

4. the Covered Employee becomes entitled to Medicare; or

5. the dependent is no longer a Covered Dependent under the terms of the Policy.

You also have a right to elect continuation of coverage if you are covered under the Policy as a retiree, or spouse or child of a retiree, and lose coverage within one year before or after the commencement of proceeding under Title 11 (bankruptcy), United States Code, by the Group from whose employment the Covered Employee retired.

Notice Requirements

You must inform us of any qualifying event under the Policy. This notification must be postmarked no later than 63 days after the date of the qualifying event that would cause a loss of coverage.

The notice must be in writing and include:

1. the name and address of the qualified beneficiary;

2. the social security number of the qualified beneficiary;

3. the name of the Group;

4. the insurance carrier's name;

5. one of the applicable qualifying events as listed above;

6. the date of the qualifying event;

7. the daytime telephone number of the qualified beneficiary;

8. the Covered Employee's social security number;

9. the Policy number; and

10. the name and address of all other qualified beneficiaries.

When we receive timely notice as described above, we will send you, by Certified Mail a premium notice and election form. You have 30 days from the date of receipt of the form to elect continuation of coverage. To elect continuation of coverage, complete and return the form with applicable premium payment to us. Continuation of coverage begins on the day after coverage would otherwise be terminated, only if we receive the form and full premium payment within the allotted time period and all other eligibility requirements are satisfied.

If you do not elect continuation of coverage and pay the premium, your group health coverage will terminate in accordance with the provisions outlined in this Booklet.

If you chose continuation of coverage, the coverage will be identical to the coverage provided under the Policy to similarly situated individuals. The law requires that you be given the opportunity to maintain continuation coverage for 18 months. However, the law also provides that your continuation of coverage may be terminated for any of the following reasons:

1. the Group no longer provides group health coverage to any of its employees;

2. the premium for your continuation of coverage is not paid within 30 days;

3. after electing continuation of coverage, you become covered under any other group health plan (as an employee or otherwise); or

4. after electing continuation of coverage, you are approved for Medicare.

Note: A qualified beneficiary who is determined under Title II or XVI of the Social Security Act, to have been disabled as of the date of termination of employment or reduction in hours may be eligible to continue coverage for an additional 11 months (29 months total). The qualified beneficiary must notify us within 60 days of receipt of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. We can charge up to 150 percent of the Rate during the 11-month extension. You must notify us within 30 days of any final determination that you are no longer disabled.

You do not have to show insurability to choose continuation of coverage. However, you may have to pay up to 115 percent of the applicable premium for continuation of coverage. The law also requires that, at the end of the 18-month or 29-month continuation of coverage period, you may enroll in an individual conversion health plan provided under the current group health plan.

Any questions regarding these provisions or notifications required by this section should be directed to the person or office shown below. If your address or marital status has changed, please notify in writing, the person or office shown below:

Florida Blue
FHICCA/COBRA
P.O. Box 45272
Jacksonville, FL 32232-5272

Toll Free (855) 509-1678

If any Covered Person is at a different address, please notify us in writing so we may send a separate notice to the separate household.

Conversion Privilege

If your coverage under the Policy has terminated you may apply for conversion to a non-group plan. Florida Blue HMO and the Group have no obligation to notify you of the conversion privilege. It is your sole responsibility to exercise this conversion privilege subject to the provisions set forth below.

Eligibility Criteria for Conversion

You are entitled to apply for a conversion contract for non-group plan if you have been continuously covered under this Policy for at least three consecutive months; or, you were covered for at least three consecutive months under another group policy providing similar benefits that this Policy immediately replaced; and

1. your coverage was terminated for any reason, including discontinuance of this Policy in its entirety and termination of continued coverage under COBRA; and
2. you maintain your primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for Health Care Services. We must receive the completed conversion application and the applicable premium payment within the 63-day period beginning on the date this Group Plan terminated. If this Policy has been terminated due to the non-payment of Premium by the Group, we must receive the completed conversion

application and the applicable Premium payment within the 63-day period beginning on the date notice was given to the Group that this Policy terminated.

In the event we do not receive the conversion application and the initial Premium payment within such 63-day period, your conversion application will be denied, and you will not be entitled to a conversion policy.

Conversion is not available if termination occurred for any of the following reasons:

1. you had not been continuously covered under the Policy for at least three months prior to termination;
2. failure to pay any required Premium unless such nonpayment was due to acts of an employer or person other than you;
3. replacement of coverage by similar group coverage occurs within 31 days of termination;
4. fraud or intentional misrepresentation in applying for the Group Plan or for any Covered Services;
5. termination for cause as set forth in the TERMINATION OF COVERAGE section;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. you are eligible for, or covered under, Medicare.

Additionally, conversion is not available:

1. if you are eligible for similar benefits, whether or not you are actually covered under any arrangement of coverage for individuals in a Group;
2. if you are covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service insured contract or medical practice or other prepayment plan, or by any other plan or program;
3. if similar benefits are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA); or
4. if the benefits provided or available to you, together with the benefits provided by us, would result in excess of coverage, as determined by us.

Conversion Coverage

The conversion contract issued to each individual who converts to non-group coverage shall include a level of benefits for "minimum Services" which is similar to the level of benefits for the Services included in this Booklet. For purposes of this section, the term "minimum Services" shall mean Services which include any of the following: emergency care, inpatient Hospital Services, Physician care, ambulatory diagnostic treatment, and preventive health services. Conversion coverage is not a continuation of the Policy. Benefits under such conversion coverage may differ from benefits under the Policy and any Endorsements attached thereto. Conversion coverage may continue in effect as long as you: (a) continue to meet all applicable eligibility requirements; (b) pay all applicable fees and charges; and (c) otherwise comply with all requirements under the conversion contract.

Effective Date of Conversion

The effective date of conversion coverage shall be the day following the termination of the Policy. However, until such time as coverage under the conversion contract becomes effective, you shall pay the

Allowed Amount for any Covered Services rendered during the 63-day period immediately following termination of the Policy. In the event such conversion coverage becomes effective, you may request reimbursement from us for any payment for Covered Services. You must submit proof of payment to us in order to obtain reimbursement.

Extension of Benefits and Continuity of Care

Continuity of Coverage and Care Upon Termination of a Group Policy Under Federal Law

Plans are required to ensure continuing care patients receive timely notification of changes in the network status of Providers and facilities.

Federal law (42 U.S. Code § 300gg–113) provides for continuity of Services for enrollees of health plans when there is a termination of a contract between a group and the group's insurer. These protections extend to individuals defined as a "Continuing Care Patient" and include patients who are undergoing a course of treatment for:

1. a serious or complex Condition,
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care;
3. a scheduled non-elective surgery including postoperative care;
4. pregnancy; or
5. a terminal illness.

Such patients will have up to 90 days of continued coverage at the In-Network Cost Share to allow for a transition of care to an In-Network Provider.

Continuity of Coverage and Care Upon Termination of a Group Policy Under State Law

If the Group Plan is terminated, coverage will end on the termination date. We will not provide coverage or benefits for any Covered Services received on or after the termination date, except as listed below. The extension of benefits described below only applies when the Group Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Booklet.

Note: You must provide proof that you are entitled to an extension of benefits.

Extension of Benefits

1. If you are pregnant on the termination date of the Policy, we will provide a limited extension of the maternity benefits, as long as the pregnancy started while you were covered by us. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate on the date the child is born.

2. If you are totally disabled on the termination date of the Policy because of a specific accident or illness that happened while you were covered under the Group Plan, we will provide a limited extension of benefits for you only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Policy.

   Note: For purposes of this subsection, you will be considered totally disabled only if, in our opinion, you are unable to work at a job for which you have the education, training, or experience; and you continue to require regular care from a Physician for the disability. This applies, even if you are not working (e.g., a student, non-working spouse, or children), if you are unable to perform the normal day-to-day activities which you would otherwise be able to perform.

We are not required to provide an extension of benefits if you leave the Service Area with the intent to relocate or establish a new residence outside the Service Area; if you intentionally left out or provided false information on any Enrollment Form in order to obtain coverage or Covered Services; or if you were terminated for disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that your continued coverage with us impairs our ability to provide coverage and/or benefits or to arrange for the delivery of Health Care Services to you or any other Covered Person.

CLAIMS PROCESSING

Introduction

This section is intended to:

- help you understand what your treating Providers must do, under the terms of this Booklet, in order to obtain payment for Covered Services that have been rendered or will be rendered to you; and
- provide you with a general description of the applicable procedures we will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying you when we deny benefits.

If the Group Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the plan administrator (usually the employer) is solely responsible for complying with ERISA. While the benefit determination timeliness standards set forth in this section are generally consistent with ERISA, we are not legally responsible for notifying you of any rights you may have under ERISA. If you are not sure of your rights under ERISA, you should contact the plan administrator or an attorney of your choice. We will follow the claim determination procedures and notice requirements set forth in this section even if the Group Plan is not subject to ERISA.

Under no circumstances will we be held responsible for, nor will we accept liability relating to, the failure of the Group Plan's sponsor or plan administrator to: (1) comply with ERISA's disclosure requirements; (2) provide you with a Summary Plan Description (SPD) as that term is defined by ERISA; or (3) comply with any other legal requirements. You should contact the plan sponsor or administrator if you have questions relating to the Group Plan's SPD. We are not the Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

For purposes of this Booklet, there are three types of claims: (1) Post-Service Claims; (2) Pre-Service Claims; and (3) Claims Involving Urgent Care. It is important that you become familiar with the types of claims that can be submitted to us and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim

Experience shows that the most common type of claim we will receive from you or your treating Providers will likely be Post-Service Claims.

In-Network Providers have agreed to file Post-Service Claims with us for Health Care Services they render to you. If you receive a bill from an In-Network Provider, you should forward it to us. If you require Emergency Services from an Out-of-Network Provider while inside or outside the Service Area or, if we refer you to an Out-of-Network Provider, we will pay for Covered Services provided to you. If you receive a bill from an Out-of-Network Provider for Covered Services, you should forward it to us. We rely on the information you provide when processing a claim.

We must receive a Post-Service Claim within 90 days of the date the Covered Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no

Post-Service Claim will be considered for payment if we do not receive it at the address indicated on your ID Card within one year of the date the Service was rendered unless you are legally incapacitated.

For Post-Service Claims, we must receive an itemized statement containing the following information:

1. the date the Service was provided;
2. a description of the Service including any applicable procedure codes;
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis codes;
5. the Provider's name and address;
6. the name of the individual who received the Service; and
7. your name and contract number as they appear on the ID Card.

Note*:* Please refer to the PRESCRIPTION DRUG PROGRAM section for information on the processing of Prescription Drug claims. Special claims processing rules may apply for Health Care Services rendered outside the state of Florida, under the BlueCard Program (See the BLUECARD PROGRAM or AWAY FROM HOME CARE sections).

Processing Post-Service Claims

We will use our best efforts to pay, contest, or deny all Post-Service Claims for which we have all of the necessary information, as determined by us, within the timeframes described below.

Payment for Post-Service Claims

When payment is due under the terms of this Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt, however all claims subject to the No Surprises Act will be paid or denied within 30 days as stated in the Surprise Billing subsection of the YOUR SHARE OF HEALTH CARE EXPENSES section of this Booklet. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more information, we may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a paper Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: (1) the contested portion or portions of the claim; (2) the reasons for contesting the claim or a portion of the claim; and (3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether more information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of the request for the information. If we do not receive the requested information, the claim or a portion of the claim will be processed based on the information in our possession at the time and may be denied. Upon

receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

Denial of Post-Service Claims

In the event we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within 20 days of receipt that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our best efforts to provide notice, within 30 days of receipt of the claim, that the claim or a portion of the claim is denied. The notice may identify the denied portions of the claim and the reasons for denial. It is your responsibility to ensure that we receive all information that we determine is necessary to adjudicate a Post-Service Claim. If we do not receive the necessary information, the claim or a portion of the claim may be denied.

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this section, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS section.

In any event, we will use our best efforts to pay or deny all (1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and (2) paper Post-Service Claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by us or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by us within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

Pre-Service Claims

How to file a Pre-Service Claim

This Booklet may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the COVERAGE ACCESS RULES section, the WHAT IS COVERED? section and other applicable sections of this Booklet. You may also call the customer service number on your ID Card for assistance.

We are not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to you unless the terms of this Booklet require approval by us (or condition payment) for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, we will use our best efforts to provide notice of the determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, we will use our best efforts to provide notice within 24 hours of: (1) the need for additional information; (2) the specific information that you or the Provider may need to provide; and (3) the date that we reasonably expect to provide notice of the decision. If we request additional information, we must receive it within 48 hours of the request. We will use our best efforts to provide notice of the decision on the Pre-Service Claim within 48 hours after the earlier of: (1) receipt of the requested information; or (2) the end of the period you were afforded to provide the specified additional information as described above.

Benefit Determinations on Pre-Service Claims That Do Not Involve Urgent Care

We will use our best efforts to provide notice of a decision of a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. This 15-day determination period may be extended by us one time for up to an additional 15 days. If such an extension is necessary, we will use our best efforts to provide notice of the extension and reasons for it. We will use our best efforts to provide notification of the decision on your Pre-Service Claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by us.

If additional information is necessary to make a determination, we will use our best efforts to: (1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; (2) identify the specific information that you or the Provider may need to provide; and (3) inform you of the date that we reasonably expect to notify you of the decision. If we request additional information, we must receive it within 45 days of the request for the information. We will use our best efforts to provide notice of the decision on the Pre-Service Claim within 15 days of receipt of the requested information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

1. we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
2. the reduction or termination occurs before the end of such previously approved time or number of Service(s); and
3. the reduction or termination of coverage or benefits by us was not due to an amendment to the Booklet or termination of your coverage as provided by this Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determinations described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: (1) we need additional information; or (2) you or your representative did not follow proper procedures in the request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in

writing, unless you or your representative specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the procedures described below.

Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

1. the date the Service or supply was provided;
2. the Provider's name;
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, ICD-10, DSM-IV), and upon request, a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;
7. a description of the specific Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
8. a description of any additional information that might change the determination and why that information is necessary;
9. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and,
10. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If the claim is a Claim Involving Urgent Care, we may notify you orally within the proper timeframes, provided we follow up with a written or electronic notification meeting the requirements of this subsection no later than two working days or three calendar days after the oral notification.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims, we may need certain information, including information regarding other health care coverage you may have and/or medical information from Providers who render Services to you. You must cooperate with us in our effort to obtain this information, including signing any release of information form at our request. If you do not fully cooperate with us, we may deny the claim and we will have no liability for such claim.

Physical Examination

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. If you do not fully cooperate with such examination, we may deny the claim and we will have no liability for such claim.

Legal Actions

No legal action arising out of or in connection with coverage under this Booklet may be brought against us within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

Fraud, Misrepresentation or Omission in Applying for Benefits

We rely on the information provided on the itemized statement when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy we may have, in denial of the claim or cancellation or Rescission of your coverage.

Communication of Claims Decisions

All claims decisions, including denial and review decisions, will be communicated to you in writing such as through your monthly member health statement. This written correspondence may indicate:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination.
3. A description of any additional information that would change the initial determination and why that information is necessary.
4. An explanation of the steps to be taken if you wish to have a claim denial reviewed.
5. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures.
6. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

Circumstances Beyond Our Control

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Covered Services, taking into account the impact of the event. For purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

COMPLAINT AND GRIEVANCE PROCESS

Introduction

We have established a process for reviewing your Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, your dissatisfaction with us, our administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent In-Network Provider. The Complaint and Grievance Process also permits you or your Physician, or a person acting on your behalf, to expedite our review of certain types of Grievances. The process described in this section must be followed if you have a Complaint or Grievance.

Informal Review

We encourage you to first attempt the informal resolution of any dissatisfaction by calling us. To advise us of a Complaint, you should first contact our customer service department, at the phone number listed on your ID Card. A service associate, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to your satisfaction. You must provide all of the facts relevant to the Complaint to the service associate. If you do not provide all requested or relevant information, it may delay our review of the Complaint. Consequently, you must cooperate with us in our review of the matter.

If you remain dissatisfied with our resolution of the Complaint, you may submit a Grievance in accordance with the Formal Review subsection below.

Formal Review

You, a Provider who has been directly involved in your treatment or diagnosis acting on your behalf, a state agency, or another person designated in writing by you, may submit a Grievance.

In order to begin the formal review process, you may fill out a pre-printed form, write a letter or meet with us in person to explain the facts and circumstances relating to the Grievance. You should provide as much detail as possible and attach copies of any relevant documentation. You are not required to use our form, however, we strongly urge you to use this form, as it was designed to help facilitate logging, identification, processing, and tracking of the Grievance through the review process. Written requests for formal review must be sent to the address listed in the Telephone Numbers and Address subsection.

If you need assistance in preparing your Grievance, you may contact us for such assistance. If you are hearing impaired you may contact us via TTY/TDD.

Review of Grievances Involving Adverse Benefit Determination

A Grievance involving an Adverse Benefit Determination will be reviewed using the process described below. The Grievance must be submitted to us in writing for an internal Grievance within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. You must cooperate fully with us in our effort to promptly review and resolve a Complaint or Grievance. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the Complaint or Grievance processed within the time frames set forth in this section.
2. We will offer to meet with you if you believe that such a meeting will help us resolve the Complaint or Grievance to your satisfaction, you may also initiate a request for such meeting by notifying us. You may elect to meet with us in person, by telephone conference call, or by video-conferencing (if facilities are available). We will not pay for your travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at our administrative offices within the Service Area. We will make these telephone or video arrangements with no additional charge to you.
3. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The Expedited Review process only applies to Pre-Service Claims or requests for extension of Concurrent Care Services made within 24 hours before the authorization for such Services expires. An expedited review will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
4. You may review pertinent documents upon request and free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.
6. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews the Adverse Benefit Determination on our behalf will be identified upon request.
10. If the claim is a Claim Involving Urgent Care, you may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method. You may call our expedited phone line at the number listed at the end of this section.
11. If your request for expedited review arises out of a concurrent review determination by us that a continued hospitalization is not Medically Necessary, coverage for the hospitalization will continue until you have been notified of the determination.

12. If you wish to give someone else permission to file a Grievance for an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the Grievance. An Appointment of Representative form is not required if the Physician is requesting review of an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.floridablue.com or by calling the customer service phone number on your ID Card.
13. The Internal Review Panel will review the Grievance and may make a decision based on medical records, additional information, and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review.
14. We will advise you of all Grievance decisions in writing, as outlined in the Timing of Our Grievance Review on Adverse Benefit Determinations subsection.
15. We will provide written confirmation of our decision concerning a Claim Involving Urgent Care within two working days or three calendar days, whichever is less, after providing notification of that decision.
16. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain Grievances, as described in the External Review subsection below.
17. The panel that reviews Grievances is composed of individuals who did not participate in the previous decision, nor are they subordinates of such individual(s).
18. You may, but are not required to, present evidence and testimony during the Grievance process.

Timing of Our Grievance Review on Adverse Benefit Determinations

We will use our best efforts to review Grievances of Adverse Benefit Determinations and communicate the decision in accordance with the following time frames:

1. Pre-Service Claims: within 30 days of our receipt of the Grievance;
2. Post-Service Claims: within 60 days of our receipt of the Grievance; or
3. Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of our receipt of the request.

Note: The nature of a claim for Services (i.e. whether it is “urgent care” or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements (“Deemed Exhaustion”) and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Plan. If ERISA applies to the Group Plan, you are entitled, after exhaustion of the procedures described in this section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

External Review

You have a right to independent external review if we have denied your request for payment of a claim (in whole or in part) in the following circumstances:

1. Our decision involved a medical judgment including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational;
2. Whether or not a Covered Service is subject to the federal No Surprises Act (H.R. 133, P.L. 116-260); and/or
3. The calculation of your Cost Sharing associated with a Covered Service that is subject to the federal No Surprises Act (H.R. 133, P.L. 116-260).

Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID Card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

Blue Cross and Blue Shield of Florida
Attention: Member External Reviews DCC9-5
Post Office Box 44197
Jacksonville, FL 32231-4197

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. 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 on the external review of your claim. Moreover, expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID Card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external

review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

If the External Reviewer decides to overturn our decision, we will provide coverage or payment for your health care item or Service.

You or someone you name to act for you may file a request for external review. To appoint someone to act on your behalf, please complete an Appointment of Representative form.

You are entitled to receive, upon written request and free of charge, reasonable access to, and copies of all documents relevant to your appeal, including a copy of the actual benefit provision, guideline protocol or other similar criterion on which the appeal decision was based.

You may request and we will provide the diagnosis and treatment codes, as well as their corresponding meanings, applicable to this notice, if available.

Telephone Numbers and Address

You may contact a Grievance Coordinator at the phone number listed on your ID Card or at the phone numbers and address listed below.

Florida Blue HMO
Attention: Grievance Department
Post Office Box 41609
Jacksonville, Florida 32230-1609

877-352-2583

877-842-9118 for Expedited Review for a Claim Involving Urgent Care

Dial 7-1-1 for Florida Relay Service assistance with TTY/TDD calls

COORDINATION OF BENEFITS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided by Florida Blue HMO. It is designed to avoid duplication of payment for Covered Services and/or supplies. We shall coordinate payment of Covered Services to the maximum extent allowed by law, provided you follow the Coverage Access Rules set forth in the COVERAGE ACCESS RULES Section. Contracts which may be subject to Coordination of Benefits include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group Plan or non-group insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
4. Medicare, as described in the Medicare Secondary Payer Provisions subsection; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of payment by us, if any, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to your coverage under other plans. When we are not primary, our payment may be reduced so that total benefits under all plans will not exceed 100 percent of the total reasonable expenses actually incurred for the Covered Services. In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount we are obligated to pay such In-Network Provider based on the Provider’s contract.

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. This plan always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile policy available to you.
2. When we cover you as a dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
    a. the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;
    b. if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.
4. When we cover you as a dependent child whose parents are not married, or are separated or divorced:
    a. the plan of the parent with custody is primary;

b. the plan of the re-married parent with custody is primary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; the step-parent's plan is secondary; and

c. the plan of the parent without custody pays last;

d. regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.

5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:

   a. the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;

   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini-COBRA), and also under another group plan, the following order of benefits applies:

   a. first, the plan covering the person as an employee, or as the employee's dependent; and

   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.

7. When rules 1, through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary.

8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

We will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

Medicare Secondary Payer Provision

When you become covered under Medicare and are still eligible and covered under the Policy, your coverage under the Policy will be primary and Medicare benefits will be secondary, but only to the extent required by law. In all other instances, your coverage under the Policy will be secondary to any Medicare benefits. When your coverage under the Policy is the primary payer, claims for Covered Services should be filed with us first.

If you become covered under Medicare and are still eligible and covered under the Policy, the Group MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, the Group MAY NOT persuade you to decline or terminate your coverage under the Policy and elect Medicare as the primary payer.

When you turn 65 or become eligible for Medicare due to End Stage Renal Disease (ESRD), you must notify the Group.

Individuals With End Stage Renal Disease

If you become entitled to Medicare coverage because of ESRD, your coverage under this Policy is primary for 30 months beginning with the earlier of:

1. the month in which you became entitled to Medicare Part A ESRD benefits; or
2. the first month in which you would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was already primary before ESRD, Medicare will remain primary. Also, if your coverage under the Policy was primary before ESRD entitlement, the Policy will remain primary for the ESRD coordination period. If you are eligible for Medicare due to ESRD, your coverage under the Policy is primary for 30 months.

Miscellaneous

This section will be changed, if necessary, to comply with federal statutory and regulatory Medicare Secondary Payer rules as they relate to Medicare beneficiaries who are covered under the Policy.

We will not be liable to the Group or anyone covered under the Policy due to any nonpayment of primary benefits that result from the failure of the Group's performance or obligations set forth in this section.

If we elect to make primary payments for Covered Services rendered to you as described in this section in a period prior to receipt of the information required by the terms of this section, we may require the Group to reimburse us for such payments. Or, we may require the Group to pay the rate difference that resulted from the Group's failure to provide us with the required information in a timely manner.

Facility of Payment

Whenever payments which should have been made by us are made by any other person, plan, or organization, we shall have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we shall determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under the Policy and, to the extent of such payments, we shall be fully discharged from liability.

Non-Duplication of Government Programs

The benefits provided under this Booklet shall not duplicate any benefits to which you are entitled, or for which you are eligible, under governmental programs such as Medicare, Veterans Administration, TRICARE, or Workers' Compensation, to the extent allowed by law or any extension of benefits of coverage under a prior plan or program which may be required by law.

GENERAL PROVISIONS

Access to Information

We shall have the right to receive, from any health care Provider rendering Services to you, information that is reasonably necessary, as determined by us, in order to administer the coverage and/or benefits we provide, subject to all applicable confidentiality requirements set forth in this section. By accepting coverage under this Group plan, you authorize every health care Provider who renders Services or furnishes supplies to you, to disclose to us or to entities affiliated with us, upon request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit us to copy any such records and reports so obtained.

Amendment

The terms of coverage and benefits to be provided by us under the Policy may be amended, without your consent or that of the Group or any other person, upon 45 days prior written notice to the Group. In the event the amendment is unacceptable to the Group, the Group may terminate the Policy upon at least ten days prior written notice to us. Any such amendment shall be without prejudice to claims filed with us and related to benefits and coverage under this Policy prior to the date of such amendment. No agent or other person, except our duly authorized officer, has the authority to modify the terms of this Booklet, or to bind us in any manner not expressly set forth herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us under the Policy may not be amended by the Group unless such amendment is evidenced in writing and signed by our duly authorized officer. The Group shall immediately notify each Covered Person of any such amendment and/or shall assist us in notifying you at our request.

Assignment and Delegation

The obligations arising hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that we may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without the Group's consent at any time. Any assignment, delegation, or transfer made in violation of this provision shall be void.

Care Profile Program – A Payer-Based Health Record Program

A care profile is available to treating Physicians for each person covered under this Policy. This care profile allows a secure, electronic view of specific claims information for Services rendered by Physicians, Hospitals, labs, Pharmacies, and other health care Providers. Unless you have chosen to opt out, here are a few of the benefits of participation in the Care Profile Program:

1. All authorized treating Physicians will have a consolidated view – or history – of your Health Care Services, assisting them in improved decision-making in the delivery of health care.
2. In times of catastrophic events or Emergency Services, the care profile will be accessible from any location by authorized Physicians so that appropriate treatment and Service can still be delivered.

3. Safe and secure transmission of claim information. Only authorized health care Providers or authorized members of the Provider's staff will have access to your information.
4. Coordination of care among your authorized treating health care Providers.
5. More efficient health care delivery for you.

Keeping your health information private is extremely important, so your care profile will not include certain health information that pertains to "sensitive" medical Conditions, for which the law provides special protection. Health care Providers access the care profile using the same secure, electronic channel they use to file claims. In addition, only authorized members of the Provider's staff will have access to the information. Remember, this will help your Physician in obtaining important information concerning your health history.

However, if for some reason you, or any of your Covered Dependents, choose not to provide your treating Physician access to your claim history, the use of this information may be restricted. Should you choose not to participate call the customer service phone number on your ID Card and inform a service associate of your decision.

Changes in Premium

We may modify the Premiums, without your consent upon at least 45 days prior notice to the Group. Payments submitted to us following receipt of any such notice of modification constitutes acceptance by the Group of any such modification.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under the Policy shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with Rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of you, the Group, or us.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and/or benefits under the Policy, specific medical information concerning you received by/from a Provider shall be kept confidential by us. Such information shall not be disclosed to third parties without your written consent, except for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and/or benefits under the Policy, specifically including our quality assurance and utilization review activities. Additionally, we may disclose such information to entities affiliated with us. However, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

Our financial arrangements with In-Network Providers may require that we release certain claims and medical information about you even if you have not sought treatment by or through that Provider. By accepting coverage, you hereby authorize us to release to In-Network Providers claims information, including related medical information, pertaining to you, in order for the In-Network Provider to evaluate financial responsibility under their contracts with us.

Cooperation Required of Covered Persons

You must cooperate with us, and must execute and submit to us such consents, releases, assignments, and other documents as may be requested by us in order to administer, and exercise our rights under the Policy. Failure to do so may result in the denial of claims.

Customer Rewards and Incentive Programs

From time to time, we may offer you rewards or incentives for participating in certain activities and programs. These may be one-time rewards, available periodically or related to completing activities under a particular program. This includes but is not limited to programs offered as part of Florida Blue HMO's Quality Improvement Strategy ("QIS") as required under Section 1311(g) of the Affordable Care Act and shared savings incentive programs as defined under Florida law.

Types of Rewards or Incentives

The rewards and incentives available to you may exceed $100 per year and may include things like Premium credits, reduced Copayments, Coinsurance or Deductibles, cash equivalents or other incentives such as gift cards, debit cards, free or low cost transportation for medical Services, discounts, contributions to a health savings account and memberships to gyms or other programs.

Types of Programs

Rewards and incentives may be earned by taking part in programs or activities that focus on (for example):

- managing specific Conditions;
- preventive or wellness Services;
- certain behaviors, such as completing an annual physical; or
- optimizing your health plan, such as filling out a health assessment upon enrollment.

These are only examples of the types of programs that may be available to you. By logging into your rewards portal, you will be able to track rewards you have earned and access other programs that may be available to you.

Transportation Program

We understand that access to transportation can sometimes be a barrier to getting the health care you need. To assist you, we may offer programs to help you access health and wellness facilities and services.

Note: We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. You may not have access to every reward, incentive, health or transportation program. You are not obligated to take part in any of these programs and they will not affect the coverage available to you under this Booklet. We reserve the right to stop or change the features of any rewards or incentive programs at any time. The rewards, incentives or transportation provided may be taxable income and you should consult a tax advisor for further guidance.

ERISA

We are not the plan sponsor or plan administrator of your Group Plan, as defined by the Employee Retirement Income Security Act (ERISA). If the Group Plan under which you are covered is subject to ERISA, the Group, as either plan sponsor or plan administrator of an employee welfare benefit plan subject to ERISA, is responsible for ensuring compliance with ERISA.

Evidence of Coverage

You have been provided with this Booklet and an ID Card as evidence of coverage under the Policy issued by us to the Group.

Florida Agency for Health Care Administration (AHCA) Performance Data

The performance outcome and financial data published by AHCA, per Florida Statutes, or any successor statute, located at www.floridahealthfinder.gov, may be accessed through the link provided on our website at www.floridablue.com.

Governing Law

The terms of coverage and benefits to be provided hereunder and the rights of the parties hereunder shall be construed in accordance with the laws of the state of Florida and/or the United States, when applicable.

Identification Cards

The ID Cards issued to you in no way create, or serve to verify, eligibility to receive coverage and benefits under this Booklet. ID cards are our property and must be destroyed or returned to us immediately following termination of your coverage.

Modification of Provider Network

Our Provider network is subject to change at any time without prior notice to, or approval of, you or the Group. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, you or the Group. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered. Under this Booklet, your financial responsibility may vary depending on a Provider's participation status.

Non-Waiver of Defaults

Any failure by us at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect our right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law, the Policy, or this Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as set forth below. Such notice shall be deemed effective as of the date delivered or so deposited in the mail.

If to us:

To the address printed on the Small Employer Application or the ID Card.

If to you:

To the latest address provided by you according to our records.

If to the Group:

To the address indicated on the Small Employer Application.

Our Obligations Upon Termination

Upon termination of your coverage for any reason, we shall have no further liability or responsibility under the Policy with respect to you, except as specifically set forth herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Booklet.

Relationships Between the Parties

Florida Blue HMO and Health Care Providers

Neither Florida Blue HMO nor any of its officers, directors or employees provides health care Services to you. By accepting this coverage and benefits, you agree that health care Providers rendering Health Care Services are not our employees or agents. In this regard, we hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider. We do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care Provider. Any decisions made by us concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for the purpose of determining whether such Services are covered, and not for the purpose of recommending any treatment or non-treatment. Neither Florida Blue HMO nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

Florida Blue HMO and the Group

Neither the Group nor any Covered Person is our agent or representative, and neither shall be liable for any acts or omissions of Florida Blue HMO, its agents, servants, or employees. Additionally, neither the Group, any Covered Person, nor Florida Blue HMO, shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which Florida Blue HMO has made or hereafter makes arrangements for the provision of Covered Services. Florida Blue HMO is not the agent, servant, or representative of the Group or any Covered Person, and shall not be liable for any acts or omissions of the Group, its agents, servants, employees, any Covered Person, or any person or

organization with which the Group has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Right to Receive and Release Necessary Information

In order to administer coverage and benefits, we may, without the consent of or notice to, any person, plan, or organization, release to obtain from any person, plan, or organization any information with respect to any person covered under this Booklet or an applicant for enrollment which we deem to be necessary.

Right of Recovery

Whenever we have made payments in excess of the maximum provided for under this Booklet, we will have the right to recover any such payments, to the extent of such excess, from you or any other person, plan, or organization that received such payments.

Subrogation and Right of Reimbursement

As used herein, the term “Third Party,” means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as “Third Party Injuries.” “Third Party” includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries.

If benefits are paid under this Booklet for expenses incurred due to Third Party Injuries, then we retain the right to repayment of the full cost of all benefits provided under this Booklet on your behalf that are associated with the Third Party Injuries. Our subrogation and reimbursement rights of recovery apply to any claim or potential claim made by you or on your behalf from the following sources, including but not limited to:

- payments made by a Third Party or any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any Workers’ Compensation or disability award or settlement;
- medical payments coverage under any automobile policy, premises or homeowners’ medical payments coverage or premises or homeowners’ insurance coverage; and
- any other payments from a source intended to compensate you for injuries resulting from an Accident or alleged negligence.

By accepting benefits under this Booklet, you specifically acknowledge our right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an Accident), and we pay benefits under this Booklet as a result of those injuries, we will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits we have paid. This means that we have the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits we have paid. In order to secure our recovery rights, you agree to assign to us any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of our subrogation and reimbursement claims. This assignment allows us to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this Booklet, you also specifically acknowledge our right of reimbursement. This right of reimbursement attaches when we have paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Booklet, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided under this Booklet. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

By accepting benefits under this Booklet, you or your representatives further agree to:

- notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
- cooperate with us and do whatever is necessary to secure our right of subrogation and reimbursement under this Booklet;
- give us a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided under this Booklet (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
- pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due to us as reimbursement for the full cost of all benefits associated with Third Party Injuries paid under this Booklet (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing;
- do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid under this Booklet; and
- serve as a constructive trustee for the benefits under this Booklet over any settlement.

We may recover the full cost of all benefits paid by us under this Booklet without regard to any claim of fault on your part, whether by comparative negligence or otherwise. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits provided by us under this Booklet in addition to costs and attorney's fees incurred by us in obtaining repayment.

Third Party Beneficiary

The Policy under which this Booklet was issued, was entered into solely and specifically for the benefit of Florida Blue HMO and the Group. The terms and provisions of this Booklet shall be binding solely upon, and inure solely to the benefit of, Florida Blue HMO, and the Group, and no other person shall have any rights, interest or claims thereunder, or under this Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Florida Blue HMO and the Group hereby specifically express their intent that health care Providers that have not entered into contracts with Florida Blue HMO to participate in our Provider networks shall not be third-party beneficiaries under the Policy or this Booklet.

OTHER IMPORTANT INFORMATION

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

Types of HMOs

Staff and Group Model HMOs

In a staff model HMO, the doctors and other Providers rendering care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract services with additional doctors and Providers. Unlike the staff or group model HMOs, the IPA model HMO does not provide Health Care Services itself. Instead, it pays independent, qualified Providers to render health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

Note: This description is not intended to be an exhaustive listing of all HMO organization models in use in the United States.

Florida Blue HMO is an IPA Model HMO. **It is not a staff or group model HMO.** This means that the doctors and other Providers with whom we contract are independent contractors and not the employees or agents, actual or ostensible, of Florida Blue HMO. Rather these independent doctors and Providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

Your Rights and Responsibilities

We are committed to providing quality health care coverage at a reasonable cost while maintaining your dignity and integrity. Consistent with our commitment, and recognizing that In-Network Providers are independent contractors and not our agents, the following statement of your Rights and Responsibilities has been adopted.

Rights

1. To be provided with information about our services, coverage and benefits, the In-Network Providers delivering care and members' rights and responsibilities.
2. To receive medical care and treatment from In-Network Providers who have met our credentialing standards.
3. To expect In-Network Providers to:
    a. discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage;
    b. permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
    c. advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments; and
    d. inform you about any medications you are told to take, how to take them, and their possible side effects
4. To expect courteous service from us and considerate care from our In-Network Providers with respect and concern for your dignity and privacy.
5. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures found in this Booklet.
6. To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision. In the event, members are encouraged (but not required) to:
    a. complete an advance directive, such as a living will and provide it to the In-Network Providers; and
    b. have someone help make decisions, or to give another person the legal responsibility to make decisions about medical care on a member's behalf.
7. To have access to your medical records and to be assured that the confidentiality of your medical records is maintained in accordance with applicable law.
8. To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding our rights and responsibilities policies. Please call the phone number on your ID Card or write to us at the address on your ID Card.

Responsibilities

1. To seek all non-emergency care through your assigned PCP or another In-Network Provider and to cooperate with anyone providing your care and treatment.
2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.

3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about your care and to ask questions if you do not understand or need an explanation.
4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
5. To pay your Cost Share amounts and be financially responsible for non-covered Services and to provide current information concerning your coverage status to any In-Network Provider.
6. To follow the process for filing an appeal about medical or administrative decisions that you feel were made in error.
7. To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
8. To follow the Coverage Access Rules established by us.
9. To review information regarding Covered Services, policies and procedures as stated in this Booklet.

Disclosure of Continuing Care Facility Resident/Retirement Facility Resident Rights

If, at the time of enrollment you are a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, your PCP must refer you to that facility's skilled nursing unit or assisted living facility if:

1. you request it and the facility agrees;
2. your PCP finds that such care is Medically Necessary;
3. the facility agrees to be reimbursed at the same contracted rate as similar Providers for the same Covered Services and supplies; and
4. the facility meets all guidelines established by us related to quality of care, utilization, referral authorization, risk assumption, use of our Provider network, and other criteria applicable to Providers under contract with us for the same Services.

If your request to be referred to the skilled nursing unit or assisted living facility that is part of your place of residence is not honored, you have the right to initiate a Complaint or Grievance under the process described in this Booklet.

Statement of Advanced Directives

The following information is provided in accordance with the Patient Self-Determination Act to advise you of your rights under Florida law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to prepare an advance directive, and explain our policy on advance directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes your right as a competent adult to make an advance directive instructing your Physician to provide, withhold, or withdraw life-prolonging procedures, or to name someone to make treatment decisions for you in the event that you are found to be incompetent and suffering from a terminal Condition. Advance directives provide patients with a way to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own health care decisions.

An "advance directive" is a witnessed oral or written statement which indicates your choices and preferences with respect to medical care made by you while you are still competent. An advance directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care Provider should consult in making treatment decisions.

There are three types of documents recognized in Florida that are commonly used to express an individual's advance directives: a Living Will, a Health Care Surrogate Designation and a Durable Power of Attorney for Health Care.

A Living Will is a declaration of a person's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal Condition and is not able to express his or her wishes. It does not become effective until the patient's Physician and one other Physician determine that the patient suffers from a terminal Condition and is incapable of making decisions.

Another common form of advance directive is the Health Care Surrogate Designation. When properly executed, a Health Care Surrogate Designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient's wishes. The surrogate's authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions the surrogate cannot make by law, such as consent to abortion or electroshock therapy, any specific limits on the surrogate's power to make decisions should be clearly expressed in the Health Care Surrogate Designation document.

Finally, there is the Durable Power of Attorney for Health Care. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical Condition.

A suggested form of Living Will and Designation of Health Care Surrogate is contained in Chapter 765 of the Florida Statutes. There is no requirement that you have an advance directive and your health care Provider cannot condition treatment on whether or not you have one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. a judicially appointed guardian;
2. a spouse;
3. an adult child or a majority of the adult children who are reasonably available for consultation;
4. a parent;
5. siblings who are reasonably available for consultation;

6. an adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health and religious or moral beliefs;

7. a close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending Physician an affidavit stating that he or she is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, religious and moral beliefs.

Deciding whether to have an advance medical directive, and if so, the type and scope of the directive, is a complex understanding. It may be helpful for you to discuss advance directives with your spouse, family, friends, religious or spiritual advisor or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, Physician and whomever else will be faced with the task of carrying out those wishes knows what you would want.

It is our policy to recognize your right to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an advance directive to guide treatment decisions in the event you become unable to do so. We will not interfere with your decision. It is your responsibility to provide notification to your Providers that an advance directive exists. If you have a written advance directive, we recommend that you furnish your Providers with a copy so that it can be made a part of your medical record.

Florida law does not require a health care Provider or facility to commit any act which is contrary to the Provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a Provider or facility in our network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another Provider or facility.

Our Providers have varying practices regarding the implementation of an individual's advance directive, in accordance with state law. Therefore, we recommend that you have discussions about advance directives with your medical care givers, family members and other friends and advisors. Your Physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical Condition or environment.

Complaints concerning noncompliance with advance directives may be submitted to the following address:

Agency for Health Care Administration
Bureau of Managed Health Care
Building 1, Room 311
2727 Mahan Drive
Tallahassee, Florida 32308

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law.

AWAY FROM HOME CARE®

Away From Home Care (AFHC) Guest Membership is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA). AFHC is available to individuals covered by a participating Blue-sponsored HMO when the program requirements are met. Guest Membership is defined as a courtesy membership for individuals who are temporarily residing outside of their Home HMO service area. Florida Blue HMO is your Home HMO.

Under AFHC, you receive a courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits, including routine and preventive Services. You will receive the benefits of the Host HMO plan while in that HMO Plan's service area. You remain a member of your Home HMO and are entitled to payment for Covered Services not payable under your AFHC Guest Membership under the terms of this Booklet. Under the AFHC Program, Premium continues to be paid to the Home HMO. Should your coverage with your Home HMO terminate, you will no longer be eligible for AFHC coverage, and if you are then in this program your AFHC coverage will also be terminated.

The Host HMO pays the Provider the lowest available rate on a fee-for-service basis and then bills the Home HMO for reimbursement. You pay any applicable Cost Share amounts to the Provider in the Host Plan's service area at the time of Service.

Guest Application

You must complete an AFHC Guest Application with the Home HMO, and then work with the Host HMO to locate a PCP in the Host Plan's service area. The AFHC Guest Application form is used to verify your eligibility and to provide the appropriate information for billing and reimbursement.

Guest Membership Types

The types of Guest Memberships are based on your eligibility and the length of time that you will be out of the Home HMO Service Area. The three types of Guest Memberships are as follows:

Long-Term Traveler

This Guest Membership is available to Covered Persons that are away from home for at least 90 consecutive days (three months) but not more than 180 days (six months).

This Guest Membership is typically used for long-term work assignments or for a retiree with a dual residence. Home HMOs may limit the number of Long-Term Traveler Guest Memberships to two per year.

Families Apart

The Families Apart Guest Membership is available to Covered Dependents that do not reside in the Home HMO Service Area for 90 or more consecutive days. A Covered Employee is not eligible for this type of Guest Membership.

To qualify for a Families Apart Guest Membership, the Covered Dependent must not be living with the Covered Employee and must live in the service area of a Blue-Sponsored HMO.

There is no administrative time limit on the length of a Families Apart Guest Membership.

Student

The Student Guest Membership is available to Covered Dependents that are out of the Home HMO Service Area for 90 or more consecutive days attending school.

To qualify for a Student Guest Membership, the Covered Dependent must not be living with the Covered Employee and must live in the service area of a Blue-Sponsored HMO.

The Student Guest Membership is typically used for students while they are away at school. The student membership should terminate when the student returns to the Home HMO Service Area for the summer. There is no administrative time limit on the length of a Student Guest Membership.

Covered Dependents under a Student Guest Membership that seek care in a third HMO service area (out of the Home HMO area and out of the Host HMO area) should be referred back to Florida Blue HMO, the Home HMO.

Guest Membership Policies

Host HMOs need enough time to process and setup Guest Memberships before the desired effective date. A 15-day notification period is provided for Host HMOs to complete the processing and set-up of the Guest Membership. Covered individuals can be under only one Guest Membership at a time.

Guest Membership Renewals

When your Guest Membership expires, you may apply for a separate, consecutive Guest Membership period to begin after your current one expires. The 15-day notification period applies to Guest Membership renewals, so it is important that you apply for renewal far enough in advance to avoid a lapse in Guest Membership.

Guest Membership renewals have the same requirements as initial Guest Memberships, including the 90-day out-of-area requirement. Renewals must be for a minimum of 90 or more consecutive days in length. A renewal requires that the Home HMO Guest Membership Coordinator re-verify eligibility, submit a new Guest Application form, obtain a new signature sticker and pay a new set-up and renewal fee.

Renewals typically apply to Families Apart and Student Guest Memberships which commonly renew on an annual basis. A Long Term Traveler Guest Membership can also renew but you would need to re-qualify by being out of area for a minimum of 90 consecutive days from the date of the requested renewal, as well as meeting all other Home HMO eligibility requirements. You are not required to return to the Home HMO Service Area to qualify for a renewal.

DEFINITIONS

The following definitions will help you understand the terms that are used in this Booklet, including the Schedule of Benefits and any Endorsements that are part of to this Booklet. As you read through this Booklet you can refer to this section; we have identified defined terms in the Booklet, the Schedule of Benefits and any Endorsements by capitalizing the first letter(s) of the term.

A

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to Sound Natural Teeth caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Adoption or Adopt(ed) means the act of creating a legal parent/child relationship where it did not exist, declaring that the child is legally the child of the adoptive parents and their heir-at-law and is entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as defined by Florida law or a similar applicable law of another state.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Booklet in connection with:

1. a Pre-Service Claim or a Post-Service Claim;
2. a Concurrent Care Decision, as described in the CLAIMS PROCESSING section; or
3. Rescission of coverage, as described in the TERMINATION OF COVERAGE section.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The allowed amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and Florida Blue HMO.
2. In the case of Out-of-Network Providers located outside of the Service Area who participate in the BlueCard Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BLUECARD PROGRAM section for more details.
3. In the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue HMO to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the allowed amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue HMO that may be based on several factors, including but not limited to: (i) payment for such Covered Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Covered Services by that

Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that we determine are comparable to the Out-of-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating Providers in other Provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by us, with our Provider network strategies (e.g., does not result in payment that encourages Providers participating in a Florida Blue HMO network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the allowed amount for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue HMO by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating providers in its geographic area for such Services.

4. In the case of Covered Services rendered by an Out-of-Network Provider where the Services are subject to either the federal No Surprises Act (H.R. 133, P.L. 116-260) or 641.513(5) F.S., then the allowed amount will be calculated in accordance with the applicable statute. For clarity, if the Provider is located in Florida and 641.513(5) F.S. applies, then the allowed amount calculated under 3. above is presumed to meet the requirements of 641.513 F.S.

In no event will the allowed amount be greater than the amount the Provider actually charges.

You may obtain an estimate of the allowed amount for particular Services by calling the customer service phone number on your ID Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Booklet apply. You should refer to the WHAT IS COVERED? section of this Booklet and your Schedule of Benefits to determine what is covered and how much we will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue HMO to provide access to a discount from the billed amount of that Provider, the allowed amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law in another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Anniversary Date means the date one year after the Effective Date stated on the Small Employer Application, and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and meets one of the following criteria:

1. The study or investigation is approved or funded by one or more of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare and Medicaid Services.
    e. A cooperative group or center of any of the entities described in items a through d or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following, if the conditions described in paragraph (2) are met:
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For a study or investigation conducted by a Department, the study or investigation must be reviewed and approved through a system of peer review that the Secretary determines: (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For purposes of this definition, the term “Life-Threatening Disease or Condition” means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

Artificial Insemination (AI) means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care Provider for the purpose of producing a pregnancy.

B

Benefit Booklet or **Booklet** means the certificate of coverage, which is evidence of coverage under the Policy.

Benefit Period means a consecutive period of time, specified by Florida Blue HMO and the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your benefit period is listed on your Schedule of Benefits, and will not be less than 12 months.

Biosimilar Prescription Drug means a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (known as a reference product). A biosimilar

Prescription Drug has no clinically meaningful difference in terms of safety and effectiveness from the reference product it is compared to.

Birth Center means any facility, institution, or place, licensed pursuant to Chapter 383 of the Florida Statutes, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy. A birth center is not an Ambulatory Surgical Center or a Hospital.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy Drugs. The term "bone marrow transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells, such as Hospital room and board and ancillary Services.

Brand Name Prescription Drug means a Prescription Drug that is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the brand name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

Breast Reconstructive Surgery means surgery to reestablish symmetry between the two breasts.

C

Calendar Year begins January 1st and ends December 31st of the same year.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for cardiac therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to you with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed without the proposed Services being rendered.

Coinsurance means the sharing of health care expenses for Covered Services between you and us. After your Deductible is met, we will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your coinsurance. Not all plans include coinsurance.

Complaint means an oral (non-written) expression of dissatisfaction, whether or not such dissatisfaction is made in person, by telephone or by another person acting on your behalf.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized coverage, benefits, or payment for that course of treatment or number of treatments in writing.

As defined herein, a concurrent care decision shall not include any decision to deny, reduce, or terminate coverage, benefits or payment under the Case Management subsection of the COVERAGE ACCESS RULES section.

Condition means a disease, illness, ailment, injury or pregnancy.

Continuing Care Patient means a patient who is undergoing a course of treatment for:

1. a serious or complex Condition:
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care;
3. a scheduled non-elective surgery including postoperative care;
4. pregnancy; or
5. a terminal illness.

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

Convenient Care Center means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Provider is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one masters level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

Copayment or **Copay** means, when applicable, the dollar amount established solely by us which must be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider. In the case of Prescription Drugs, the amount you must pay to an In-Network Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost share may include, but is not limited to Coinsurance, Copayment and Deductible amounts. Applicable cost share amounts are identified in your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements described in the ELIGIBILITY FOR COVERAGE section and who is enrolled and actually covered under the Small Policy other than as a Covered Employee.

Covered Employee means an Eligible Employee or other individual who continues to meet all applicable eligibility requirements described in the ELIGIBILITY FOR COVERAGE section and who is enrolled and actually covered under the Policy other than as a Covered Dependent.

Covered OTC Drug means an Over-the-Counter Drug that is designated in the Medication Guide as a Covered OTC Drug.

Covered Person means a Covered Employee or Covered Dependent.

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under the Pharmacy Program.

Covered Prescription Drug(s) and Supply(ies) means Covered Prescription Drugs and Covered Prescription Supplies.

Covered Prescription Supply(ies) means only the following Supplies:

1. Prescription diaphragms indicated as covered in the Medication Guide;
2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage by us;
3. syringes and needles prescribed with a Prescription Drug authorized for coverage by us;
4. syringes and needles contained in anaphylactic kits; and
5. Prescription Supplies used in the treatment of diabetes, limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

Covered Services means those Health Care Services which meet the criteria listed in the WHAT IS COVERED? section.

Custodial or **Custodial Care** means care that serves to assist a person in the Activities of Daily Living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, consideration is given to the frequency, intensity and level of care and medical supervision required and

furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

D

Daily Living means age appropriate basic tasks of everyday life such as bathing, dressing, eating, toileting, transferring and walking.

Day Supply means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to appropriate licensed health care Providers who are recognized for payment under this Booklet, before our payment for Covered Services begins. Not all plans include a deductible.

Dentist means a person who is properly licensed by the state of Florida, or a similar applicable law of another state, as a doctor of Dental Surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the Service is rendered, and acting within the scope of his or her license.

Designated Transplant Facility is a licensed facility that is designated by us and has a contract with us to provide covered transplant Services at the time the Services are rendered. Designated transplant facilities may or may not be located in the Service Area. The fact that a Hospital is an In-Network Hospital does not mean that it is a designated facility.

Detoxification means a process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a Physician, while keeping the physiological risk to the person at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or similar applicable laws of another state, to supervise diabetes outpatient self-management training and educational Services.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services and appropriate behavioral health Conditions covered under this plan.

Domestic Partner means a person of the same or opposite gender with whom the Covered Employee has established a Domestic Partnership.

Domestic Partnership means a relationship between the Covered Employee and one other person of the same or opposite gender who meet, at a minimum, the following eligibility requirements:

- both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;

- individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
- both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the domestic partnership;
- the Covered Employee has submitted to the Group, acceptable proof of evidence of common residence and joint financial responsibility; and
- the Covered Employee has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) is not for comfort or convenience; (4) generally is not useful to an individual in the absence of a Condition; and (5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law (or a similar applicable law of another state) to provide Durable Medical Equipment in the patient's home under a Physician's prescription.

E

Effective Date for the Group, means 12:01 a.m. on the date specified on the Small Employer Application and for you means 12:01 a.m. on the date coverage will begin as specified in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the ELIGIBILITY FOR COVERAGE section.

Eligible Employee means an employee who meets and continues to meet all of the eligibility requirements set forth in the ELIGIBILITY FOR COVERAGE section and is eligible to enroll as a Covered Employee. An eligible employee is not a Covered Employee until actually enrolled and accepted for coverage as a Covered Employee by us.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may reasonably be expected to result in a Condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

Emergency Services means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient.

Endorsement means a document issued by us that changes or modifies language in the Policy or this Booklet. Endorsements may also be referred to as amendments.

Enrollment Date means the date of enrollment of the individual under the Policy or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those forms, electronic or paper, which are approved by us and used to maintain accurate enrollment files under the Policy.

Experimental or **Investigational** means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, or chemical compounds, if, as determined solely by us:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by us):

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;

2. reports, articles, or written assessments in authoritative Medical Literature and scientific literature;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Services or supplies which are determined by us to be experimental or investigational are excluded as described in the WHAT IS NOT COVERED? section. In making benefit determinations, we may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

F

FDA means the United States Food and Drug Administration.

Florida Blue HMO is a trade name of Health Options, Inc., an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. D/B/A Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association. Health Options, Inc. is a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health and Rehabilitative Services in compliance with Florida Statutes or by a similar applicable law in another state.

G

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care Provider. Fertilization takes place inside the tube.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (1) has been approved by the United States Food and Drug Administration (FDA) for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (2) is a Prescription Drug that is

not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of Florida Blue HMO, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic Prescription Drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Prescription Drug.

Grievance means a written expression of dissatisfaction that is not an Adverse Benefit Determination.

Group means the Small Employer through which coverage and benefits are issued by us.

Group Master Policy or Policy means the written document, which is the evidence of the entire agreement between the Group and Florida Blue HMO whereby coverage and benefits are provided to Covered Persons. The Policy includes this Booklet, the Schedule of Benefits, the Small Employer Application, Enrollment Forms and any Endorsements to this Booklet or the Policy.

Group Plan means the employee welfare benefit plan established by the Group and through which you become entitled to coverage and benefits for the Covered Services described in this Booklet.

H

Habilitative Services means Health Care Services that help a person keep, learn or improve skills and functioning for Daily Living.

Health Care Services or **Services** means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other Services rendered or supplied, by or at the direction of, a licensed Provider.

Home Health Agency means a properly licensed agency or organization which provides health Services in the home pursuant to Chapter 400 of the Florida Statutes, or similar applicable laws of another state.

Home Health Care or **Home Health Care Services** means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization duly licensed pursuant to Florida Statutes, or a similar applicable law in another state to provide hospice Services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive Services to terminally ill people and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, that offers Services which are more intensive than those required for room, board, personal Services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory Services, diagnostic x-ray Services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term hospital does not include: an Ambulatory Surgical Center, a Skilled Nursing Facility, a stand-alone Birth Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by The Joint Commission, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services; it only expands the setting where Covered Services can be performed for coverage purposes.

I

Identification (ID) Card means the cards we issue to Covered Employees. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, the Policy.

Independent Clinical Laboratory means a laboratory, independent of a Hospital or Physician's office, which is a fixed location, properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Center means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An independent diagnostic testing center must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida laws or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an independent diagnostic testing center.

In-Network Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for the Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also In-Network Pharmacies.

In-Network Pharmacy Allowance means the maximum amount allowed to be charged by an In-Network Pharmacy per Prescription for a Covered Prescription Drug, Covered OTC Drug or Covered Prescription Supply under the Pharmacy Program.

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to provide Covered Services described in this Booklet.

Intensive Outpatient Treatment means treatment in which an individual receives at least 3 clinical hours of institutional care per day (24-hour period) for at least 3 days a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Internal Review Panel means a panel established by us to review Grievances related to Adverse Benefit Determinations that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medical

Necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to a women's uterus.

L

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

M

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

Massage or **Massage Therapy** means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Booklet, the term massage or massage therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Massage Therapist means a person properly licensed to practice Massage pursuant to Chapter 480 of the Florida Statutes, or similar applicable laws of another state.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Maximum means the amount designated in the Medication Guide as the maximum, including, but not limited to, frequency, dosage and duration of therapy.

Medical Literature means peer reviewed literature included in the PubMed/Medline database of the National Library of Medicine.

Medically Necessary or **Medical Necessity** means that, with respect to a Health Care Service, a Provider, exercising prudent clinical judgment, provided, or is proposing or recommending to provide, the Health Care Service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was/is:

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, disease or symptoms;
3. not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider, and
4. not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. inpatient), and/or an

alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

When determining whether a Service is not more costly than the same or similar Service as referenced above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

a. the Allowed Amount for Service at the location for the delivery of the Service versus an alternate setting;

b. the amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or,

c. an analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

Note: The distance you have to travel to receive a Health Care Service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

Reviews we perform of medical necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular Service. In performing medical necessity reviews, we may take into consideration and use cost data which may be proprietary.

It is important to remember that any review of medical necessity by us is solely for the purpose of determining coverage or benefits under this Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of medical necessity in this Booklet as determined by us. In applying the definition of medical necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not medically necessary; however, you will be solely responsible for paying for the Service.

Medically Necessary Orthodontic Treatment means treatment as a result of a handicapping malocclusion and congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip.

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.

Mental Health Professional means a person properly licensed to provide mental health Services, pursuant to Chapter 491 of the Florida Statutes, or a similar applicable law of another state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A

mental health professional does not include members of any religious denomination who provide counseling Services.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD-10-CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state.

N

National Drug Code (NDC) means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

National Network Pharmacy means a Pharmacy located outside of Florida that is part of the national network of Pharmacies established by our contracting Pharmacy Benefit Manager.

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Non-Formulary Drug means a Brand Name Prescription Drug that is not included on the Formulary List then in effect.

O

Occupational Therapist means a person properly licensed to practice occupational therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Occupational Therapy means Habilitative Services or a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

One-Month Supply means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer’s daily dosing recommendations. Certain Drugs (e.g. Specialty Drugs) may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network Pharmacy means a Pharmacy that has not agreed to participate in the network for this Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to provide Covered Services described in this Booklet.

Outpatient Facility for Habilitative and Rehabilitative Therapy (Outpatient Hab/Rehab Facility) means an entity which renders, through Providers properly licensed pursuant to Florida law or a similar applicable law of another state: outpatient Physical Therapy; Speech Therapy; Occupational Therapy; Cardiac Therapy; and Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition or to keep, learn or improve skills and functioning for Daily Living. Further, such an entity must meet our criteria for eligibility as an outpatient facility for habilitative and rehabilitative therapy. The term outpatient facility for habilitative and rehabilitative therapy, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical habilitative or rehabilitative inpatient Services, or habilitative or rehabilitative outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

Over-the-Counter (OTC) Drug means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

P

Pain Management includes, but is not limited to, Services for pain assessment, medication, Physical Therapy, biofeedback, and/or counseling. Pain management programs feature multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 6 clinical hours of institutional care per day (24-hour period) for at least 5 days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Per Admission Deductible (PAD) means the amount of charges, up to the Allowed Amount, for inpatient Covered Services, which you must actually pay, for each Hospital admission to an appropriately licensed Hospital recognized for payment under this Booklet, before our payment for any inpatient Covered Services begins. The Hospital PAD applies regardless of the reason for the admission and is in addition to the Deductible requirement, if applicable.

Per Visit Deductible (PVD) means the amount of charges, up to the Allowed Amount, for Covered Services rendered in an outpatient facility, which you must actually pay, for each visit to an appropriately licensed outpatient facility recognized for payment under this Booklet, before our payment begins. The PVD applies regardless of the reason for the visit and is in addition to the Deductible requirement, if applicable.

Pharmacist means a person properly licensed to practice the profession of Pharmacy per Chapter 465 of the Florida Statutes, or a similar law of another state that regulates the profession of Pharmacy.

Pharmacy means an establishment licensed as a pharmacy per Chapter 465 of the Florida Statutes, or a similar law of another state, where a Pharmacist dispenses Prescription Drugs.

Pharmacy Benefit Manager means an organization that has established, and manages, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such networks and/or programs available to you.

Pharmacy Deductible means the amount of charges, up to the In-Network Pharmacy Allowance for Covered Prescription Drugs and Supplies that you must actually pay per Benefit Period, in addition to any applicable Copayment or Coinsurance, to a Pharmacy, who is recognized for payment under this Booklet, before our payment for Covered Prescription Drugs and Supplies begins.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the Florida Statutes, or a similar applicable law of another state.

Physical Therapy means Habilitative Services or the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or hot or cold therapy.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

Physician Specialty Society means a United States medical specialty society that represents diplomates certified by a board recognized by the American Board of Medical Specialties.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

Premium means the total amount required to be paid by the Group to us in order for there to be coverage under this Policy.

Prescription means an order for Drugs, Services or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs, Services or supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of the Pharmacy Program, insulin and emergency contraceptives are considered prescription drugs because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

Preferred Pharmacy means an In-Network Pharmacy which has been designated by us or our Pharmacy Benefit Manager as a preferred Pharmacy. Preferred Pharmacies are identified in the Pharmacy Program Provider Directory then in effect, which can be viewed at www.floridablue.com.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and, with respect to which the terms of this Booklet, condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A pre-service claim may be a Claim Involving Urgent Care. As defined herein, a pre-service claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Services covered under your plan. **Note:** The Preventive Services Guide is subject to change at any time. Please refer to our website at www.floridablue.com/healthresources for the most current guide.

Primary Care Provider or **Primary Care Physician (PCP)** means a Provider who, at the time Covered Services are rendered, was under a primary care Provider contract with us. A primary care Provider may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist, or APRN may elect to contract with us as a primary care Provider.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or nonfunctional body part or organ.

Prosthetist/Orthotist means a person or entity that is properly licensed or registered, if applicable, under Florida law, or a similar applicable law of another state, to provide Services consisting of the design and fabrication of medical devices such as braces, splints and artificial limbs prescribed by a Physician.

Provider means any facility, person or entity recognized for payment by us under this Booklet.

Psychiatric Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a psychiatric facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state.

R

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse First Assistant means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

Rehabilitative Services means Services rendered for the purpose of restoring function lost due to illness, injury or surgical procedures, including but not limited to Cardiac Therapy, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage.

Repackaged Drug(s) means a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

Rescission or **Rescind** refers to Florida Blue HMO's action to retroactively cancel or discontinue coverage under this Booklet. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

Residential Treatment Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide care and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

- has Mental Health Professionals on-site 24 hours per day and 7 days per week;
- provides access to necessary medical services 24 hours per day and 7 days per week;
- provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- provides a level of skilled intervention consistent with patient risk;
- is not a wilderness treatment program or any such related or similar program, school and/or education service.

With regard to Substance Dependency treatment, in addition to the above, must meet the following:

- if Detoxification Services are necessary, provides access to necessary on-site medical services 24 hours per day and 7 days per week, which must be actively supervised by an attending Physician;
- ability to assess and recognize withdrawal complications that threaten life or bodily function and to obtain needed Services either on site or externally;
- is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation.

Residential Treatment Services means treatment in which an individual is admitted by a Physician overnight to a Hospital, Psychiatric Hospital or Residential Treatment Facility and receives daily face to face treatment by a Mental Health Professional for at least 8 hours per day, each day. The Physician must perform the admission evaluation with documentation and treatment orders within 48 hours and provide evaluations at least weekly with documentation. A multidisciplinary treatment plan must be developed within 3 days of admission and must be updated weekly.

S

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, (except insulin). Covered self-administered injectable Prescription Drugs are denoted with a symbol in the Medication Guide.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Service Area means the geographic area approved by the Agency for Health Care Administration (AHCA); and in which rates have been approved by the Florida Office of Insurance Regulation (OIR). A listing of the applicable service area is available at: https://www.floridablue.com/sites/floridablue.com /files/docs/county_landing_page.pdf.

Skilled Nursing Facility means a facility or part thereof which is properly licensed under Florida law, or a similar applicable law of another state, , to provide care and treatment of medical Conditions and meets all of the following requirements:

1. is accredited as a skilled nursing facility by The Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us;
2. has nursing staff on-site 24 hours per day and 7 days per week;
3. provides access to necessary medical Services 24 hours per day and 7 days per week;
4. provides appropriate access to any Physician-ordered Services required for treatment of your Condition on at least a daily basis (and likely multiple times per day). These Services may consist of skilled nursing Services, (e.g., intravenous fluids and medication administration, wound care, etc.) and therapy Services (i.e., physical, occupational and speech);
5. has individualized active treatment plan (e.g., skilled nursing and therapy Services) directed toward the management and improvement of the Condition that caused the admission; and
6. provides a level of skilled care consistent with your Condition and care needs.

Small Employer means any employer that has its principal place of business in this state, employed an average of at least one but not more than 50 employees on business days during the preceding Calendar Year, and employs at least one (1) employee on the first day of the plan year. The terms “employee” and “employer” have the same meaning as provided in 29 U.S.C. § 1002(5) and § 1002(6), respectively, as may be amended from time to time.

Small Employer Application means the Florida Blue HMO application form that a Small Employer must submit to Florida Blue HMO when requesting the issuance of the Policy.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not sound natural teeth.

Specialist means a Physician who limits practice to specific Services or procedures such as surgery, radiology, pathology, certain age categories of patients such as pediatrics or geriatrics, certain body systems such as dermatology, orthopedics, cardiology, internal medicine or types of diseases such as allergy, psychiatry, infectious diseases, oncology. Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board.

Specialty Drug means an FDA-approved Prescription Drug that has been designated solely by us, as a specialty drug due to requirements such as special handling, storage, training, distribution requirements

and/or management of the therapy. Specialty Drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. In-Network specialty pharmacies are listed in the Medication Guide. The fact that a Pharmacy is an In-Network Pharmacy does not mean that it is a specialty pharmacy.

Speech Therapist means a person properly licensed to practice speech therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Speech Therapy means Health Care Services provided for the treatment of speech and language disorders by a Physician, Speech Therapist, or licensed audiologist, including language assessment and language restorative therapy Services.

Stabilize shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act.

Standard Pharmacy means an In-Network Pharmacy which has not been designated by us or our Pharmacy Benefit Manager as a Preferred Pharmacy.

Standard Reference Compendium means (1) the United States Pharmacopoeia Drug Information; (2) the American Medical Association Drug Evaluation; and/or (3) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For purposes of this Booklet a substance abuse facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Supply(ies) means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, bandages, cotton swabs, and similar items and any birth control device.

T

Three-Month Supply means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer's dosing recommendations.

Transplant Travel Benefit Period begins with pre-evaluation testing and ends when post-transplant Services are complete, but not to exceed 12 months after organ transplantation.

U

Urgent Care Center means a properly licensed facility that: (1) is available to provide Services to patients at least 60 hours per week with at least 25 of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; (2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the urgent care center is closed; (3) employs or contracts with at least one or more board certified or board eligible Physician and Registered Nurse (RN) who are physically present during all hours of operation (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and (4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations. For purposes of this Benefit Booklet, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Hab/Rehab Facility.

V

ValueScript Rx Medication Guide (herein "Medication Guide") means the guide then in effect issued by us that contains the Formulary List which designates the following categories of Prescription Drugs: Generic Prescription Drugs and Brand Name Prescription Drugs. **Note**: The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card.

Virtual Care Provider means (1) an In-Network Provider that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications.

W

Waiting Period means the period of time specified on the Small Employer Application, if any, which must be met by an individual before that individual is eligible to enroll for coverage under this Policy. Such waiting period cannot be more than 90 days in accordance with federal law.

Z

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the result zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.