BlueOptions

Benefit Booklet

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueOptions Large Group
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BlueOptions

Benefit Booklet

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Chairman of the Board and Chief Executive Officer

This Benefit Booklet Contains Deductible Provisions

For Customer Service Assistance: 1-877-352-2583

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Table of Contents

Section 1: 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 BlueOptions benefits
- what is covered
- what is excluded or not covered
- our coverage and payment rules
- our Blueprint for Health Programs
- how and when to file a claim
- how much, 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 included in this booklet to determine how much you have to pay for particular Health Care Services.

When reading your Booklet, please remember that:

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Benefit Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- 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 Dependent(s) will be noted as such.
- references to "we", "us", and "our" throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as "BCBSF."
- 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 defined within the particular section where it is used.

Where do you find information on…

- **what particular types of Health Care Services are covered?**

  Read the "What Is Covered?" and "What is Not Covered?" sections.

- **how much does BCBSF pay and how much do you have to pay?**

  Read the "Understanding Your Share of Health Care Expenses" section along with the Schedule of Benefits.

- **how to take advantage of the BlueCard® (Out-of-State) Program when you receive Services out-of-state?**

  Read the "BlueCard® (Out-of-State) Program" section.

- **how to add or remove a Dependent?**

  Read the "Enrollment and Effective Date of Coverage" section.

- **what happens if you are covered under BlueOptions and another health plan?**

  Read the “Duplication of Coverage Under Other Health Plans / Programs” section.

- **what happens when your coverage ends?**
  Read the “Termination of Coverage” section.

- **what the terms used throughout this Booklet mean?**

  Read the Definitions section.

Overview of How BlueOptions Works

Whenever you need care, you have a choice. If you visit an:	
In-Network Provider	**Out-of-Network Provider**
You receive In-Network benefits, the highest level of coverage available.	You receive the Out-of-Network level of benefits – you will share more of the cost of your care.
You do not have to file a claim; the claim will be filed by the In-Network Provider for you.	You may be required to submit a claim form.
The In-Network Provider* is responsible for admission notification if you are admitted to the Hospital.	You should notify BCBSF of inpatient admissions.

*For Services rendered by an In-Network Provider located outside of Florida, you should notify us of inpatient admissions.

Section 2: What Is Covered?

Introduction

This section describes the Health Care Services that are covered under this Benefit Booklet. All benefits for Covered Services are subject to your share of the cost and the benefit maximums listed on your Schedule of Benefits, the applicable Allowed Amount, any limitations and/or exclusions, as well as other provisions contained in this Booklet, and any Endorsement(s) in accordance with our Medical Necessity coverage criteria and benefit guidelines then in effect.

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the "What is Not Covered?" section. More than one limitation or exclusion may apply to a specific Service or a particular situation.

Expenses for the Health Care Services listed in this section will be covered under this Booklet only if the Services are:

1. within the Health Care Services categories in this "What Is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment by us and for which we receive an itemized statement or description of the procedure or Service, which was rendered, including any applicable procedure code, diagnosis code and other information we require in order to process a claim for the Service;
3. Medically Necessary, as defined in this Booklet and determined by us in accordance with our Medical Necessity coverage criteria then in effect, except as specified in this section;
4. in accordance with our benefit guidelines listed below;
5. rendered while your coverage is in force; and
6. not specifically or generally limited (e.g., Pre-existing Condition exclusionary period) or excluded under this Booklet.

We will determine whether Services are Covered Services under this Booklet after you have obtained the Services and we have received a claim for the Services. In some circumstances we may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, we may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. We are not obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service.

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

Our Benefit Guidelines

In providing benefits for Covered Services, we may apply the benefit guidelines listed below as well as any other applicable payment rules specific to particular categories of Services:

1. Our payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable by us for any such Services.
2. Our payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service nor the day of the week nor the time of day the procedure is performed.
3. Our payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Accident Care

Health Care Services to treat an injury resulting from an Accident not related to your job or employment are covered.

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded except for Services (not otherwise excluded) when you are not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by you.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum are 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 upon the type and number of doses.

Ambulance Services

Ambulance Services provided by a ground vehicle may be covered provided it is necessary to transport you from:

1. a Hospital which is unable to provide proper care to the nearest Hospital that can provide proper care;
2. a Hospital to your nearest home, or to a Skilled Nursing Facility; or
3. the place a medical emergency occurs to the nearest Hospital that can provide proper care.

Expenses for Ambulance Services by boat, airplane, or helicopter shall be limited to the Allowed Amount for a ground vehicle unless:

1. the pick-up point is inaccessible by ground vehicle;
2. speed in excess of ground vehicle speed is critical; or
3. the travel distance involved in getting you to the nearest Hospital that can provide proper care is too far for medical safety, as determined by us.

Please refer to your Schedule of Benefits for the separate per-day maximums for ground transportation and air/water transportation.

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center are covered and include:

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. drugs and medicines administered (except for take home drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products;
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

Anesthesia Administration Services

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, our payment for Covered Services, if any, will be made for both the CRNA and the Physician Health Care Services at the lower directed-services Allowed Amount in accordance with our payment program for such Covered Services then in effect.

Exclusion:

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

Breast Reconstructive Surgery

Surgery to reestablish symmetry between two breasts and implanted prostheses incident to Mastectomy is covered. In order to be covered, such surgery must be provided in a manner chosen by your Physician, consistent with prevailing medical standards, and in consultation with you.

Child Cleft Lip and Cleft Palate Treatment

Treatment and Services for Child Cleft Lip and Cleft Palate, 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 are covered. In order for such Services to be covered, your Covered Dependent's Physician must specifically prescribe such Services and such Services must be consequent to treatment of the cleft lip or cleft palate.

Concurrent Physician Care

Concurrent Physician care Services are covered, provided: (a) the additional Physician actively participates in your treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the same specialty with different sub-specialties.

Consultations

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

Contraceptive Injections

Medication by injection is covered when provided and administered by a Physician, for the purpose of contraception, and is limited to the medication and administration.

Payment Guidelines for Medication and Administration by Injection for Contraception

Physician office Services, rendered on the same day, in connection with the administration by injection of the contraceptive medication, for well or preventive Services, are not reimbursed separately unless the Group has purchased the adult wellness benefit.

Dental

Dental care is limited to the following:

1. Care and treatment initiated within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to sound natural teeth.
2. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
    a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that:
        i. dental treatment is necessary due to a dental Condition that is significantly complex; or
        ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
    b) you have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Diabetes Outpatient Self-Management

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

Notwithstanding the above, if your Benefit Booklet was amended by a BCBSF Pharmacy Program Endorsement which covers diabetes equipment and supplies, then diabetes equipment and supplies will be covered in accordance with the terms and conditions of such Pharmacy Program Endorsement.

Diagnostic Services

Diagnostic Services when ordered by a Physician are limited to the following:

1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);
2. laboratory and pathology Services;
3. Services involving bones or joints of the jaw (e.g., 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;
4. approved machine testing (e.g., electrocardiogram [EKG],

electroencephalograph [EEG], and other electronic diagnostic medical procedures); and

5. genetic testing for the purpose of explaining current signs and symptoms of a possible hereditary disease.

Dialysis Services

Dialysis Services including equipment, training, and medical supplies, when provided at any location by a Provider licensed to perform dialysis including a Dialysis Center are covered.

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, limited to the most cost effective equipment as determined by us is covered.

Payment Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Our payment 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 such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of Durable Medical Equipment due to growth of a child or significant change in functional status is a Covered Service.

Exclusion:

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 solely because it is old or used are excluded.

Enteral Formulas

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

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

Eye Care

Coverage includes the following Services:

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.

Exclusion:

Health Care Services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercises or visual training; eye glasses and contact lenses and their fitting are excluded. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders

(e.g., radial keratotomy, PRK and LASIK) are also excluded.

Home Health Care

The Home Health Care Services listed below are covered when the following criteria are met:

1. you are unable to leave your home without considerable effort and the assistance of another person 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; and
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan which has been reviewed and renewed by the prescribing Physician every 30 days. We reserve the right to request a copy of any written treatment plan in order to determine whether such Services are covered under this Booklet.
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide Services;
2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
3. medical social services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen); and
6. Physical Therapy by a Physical Therapist, Occupational Therapy by a Occupational Therapist, and Speech Therapy by a Speech Therapist.

Exclusions:

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 a 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 approved by your Physician. We reserve the right to request that your Physician certify in writing your life expectancy.

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 (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
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 (e.g., EKG);
13. Physical, Speech, Occupational, and Cardiac Therapies; and
14. transplants as described in the Transplant Services subsection.

Exclusion:

Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital: 1) room and board provided during the admission; 2) Physician visits provided while you were an inpatient; 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and 4) other Services provided while you were an inpatient.

In addition, expenses for the following and similar items are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

Inpatient Rehabilitation

Inpatient Rehabilitation Services are covered when 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 limited to the specific acute, catastrophic target diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders, and/or severe burns;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration as to make it impractical for the individual to receive services in a less intensive setting.

Inpatient Rehabilitation Services are subject to the inpatient facility Copayment, if applicable, and the benefit maximum set forth in the Schedule of Benefits.

Exclusion:

All Substance Dependency, drug and alcohol related diagnoses, 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 Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening are Covered Services.

Benefits for mammograms may not be subject to the Calendar Year Deductible, Coinsurance, or Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

Mastectomy Services

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

Maternity Services

Health Care Services, including prenatal care, delivery and postpartum care and assessment, provided to you, by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife may be Covered Services. Care for the mother includes the postpartum assessment.

In order for the postpartum assessment to be covered, such assessment must be provided at a Hospital, an attending Physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in care for a mother. Coverage under this Booklet for the postpartum assessment includes coverage for the physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards.

Exclusion:

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement are excluded. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

For the definition of Gestational Surrogate and Gestational Surrogacy Contract, see the "Definitions" section of this Benefit Booklet.

Mental Health Services

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy provided to you by a Physician, Psychologist, or Mental Health Professional for the treatment of a Mental and Nervous Disorder may be covered. These Health Care Services include inpatient, outpatient, and Partial Hospitalization services.

Partial Hospitalization is a Covered Service when provided under the direction of a Physician and in lieu of inpatient hospitalization and is combined with the inpatient Hospital benefit. Two days of Partial Hospitalization will count as one day toward the inpatient Mental and Nervous Disorder benefit.

Exclusion:

1. Services rendered in connection with a Condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;

3. Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. Services for marriage counseling, when not rendered in connection with a Condition classified in the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;
5. Services for pre-marital counseling;
6. Services for court-ordered care or testing, or required as a condition of parole or probation;
7. Services for testing of aptitude, ability, intelligence or interest;
8. Services for testing and evaluation for the purpose of maintaining employment;
9. Services for cognitive remediation;
10. inpatient confinements that are primarily intended as a change of environment; and
11. mental health Services received in a residential treatment facility.

Newborn Care

A newborn child will be covered from the moment of birth provided that the newborn child is eligible for coverage and properly enrolled. Covered Services shall consist of coverage for injury or sickness, 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 provided the Services were rendered at a Hospital, the attending Physician's office, a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These Services are not subject to the Calendar Year Deductible.

Ambulance Services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn 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, are covered.

Orthotic Devices

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

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

Payment for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six-month period unless a more frequent replacement is determined by us to be Medically Necessary.

Exclusion:

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, inserts, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease are excluded.

Osteoporosis Screening, Diagnosis, and Treatment

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

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

Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulation Services

1. Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

    a) **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 are covered.

    b) **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 are covered.

    c) **Speech Therapy** Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition are covered.

    d) **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 are covered.

    e) **Massage Therapy** Massage provided by a Physician, Massage Therapist, or Physical Therapist when the Massage is prescribed as being Medically Necessary by a Physician licensed pursuant to Florida Statutes Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Physician's prescription must specify the number of treatments.

Payment Guidelines for Physical and Massage Therapy

Massage or a combination of Massage and Physical Therapy Services are limited to four (4) modalities per day not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.

Exclusion:

Application or use of the following or similar techniques or items for the purpose of aiding in the provision of a Massage: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; contrast baths are excluded.

2. **Spinal Manipulations:** Services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered.

Payment Guidelines for Spinal Manipulations

We will cover up to 26 spinal manipulations per Calendar Year, or the maximum benefit

listed in the Schedule of Benefits, whichever occurs first.

The Schedule of Benefits sets forth the maximum amount that we will pay for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, you may have only utilized two (2) of your spinal manipulations for the Calendar Year, but if you have already met the combined therapy maximum with other Services, this Benefit Booklet will not cover any additional spinal manipulations for that Calendar Year.

Oxygen

Expenses for oxygen, the equipment necessary to administer it, and the administration of oxygen are covered.

Physician Services

Medical or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office, in an outpatient facility, or electronically through a computer via the Internet.

Payment Guidelines for Physician Services Provided by Electronic Means through a Computer:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet will be covered only if such Services:

1. were provided to a covered individual who was, at the time the Services were provided, an established patient of the Physician rendering the Services;
2. were in response to an online inquiry received through the Internet from the covered individual with respect to which the Services were provided; and
3. were provided by a Physician through a secure online healthcare communication services vendor that, at the time the Services were rendered, was under contract with BCBSF.

The term "established patient," as used herein, shall mean that the covered individual has received professional services from the Physician who provided the online medical Services, or another physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

Exclusion:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet other than through a healthcare communication services vendor that has entered into contract with BCBSF are excluded. Expenses for online medical Services provided by a health care provider that is not a Physician and expenses for Health Care Services rendered by telephone are also excluded.

Preventive Adult Wellness Services

If the preventive adult wellness category is listed on your Schedule of Benefits, Covered Services for preventive adult wellness Services may be covered under your Benefit Booklet. Please refer to your Schedule of Benefits for any applicable preventive adult wellness Services benefit maximums or limitations.

Preventive Child Health Supervision Services

Periodic Physician-delivered or Physician-supervised Services from the moment of birth up to the 17th birthday are covered as follows:

1. periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
2. oral and/or injectable immunizations; and
3. laboratory tests normally performed for a well child.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Expenses for these Services are not subject to the Calendar Year Deductible, but are subject to the Coinsurance or the Copayment (if applicable).

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;
2. appliances needed to effectively use artificial limbs or corrective braces; or
3. penile prosthesis and surgery to insert a penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of:
    a) prostate cancer;
    b) diabetes mellitus;
    c) peripheral neuropathy;
    d) medical endocrine causes of impotence;
    e) arteriosclerosis/postoperative bilateral sympathectomy;
    f) spinal cord injury;
    g) pelvic-perineal injury;
    h) post-prostatectomy;
    i) post-priapism;
    j) epispadias; and
    k) exstrophy.

Covered Prosthetic Devices (except cardiac pacemakers, and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition.

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 necessitated due to growth of a child.

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 (e.g., oxygen);
3. drugs and medicines administered while an inpatient (except take-home drugs);
4. intravenous solutions;
5. administration of, including the cost of, whole blood or blood products;
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease; and
10. Physical, Speech, and Occupational Therapies;

We reserve the right to request a treatment plan for determining coverage and payment.

<u>Exclusion:</u>

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other Service primarily for the convenience of you and/or your family members or the Provider are excluded. Expenses for any inpatient days beyond the per person per Calendar Year maximum number of

days listed on the Schedule of Benefits are also excluded.

Substance Dependency Care and Treatment

Care and treatment for Substance Dependency includes the following:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided by a Physician, Psychologist or Mental Health Professional in a program accredited by the Joint Commission on the Accreditation of Healthcare Organizations 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 as listed in the Schedule of Benefits.

Exclusion:

Expenses for prolonged care and treatment of Substance Dependency in a specialized inpatient or residential facility or inpatient confinements that are primarily intended as a change of environment are excluded.

Surgical Assistant Services

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary are covered.

Payment Guidelines for Surgical Assistant Services

The Allowed Amount is limited to 20 percent of the surgical procedure's Allowed Amount.

Surgical Procedures

Surgical procedures performed by a Physician may be covered including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;
4. surgical procedures involving bones or joints of the jaw (e.g., 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
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.

Payment Guidelines for Surgical Procedures

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits. This guideline is applicable 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 (i.e., 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 of the surgical procedure.

Transplant Services

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to us, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge Services, and treatment of complications after transplantation. We will pay benefits only for Services, care and treatment received or provided in connection with a:

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule 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 the 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 (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

We will cover donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

You may call the customer service phone number indicated in this Booklet or on your Identification Card in order to determine which Bone Marrow Transplants are covered under this Booklet.

<u>Exclusion:</u>

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;

5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule 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;
7. 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;
8. 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; and
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Section 3: What Is Not Covered?

Introduction

Your Booklet expressly excludes the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the "What Is Covered?" section.

Abortions which are elective.

Adult Wellness preventive care or routine screening Services, except as specified under the Preventive Adult Wellness Services category on the Schedule of Benefits.

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) for the treatment of severe diabetic foot disease.

Assisted Reproductive Therapy (Infertility) including, but not limited to, associated Services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; and infertility treatment medication.

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

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; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition which is a complication of a non-covered Health Care Service (e.g., Health Care Services to treat a complication of cosmetic surgery are not covered).

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the adult wellness benefit, on the Schedule of Benefits (when selected by the Group), or otherwise covered in the "What Is Covered?" section.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

Costs related to telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial Care and any service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; respite care; and provision of services which are for the sole purposes of allowing a family member or caregiver of a Covered Person to return to work.

Dental 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 or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to an Accidental Dental Injury and the Child Cleft Lip and Cleft Palate Treatment Services category as described in the "What Is Covered?" section.

Diabetic Equipment and Supplies used for the treatment of diabetes which are otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet.

Drugs

1. Prescribed for uses other than the 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. All drugs dispensed to, or purchased by, you from a pharmacy. 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 by a pharmacy under contract with us to provide injectable medications to you at home for self-administration, or to provide injectable medications to your Physician for administration to you in the Physician's office; 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 (e.g., Viagra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine).

Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category, and except for any drug prescribed for the treatment of cancer that has been approved by the Federal Food and Drug Administration (FDA) for at least one indication, provided the drug is recognized for treatment of the 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.

Foot Care which is routine, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to: non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails, corns or calluses.

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 Services not within the service categories described in the "What Is Covered?" section, any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
3. any Health Care Services provided by a Physician or other health care Provider related to you by blood or marriage;
4. any Health Care Service which is not Medically Necessary as determined by us and defined in this Booklet. 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 Services 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 Services 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 misdemeanor or felony, or which constitutes riot, or rebellion;
   c) your engaging in an illegal occupation;
   d) Services received at military or government facilities; or
   e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard;
8. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
9. any Health Care Services 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.

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.

Hearing Aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair.

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

For the definition of Gestational Surrogate and Gestational Surrogacy Contract see the Definitions section of this Benefit Booklet.

Oral Surgery except as provided under the "What Is Covered?" section.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

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. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. 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;
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the ”What Is Covered?” section of this Booklet.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations categories of the “What Is Covered?” section. Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.

Reversal of Voluntary, Surgically-Induced Sterility including the reversal of tubal ligations and vasectomies.

Sexual Reassignment, or Modification Services including, but not limited to, any Health Care Services related to such treatment, such as psychiatric Services.

Smoking Cessation Programs including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

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.

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 Outpatient Self Management category of the ”What Is Covered?” section.

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

Volunteer Services or Services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment (if applicable) requirements which are waived by a health care Provider.

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. 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.

Wigs and/or cranial prosthesis.

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.

Section 4: Medical Necessity

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

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

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. We are solely responsible for determining whether expenses incurred for 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.

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to:

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 inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department); 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 Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by us) or a Covered Service. Please refer to the Definitions section for the definitions of "Medically Necessary" or "Medical Necessity".

Section 5: Understanding Your Share of Health Care Expenses

This section explains what your share of the health care expenses will be for Covered Services you receive. In addition to the information explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Calendar Year Deductible

1. Individual Calendar Year Deductible:

   This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Calendar Year, before any payment will be made. Only those charges indicated on claims we receive for Covered Services will be credited toward the Individual Calendar Year Deductible and only up to the applicable Allowed Amount. Covered Services which are subject to a Copayment are not subject to the Calendar Year Deductible.

2. Family Calendar Year Deductible:

   Once your family has met the family Calendar Year Deductible, neither you nor your Covered Dependents will have any additional Calendar Year Deductible responsibility for the remainder of that Calendar Year. The maximum amount that any one Covered Person in your family can contribute toward the family Calendar Year Deductible is the amount applied toward the Individual Calendar Year Deductible.

   Note: Please see your Schedule of Benefits for more information.

Copayment Requirements

Covered Services rendered by certain Providers or at certain locations or settings will be subject to a Copayment requirement. This is the dollar amount you have to pay when you receive these Services. Please refer to your Schedule of Benefits for the specific Covered Services which are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your plan. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you must pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

1. Office Services Copayment:

   If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office (when applicable) must be satisfied by you, for each office Service before any payment will be made. The office Services Copayment applies regardless of the reason for the office visit and applies to all Covered Services rendered in the office, with the exception of Durable Medical Equipment, Prosthetics, and Orthotics.

   Generally, if more than one Covered Service that is subject to a Copayment is rendered during the same office visit, you will be responsible for a single Copayment which will not exceed the highest Copayment specified in the Schedule of Benefits for the particular Health Care Services rendered.

2. Copayment for Inpatient Facility Services:

   The Copayment for inpatient facility Services, if applicable to your plan, must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made by us for any claim for inpatient Covered Services. The

Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions to a Hospital, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals for inpatient admissions.

Note: Copayments for inpatient facility Services vary depending on the facility chosen. (Please see the Schedule of Benefits for more information).

3. Copayment for Outpatient Facility Services:

   The Copayment for outpatient facility Services, if applicable to your plan, must be satisfied by you, for each outpatient visit to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Facility, Psychiatric Facility or Substance Abuse Facility, before any payment will be made by us for any claim for outpatient Covered Services. The Copayment for outpatient facility Services, if applicable to your plan, applies regardless of the reason for the visit, and applies to all outpatient visits to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Facility, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other healthcare professionals.

   Note: Copayments for outpatient facility Services vary depending on the facility chosen. (Please see the Schedule of Benefits for more information).

4. Copayment for Emergency Room Facility Services:

   The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit. If you are admitted to the Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.

Coinsurance Requirements

All applicable Calendar Year Deductible or Copayment amounts must be satisfied before we will pay any portion of the Allowed Amount for Covered Services. For Services that are subject to Coinsurance, the Coinsurance percentage of the applicable Allowed Amount you are responsible for is listed in the Schedule of Benefits.

Note: If a particular Covered Service is not available from any In-Network Provider, the Coinsurance percentage that we will base payment on for that Covered Service will not be less than ten (10%) percentage points lower than the Coinsurance percentage we would have based payment on had the Covered Services been available from an In-Network Provider.

Out-of-Pocket Calendar Year Maximum

Out-of-Pocket Maximum Amount

1. Individual out-of-pocket Calendar Year maximum:

   Once you have reached the individual out-of-pocket Calendar Year maximum amount listed in the Schedule of Benefits, you will

have no additional out-of-pocket responsibility for the remainder of the Calendar Year and we will pay for Covered Services rendered during the remainder of that Calendar Year at 100 percent of the Allowed Amount.

2. Family out-of-pocket Calendar Year maximum:

   Once your family has reached the family out-of-pocket Calendar Year maximum amount listed in the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Calendar Year and we will pay for Covered Services rendered during the remainder of that Calendar Year at 100 percent of the Allowed Amount. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket Calendar Year maximum is the amount applied toward the individual out-of-pocket Calendar Year maximum. Please see your Schedule of Benefits for more information.

Note: The Calendar Year Deductible, any applicable Copayments and Coinsurance amounts will accumulate towards the Calendar Year out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate towards the out-of-pocket Calendar Year maximums. If the Group has purchased prescription drug coverage, any applicable Deductible, Coinsurance or Copayments, under the prescription drug coverage, will not apply to the Calendar Year Deductible or the out-of-pocket Calendar Year maximums under this Booklet.

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Calendar Year Deductible and Calendar Year Coinsurance maximums met by you under a prior group insurance, blanket insurance, franchise insurance or group Health Maintenance Organization (HMO) policy maintained by the Group if the Group Master Policy replaces such a policy. This provision only applies if the prior group insurance, blanket insurance, franchise insurance or HMO coverage purchased by the Group was in effect immediately preceding the Effective Date of this Group policy. This provision is only applicable for you during the initial Calendar Year of coverage under the Group Master Policy and the following rules apply:

1. Prior Coverage Credit for Deductible:

   For the initial Calendar Year of coverage under the Group Master Policy only**,** charges credited by the Group's prior insurer, towards your Deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of the Group Master Policy, will be credited to the Calendar Year Deductible requirement under this Booklet.

2. Prior Coverage Credit for Coinsurance:

   Charges credited by the Group's prior insurer, towards your Coinsurance Calendar Year Maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of the Group Master Policy, will be credited to your out-of-pocket Calendar Year maximum under this Booklet.

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

4. 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.

Benefit Maximum Carryover

If immediately before the Effective Date of the Group, you were covered under a prior group policy issued by BCBSF to the Group, amounts applied to your Calendar Year benefit maximums and lifetime maximums under the prior BCBSF policy, will be applied toward your Calendar Year benefit maximums and lifetime maximums under this Booklet. Unless otherwise specified on your Schedule of Benefits.

Additional Expenses You Must Pay

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

1. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., the lifetime maximums and Calendar Year maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of 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; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any Premium contribution amount required by your Group.

How we will Credit Calendar Year Benefit Maximums and the Total Maximum Benefit per Person

Except as described below, only amounts actually paid by us for Covered Services will be credited towards any applicable Calendar Year benefit maximums and the total maximum benefit per person (lifetime maximum). The amounts we pay which are credited towards your Calendar Year benefit maximums and your total maximum benefit per person will be based on our Allowed Amount for the Covered Services provided.

Section 6: Physicians, Hospitals and Other Provider Options

Introduction

It is important for you to understand how the Provider you select and the setting in which you receive Health Care Services affects how much you are responsible for paying under this Booklet. This section, along with the Schedule of Benefits and our Provider Directory, describes the health care Provider options available to you and our payment rules for Services you receive.

As used throughout this section "out-of-pocket expenses" or "out-of-pocket" refers to the amounts you are required to pay including any applicable Copayments, the Calendar Year Deductible and/or Coinsurance amounts for Covered Services.

[1][You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard® (Out-of-State) Traditional Program Providers, in conformity with Section 7: "BlueCard® (Out-of-State) Program".]

Provider Participation Status

In order to help control health care costs, we have entered into contracts with certain Providers to participate in NetworkBlue, one of our preferred provider networks. We have also entered into contracts with certain Providers to participate in our Traditional Program. We negotiate with these Providers to establish maximum allowances and payment rules for Covered Services as one way to control health care costs. The allowances we establish are called our Allowed Amounts. The amount you are responsible for paying out-of-pocket for a particular Covered Service is based on our Allowed Amount for that Covered Service.

Your Schedule of Benefits designates the panel of NetworkBlue Providers who are participating for your specific plan of coverage. This is important because these Providers are considered your In-Network Providers for purposes of this Benefit Booklet.

With BlueOptions, you may choose to receive Services from any Provider. However, you will be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider. Although you have the option to select any Provider you choose, we encourage you to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs. Developing and continuing a relationship with a Family Physician allows the physician to become knowledgeable about you and your family's health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers will result in lower out-of-

[1] This language will not be included for the product which does not provide access to Traditional Program Providers as part of the benefits.

pocket expenses for you. You should always determine whether a Provider is In-Network or Out-of-Network prior to receiving Services to determine the amount you are responsible for paying out-of-pocket.

Location of Service

In addition to the participation status of the Provider, the location or setting where you receive Services can affect the amount you pay. For example, the amount you are responsible for paying out-of-pocket will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. Please refer to your Schedule of Benefits for specific information regarding your out-of-pocket expenses for such situations. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the "What Is Covered?" section and your Schedule of Benefits to find out if the specific Health Care Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

To verify if a Provider is In-Network for your plan you can:

1) review your current BlueOptions Provider Directory;
2) access the BlueOptions Provider directory at our web-site at www.bcbsfl.com; and/or
3) call the customer service phone number in this Booklet or on your Identification Card.

In-Network Providers

When you use In-Network Providers, your out-of-pocket expenses for Covered Services will be lower. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in the Schedule of Benefits. Consult your Schedule of Benefits to determine what panel of Providers in the BlueOptions Provider directory is designated as In-Network for your plan.

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in the Schedule of Benefits. [Further, if the Out-of-Network Provider is a Traditional Program Provider or a BlueCard® (Out-of-State) Traditional Program Provider, our payment to such Provider may be under the terms of that Provider's contract.] If your Schedule of Benefits and BlueOptions Provider directory do not include a Provider as In-Network under your benefit plan, the Provider is considered Out-of-Network.

	In-Network	Out-of-Network
What expenses are you responsible for paying?	• Any applicable Copayments, Deductible(s) and/or Coinsurance requirements; • Expenses for Services which are not covered; • Expenses for Services in excess of any benefit maximum limitations; • 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; and • Expenses for Services which are excluded.	
Who is responsible for filing your claims?	• The Provider will file the claim for you and payment will be made directly to the Provider.	• You are responsible for filing the claim and payment will be made directly to the Covered Employee. If you receive Services from a Provider who participates in our Traditional Program or is a BlueCard® (Out-of-State) Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.
Can you be billed the difference between what we pay the Provider and the Provider's charge?	• **NO.** You are protected from being billed for the difference in our Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept our Allowed Amount as payment in full for Covered Services except as otherwise permitted under the terms of the Provider's contract and this Booklet.	• **YES.** You are responsible for paying the difference between what we pay and the Provider's charge. However, if you receive Services from a Provider who participates in our Traditional Program, the Provider will accept our Allowed Amount as payment in full for Covered Services since such Traditional Program Providers have agreed not to bill you for the difference. Further, under the BlueCard® (Out-of-State) Program, when you receive Covered Services from a BlueCard® (Out-of-State) Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.

Note: You are solely responsible for selecting a Provider when obtaining Health Care Services and for verifying whether that Provider is In-Network or Out-of-Network at the time Health Care Services are rendered. You are also responsible for determining the corresponding payment options, if any, at the time the Health Care Services are rendered.

Physicians

When you receive Covered Services from a Physician you will be responsible for a Copayment and/or the Calendar Year Deductible and the applicable Coinsurance. Several factors will determine your out-of-pocket expenses including your Schedule of Benefits, whether the Physician is In-Network or Out-of-Network, the location of service, the type of service rendered, and the Physician's specialty.

Remember that the location or setting where a Service is rendered can affect the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

Refer to your Schedule of Benefits to determine the applicable Copayments, Coinsurance percentage and/or Calendar Year Deductible amount you are responsible for paying for Physician Services.

Hospitals

Each time you receive inpatient or outpatient Covered Services at a Hospital, in addition to any out-of-pocket expenses related to Physician Services, you will be responsible for out-of-pocket expenses related to Hospital Services.

We are able to negotiate lower payment amounts with some Hospitals than with others. Because of this, In-Network Hospitals have been divided into two groups which are referred to as "options" on the Schedule of Benefits. The amount you are responsible for paying out-of-pocket is different for each of these options. Remember that there are also different out-of-pocket expenses for Out-of-Network Hospitals.

Since not all Physicians admit patients to every Hospital, it is important when choosing a Physician that you determine the Hospitals where your Physician has admitting privileges. You can find out what Hospitals your Physician admits to by contacting the Physician's office. This will provide you with information that will help you determine a portion of what your out-of-pocket costs may be in the event you are hospitalized.

Refer to your Schedule of Benefits to determine the applicable out-of-pocket expenses you are responsible for paying for Hospital Services.

Other Providers

With BlueOptions you have access to other Providers in addition to the ones previously described in this section. Other Providers include facilities that provide alternative outpatient settings or other persons and entities that specialize in a specific Service(s). While these Providers may be recognized for payment, they may not be included as In-Network Providers for your plan. Additionally, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Booklet. Please refer to the "What Is Covered?" and "What is Not Covered?" sections of this Booklet and your Schedule of Benefits to determine your out-of-pocket expenses for Covered Services rendered by these Providers.

You may be able to receive certain outpatient Services at a location other than a Hospital. The amount you are responsible for paying for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Remember that the location of Service can impact the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care

and financial needs. When Services are rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense for the facility Provider as well as an out-of-pocket expense for other types of Providers.

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:

- an assignment of the benefits due to you for Covered Services under this Benefit Booklet;
- an assignment of your right to receive payments for Covered Services under this Benefit Booklet; or
- an assignment of a claim for damage resulting from a breach, or an alleged breach, of the Group Master Policy.

[We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard® (Out-of-State) PPO Program Provider; 5) is a BlueCard® (Out-of-State) Traditional Program Provider; or 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.]

[We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a BlueCard® (Out-of-State) PPO Program Provider; or 4) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.]

Section 7: BlueCard® (Out-of-State) Program

Providers Outside the State of Florida

When you obtain Health Care Services from BlueCard® participating Providers outside the geographic area we serve, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be prospectively adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a covered individual's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard® method noted above in paragraph one of this section or require a surcharge, we will then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

Section 8: Blueprint for Health Programs

Introduction

We have established (and from time to time establish) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health; 2) help us facilitate the management and review of coverage and benefits provided under our policies; and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services.

Admission Notification

Our admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network. To find out about the participation status of any of these providers, you can:

1. review the Provider Directory then in effect;
2. access our web-site at www.bcbsfl.com; and/or
3. call the customer service phone number in this Booklet or on your Identification Card.

In-Network

Under the admission notification requirement, we must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric Facilities, Substance Abuse Facilities or Skilled Nursing Facilities. While it is the sole responsibility of the In-Network Provider located in Florida to comply with our admission notification requirements, you should ask the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) if we have been notified of your admission. For an admission outside of Florida, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) may notify us of your admission by calling the toll free customer service number on your ID card.

Out-of-Network

For admissions to an Out-of-Network Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility should notify us of the admission. Notifying us of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital may notify us of your admission by calling the toll free customer service number on your Identification Card.

Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, Skilled Nursing Facility (SNF) Services, and other Health Care Services rendered during the course of an inpatient stay or treatment program. We may conduct this review while you are inpatient or after your discharge. The review is conducted solely to determine whether we should provide coverage and/or payment for a particular admission or

Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals. We will provide notification to your Physician when inpatient coverage criteria is no longer met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

In anticipation of your needs following an inpatient stay, we may provide you and your Physician with information about other Blueprint for Health Programs which may be beneficial to you, and help you and your Physician identify health care resources which may be available in your community. Upon request, we will answer questions your Physician has regarding your coverage or benefits following discharge from the Hospital.

Provider Focused Utilization Management Program

Certain NetworkBlue Providers have agreed to participate in our focused utilization management program. This pre-service review program is intended to promote the efficient delivery of medically appropriate Health Care Services by NetworkBlue Providers. Under this program we may perform focused prospective reviews of all or specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit to us specific medical information relating to Health Care Services proposed for you. NetworkBlue Providers have agreed not to bill, or collect, any payment whatsoever from you or us, or any other person or entity, with respect to Health Care Services if: 1) we perform a focused review under the focused utilization management program; and 2) we determine that the Health Care Services are not Medically Necessary in accordance with our Medical Necessity criteria or inconsistent with our benefit guidelines then in effect.

Member Focused Programs

The Blueprint for Health Programs may include voluntary programs for certain members. These programs may address health promotion, prevention and early detection of disease, chronic illness management programs, case management programs and other member focused programs.

Personal Case Management Program

The personal case management program focuses on members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, we may, in our sole discretion, assign a Personal Case Manager to you to help 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 elect to 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 Benefit 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

Health Information, Promotion, Prevention and Illness Management Programs

These Blueprint for Health Programs may include health information that supports member education and choices for healthcare issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help members with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include prenatal educational programs and illness management programs for Conditions such as diabetes, cancer and heart disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll free customer service number on your Identification Card for more information. Your participation in this program is completely voluntary.

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

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 the responsibility of your Physicians and other health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. We are solely responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Booklet. In fulfilling this responsibility, we will not be deemed to participate in or override the medical decisions of your health care Provider.

You, a treating Physician, Hospital, or other Provider may request that we review a Blueprint for Health Program coverage or payment decision, provided such a request is received by us, in writing, within 90 days of the date of the decision. The review request must include all information deemed relevant or necessary by us. We will review the decision in light of such information and notify you or your representative, the Hospital and/or the Physician of the review decision.

Please note that we reserve the right to discontinue or modify the Hospital admission notification requirement and any Blueprint for Health Program at any time without consent from you or the Group.

Section 9: Pre-existing Conditions Exclusion Period

Introduction

Generally, there is no coverage under this Booklet for Health Care Services to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until you have been continuously covered under this Booklet for a 12-month period. This 12-month Pre-existing Condition exclusionary period begins on the first day of the Waiting Period if you are an initial enrollee; or your Effective Date of coverage under the Booklet if you are a special or annual enrollee. This exclusionary period also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

This Pre-existing Condition exclusionary period does not apply to:

1. the Covered Employee and each Covered Dependent who was covered under the Group's prior medical plan on the date immediately preceding the Effective Date of coverage under this Booklet;
2. you if you were enrolled during the Initial Enrollment Period prior to the Effective Date of the Group; or
3. you when the Group has elected to waive, in writing, at the time of Group Application the Pre-existing Conditions exclusionary period for all subsequent Eligible Employees and/or Eligible Dependents;
4. pregnancy;
5. a newborn child or an adopted newborn child properly enrolled under this Booklet;
6. an adopted child that has Creditable Coverage;
7. Genetic Information in the absence of a diagnosis of the Condition;
8. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
9. Conditions arising from domestic violence; or
10. inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Genetic Information, as used above, means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Pre-existing Condition Definition

A Pre-existing Condition means any Condition related to a physical or mental Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately preceding:

1. the first day of your Waiting Period for initial enrollees; or
2. your Effective Date of coverage under the Group Master Policy for special and annual enrollees.

Reducing the Pre-existing Conditions Exclusionary Period

No matter whether you enroll when first eligible or at a later date (such as an Annual Open Enrollment Period or as a result of special enrollment), you may be able to reduce or even eliminate the Pre-existing Conditions exclusionary period if you have prior Creditable Coverage.

If you are enrolling when you are first eligible for coverage and you have no more than a 63-day break in Creditable Coverage as of your Enrollment Date under this Booklet, your Pre-existing Conditions exclusionary period will be reduced by the amount of prior Creditable Coverage you have.

If, on the other hand, you are enrolling under this Booklet at any other time as allowed under its terms, such as during an Annual Open Enrollment Period or a Special Enrollment Period, your Pre-existing Conditions exclusionary period will be reduced by the amount of any Creditable Coverage you have; provided there is no more than a 63-day break in coverage prior to your Enrollment Date in this Booklet.

If you have no Creditable Coverage or none that can reduce the Pre-existing Conditions exclusionary period, the full 12-month Pre-existing Conditions exclusionary period will apply.

Creditable Coverage

Creditable Coverage is health care coverage that may include any of the following:

1. a group health insurance plan;
2. individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. benefits to members and certain former members of the uniformed services and their dependents;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a State health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan;
10. a health benefit plan of the Peace Corps;
11. State Children's Health Insurance Program (S-CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Proving Creditable Coverage

You may provide a Prior/Concurrent Coverage Affidavit or Certification of Creditable Coverage to prove the amount of time you were covered under Creditable Coverage. Prior health insurers and/or group health plans are required to provide a certification of Creditable Coverage to you upon termination of your coverage and at any time upon request up to 24 months after termination of your prior health coverage. If you do not provide a certification, then you must provide us some other evidence of Creditable Coverage such as a copy of an ID card or health insurance bill from a prior carrier and attest to the amount of time you were covered under the Creditable Coverage.

Section 10: Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Group Plan, and who meets and continues to meet our eligibility requirements described in this Booklet, shall be entitled to apply for coverage with us under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members as well as the Group. No changes in our eligibility requirements 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.

Eligibility Requirements for Covered Employees

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 be a bona fide employee;
2. The employee's job must fall within a job classification identified on the Group Application;
3. The employee must have completed any applicable Waiting Period identified on the Group Application; and
4. The employee must meet any additional eligibility requirement(s) identified on the Group Application.

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 (e.g., members of associations or labor unions).

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

Eligibility Requirements for Dependent(s)

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;
2. The Covered Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year in which the child reaches age 25 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), and who is:
    a) dependent upon the Covered Employee for financial support; and
        i. living in the household of the Covered Employee or a full-time or part-time student; or
        ii. the child does not live in the household of the Covered Employee and is not enrolled as a full or part-

time student because the child has not met the age requirement to begin elementary school education; or

b) in the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 25, as a Covered Dependent if the child is:

i. otherwise eligible for coverage under the Group Master Policy;

ii. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

iii. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 25th birthday.

This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

or

3. 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: It is your sole responsibility as the Covered Employee to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Section 11: Enrollment and Effective Date of Coverage

Eligible Employees and Eligible Dependents may enroll for coverage according to the provisions below.

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. Any Employee and/or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage by completing and submitting an Enrollment Form to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) we may have, in disqualification for, termination of, or rescission of coverage.
3. We will not provide coverage and benefits to any individual who would not have been entitled to enrollment with us, had accurate and complete information been provided on a timely basis on the Enrollment Forms. In such cases, we may require you or an individual legally responsible for you, to reimburse us for any payments we made on your behalf.

Enrollment Forms/Electing Coverage

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

1. complete and submit, through your Group, the Enrollment Form;
2. provide any additional information needed to determine eligibility, at our request;
3. agree to pay your portion of the required Premium; and
4. complete and submit, through your Group, an Enrollment Form to add Eligible Dependents or delete Covered Dependents.

When making application for coverage, you must elect one of the types of coverage available under your Group's program. Such types may include:

Employee Only Coverage - This type of coverage provides coverage for the Eligible Employee only.

Employee/Spouse Coverage - This type of coverage provides coverage for the Eligible Employee and the employee's spouse under a legally valid existing marriage.

Employee/Child(ren) Coverage - This type of coverage provides coverage for the Eligible Employee and the employee's eligible child(ren) only.

Employee/Family Coverage - This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

There may be an additional Premium charge for each Covered Dependent based on the coverage selected by the Group.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the Group's health benefit program. The period is established by us, occurs annually, and will take place prior to the Anniversary Date.

Special Enrollment Period is the 30-day period of time immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for coverage. Special circumstances are described in the Special Enrollment Period subsection.

Employee Enrollment

1. An Eligible Employee must enroll during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) will be the same as the Covered Employee's Effective Date.
2. An individual who becomes an Eligible Employee after the Group's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will begin on the date specified on the Group Application.

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 submit an Enrollment Form to us through the Group. The Effective Date of coverage for a newborn child will be the date of birth. We must be notified, in writing, and the following guidelines will be applied when enrolling a newborn child:

a. If we receive written notice within 30 days after the date of birth, the Effective Date of coverage will be the date of birth and no Premium will be charged for the newborn child for the first 30 days of coverage.
b. If we receive written notice 31 to 60 days after the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.
c. If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has not** occurred since the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.
d. If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has** occurred, the newborn child may not be added until the next Annual Open Enrollment Period or Special Enrollment Period.

Note: 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 and was not added during the Initial Enrollment Period, we must receive an Enrollment Form. If the Enrollment Form is received within 30 days after the birth of the child, no Premium will be charged for the first 30 days of coverage. If the Enrollment Form is received 31-60 days after the birth of the child, any applicable Premium must be paid back to the Effective Date of coverage of the Covered Employee. In the event we are not notified within 60 days of the birth of the newborn child, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period.

Note: Coverage for a newborn child of a Covered Dependent child will automatically terminate 18 months after the birth of the newborn child.

Adopted Newborn Child – To enroll an adopted newborn child, the Covered Employee must submit an Enrollment Form through the Group to us. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Employee 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. The following guidelines will be applied when enrolling an adopted newborn child:

a. If we receive written notice within 30 days after the birth, the Effective Date of coverage will be the date of birth and no Premium will be charged for the first 30 days of coverage for the adopted newborn child.

b. If we receive written notice 31 to 60 days after the birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

c. If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has not** occurred, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

d. If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has** occurred, the adopted newborn child may not be added until the next Annual Open Enrollment Period or Special Enrollment Period.

Note: The guidelines above only apply to adopted newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment Period, we must receive an Enrollment Form. If the Enrollment Form is received within 30 days after the birth of the child, no Premium will be charged for the first 30 days of coverage. If the Enrollment Form is received 31-60 days after the birth of the adopted newborn child, any applicable Premium must be paid back to the Effective Date of coverage of the Covered Employee. In the event we are not notified within 60 days of the birth of the adopted newborn child, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Employee, 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.

Adopted/Foster Children – To enroll an adopted child or Foster Child, the Covered Employee must submit an Enrollment Form during the 30-day period immediately following the date of placement and pay the additional Premium, if any. The Effective Date for an adopted child or Foster Child (other than an adopted newborn child) will be the date such adopted or Foster Child is placed in the residence of the Covered Employee in compliance with Florida law. If timely notice is given, no additional Premium will be charged for coverage of the adopted child for the duration of the notice period. Any Pre-existing Condition exclusionary period will not apply to an adopted child but will apply to a Foster Child. We may

require the Covered Employee to provide any information and/or documents we deem necessary, in order to properly administer this section.

In the event we are not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as the Covered Employee provides notice to the Group, and we receive the Enrollment Form within 60 days of the placement, and any applicable Premium is paid back to the date of placement. In the event 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 child or Foster Child to be covered.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child. It is the responsibility of 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 upon receipt of the written notice.

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

Marital Status –The Covered Employee may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered Employee must complete the Enrollment Form through the Group and forward it to us. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under their plan. To apply for coverage, the Covered Employee must complete an Enrollment Form through the Group and forward it to us. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Enrollment Form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the first billing date following the Annual Open Enrollment Period.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee or the Eligible Dependent is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependents 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, the Eligible Employee and/or the Employee's Eligible Dependents must complete the applicable Enrollment Form and forward it to the Group within 30 days of the date of the special enrollment event. For purposes of this subsection, the following are the special enrollment events:

1. you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance, or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:

   a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

   b) you lost your other coverage under a group health benefit plan or health insurance coverage as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated.

   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.

2. you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Employee).

Other Provisions Regarding Enrollment and Effective Date Of Coverage

1. Rehired Employees:

   Individuals who are rehired as employees of the Group are considered newly hired employees for purposes of this section. The provisions of the Group Master Policy (which includes this Booklet), which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

2. 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, provided we receive the applicable 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 Group Master Policy if we do not receive the applicable Premium payment within such time period.

Section 12: Termination of Coverage

Termination of a Covered Employee's Coverage

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

1. on the date the Group Master Policy terminates;
2. on the last day of the first month that the Covered Employee fails to continue to meet any of the applicable eligibility requirements;
3. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
4. on the date specified by the Group that the Covered Employee's coverage terminates.

Termination of a Covered Dependent's Coverage

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

1. on the date the Group Master Policy terminates;
2. on the date Covered Employee's coverage terminates for any reason;
3. on the last day of the first month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Employee);
4. on the date we specify that the Covered Dependent's coverage is terminated by us for cause; or
5. on the date specified by the Group that the Covered Dependent's coverage terminates.

In the event you as the Covered Employee wish to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to us through the Group.

In the event you as the Covered Employee wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit an Enrollment Form to the Group, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

Termination of an Individual's Coverage for Cause

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

1. fraud, material misrepresentation or omission in applying for coverage or benefits;
2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed for us, by or on your behalf; or
3. misuse of the Identification Card.

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.

Notice of Termination

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

Responsibilities of BCBSF 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.

Certification of Creditable Coverage

In the event coverage terminates for any reason, we will issue a written certification of Creditable Coverage to you.

The certification of Creditable Coverage will indicate the period of time you were enrolled with us. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time you had prior Creditable Coverage.

Upon request, we will send you another certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if our coverage meets the qualifying Creditable Coverage guidelines (e.g., no more than a 63-day break in coverage).

Section 13: Continuing Coverage Under COBRA

A Federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to the Group. If COBRA applies to the Group, you or your Covered Dependents 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 the Group to determine if you or your Covered Dependent are entitled to COBRA continuation of coverage. The Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Covered Persons of their rights under COBRA. If the Group or you fail to meet your obligations under COBRA and this Group Master Policy, we will not be liable for any claims incurred by you or your Covered Dependent(s) after termination of coverage.

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 Group Master 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 the Group and you are eligible for such coverage:

1. You may elect to continue their 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 or your Covered Dependent is 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. The Covered Person 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 Dependent(s) 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 of the Covered Employee;
    c) death of the Covered Employee;
    d) the employer files bankruptcy (subject to bankruptcy court approval); or
    e) a Dependent child may elect the 36 month extension if the Dependent child ceases to be an Eligible Dependent under the terms of the Group's coverage.

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, which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet 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 the coverage terminates; 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 insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
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 Social Security Administration that you are no longer disabled. You must inform the Group of the Social Security Administration'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, in the Group Master Policy.
7. The Group must continue to provide group health coverage to its employees.

An election by an 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 Group Master 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.

Section 14: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for a BCBSF individual policy (hereinafter referred to as a "converted policy" or "conversion policy") if:

1. you were continuously covered for at least three months under the Group Master Policy, and/or under another group policy with your Group, that provided similar benefits immediately prior to the Group Master Policy; and
2. your coverage was terminated for any reason, including discontinuance of the Group Master Policy in its entirety and termination of continued coverage under COBRA.

Notify us in writing or by telephone if you are interested in a conversion policy. Within 14 days of such notice, we will send you a conversion policy application, premium notice and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

We must receive a completed application for a converted policy, and the applicable premium payment, within the 63-day period beginning on the date the coverage under the Group Master Policy terminated. If coverage has been terminated, due to the non-payment of premium by the Group, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Master Policy terminated.

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

Additionally, you are not entitled to a converted policy if:

1. you are eligible for or covered under the Medicare program;
2. you failed to pay, on a timely basis, the contribution required by the Group for coverage under this Group Master Policy;
3. the Group Master Policy was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under this Booklet; or
4. a) you fall under one of the following categories and meet the requirements of 4.b. below:
    i. you are covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Booklet; or
    ii. you are eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Booklet; or
    iii. benefits similar to the benefits provided under this Booklet 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, Medicaid); and

b) the benefits provided under the sources referred to in paragraph 4.a.i or the benefits provided or available under the source referred to in paragraph 4.a.ii. and 4.a.iii. above, together with the benefits provided by our converted policy would result in over insurance in accordance with our over insurance standards, as determined by us.

We have no obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial premium payment to us on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under the Group Master Policy terminated.

Note: Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Booklet. When applying for our converted policy, you have two options: 1) a converted policy providing major medical coverage meeting the requirements of 627.6675(10) *Florida Statutes* or 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) *Florida Statutes*. In any event, we will not be required to issue a converted policy unless required to do so by Florida law. We may have other options available to you. Call the telephone number on your Identification card for more information.

Section 15: Extension of Benefits

Extension of Benefits

In the event the Group Master Policy is terminated, we will not provide coverage for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire Group Master Policy is terminated. The extension of benefits described in this section do not apply when your coverage terminates if the Group Master Policy remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is your sole responsibility to provide acceptable documentation to us showing that you are entitled to an extension of benefits.

1. In the event you are totally disabled on the termination date of the Group Master Policy as a result of a specific Accident or illness incurred while you were covered under this Booklet, as determined by us, we will provide a limited extension of benefits for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. 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 Group Master Policy.

   For purposes of this section, you will be considered "totally disabled" only if, in our opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. You are totally disabled only if, in our opinion, you are unable to perform those normal day-to-day activities which you would otherwise perform and you require regular care and attendance by a Physician.

2. In the event you are receiving covered dental treatment as of the termination date of the Group Master Policy, we will provide a limited extension of such covered dental treatment provided:

   a) a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while you were covered under the Group Master Policy;

   b) the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and

   c) the dental procedures were performed within 90 days after the Group Master Policy terminated.

   This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Group Master Policy or on the date you become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. You are not required to be totally disabled in order to be eligible for this extension of benefits.

   Please refer to the Dental Care category of the "What Is Covered?" section for a description of the dental care Services covered under this Booklet.

3. In the event you are pregnant as of the termination date of the Group Master Policy, we will provide a limited extension of the maternity expense benefits provided by this Booklet, provided the pregnancy commenced while the pregnant individual was covered under the Group Master Policy, as determined by us. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. You are not required to be totally disabled in order to be eligible for this extension of benefits.

Section 16: The Effect of Medicare Coverage/ Medicare Secondary Payer Provisions

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

Under Medicare, your Group MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, your Group MAY NOT induce you to decline or terminate your group health insurance coverage and elect Medicare as primary payer.

If you become 65 or become eligible for Medicare due to End Stage Renal Disease ("ESRD"), you must notify your Group.

Individuals With End Stage Renal Disease

If you are entitled to Medicare coverage because of ESRD, we will provide group health coverage on a primary basis 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 primary prior to the time you became eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health insurance coverage will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, we will provide group health coverage, as described in this section, on a primary basis for 30 months.

Disabled Active Individuals

We will provide primary coverage to you if:

1. the Group is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year; and
2. you are entitled to Medicare coverage because of disability (unless you have ESRD).

Primary coverage under the Group Master Policy is subject to the following terms:

1. For a Covered Person, we will provide coverage on a primary basis during any month in which that individual meets the description set out in the above paragraphs.
2. Individual entitlement to primary coverage under this subsection will terminate automatically when:
   a) the Covered Person turns 65 years of age; or
   b) the Covered Person no longer qualifies for Medicare coverage because of disability; or
   c) the Covered Person elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

3. Entitlement of the Covered Person to primary coverage under this subsection will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions. The Group must notify us, without delay, of any such change in status.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Group Master Policy.
2. We will not be liable to the Group or to any individual covered under the Group Master Policy on account of any nonpayment of primary benefits resulting from any failure of performance of the Group's obligations as described in this section.
3. If we should elect to make primary payments for Covered Services rendered to an employee or Dependent 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. Alternatively, we may require the Group to pay the Rate differential that resulted from the Group's failure to provide us with the required information in a timely manner.

Section 17: Duplication of Coverage Under Other Health Plans/Programs

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided by us. This provision is required by and subject to applicable federal and/or Florida law concerning coordination of health insurance benefits and will be modified to the extent necessary to enable us to comply with such laws.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is your responsibility to provide us and your Physician with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If we do not receive the information we request from you, we may deny your claims and you will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies which may be subject to COB include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage which the law permits us to coordinate benefits with;
4. Medicare, as described in "The Effect of Medicare Coverage/Medicare Secondary Payer Provisions" section; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of our payment, if any, when we coordinate benefits under this section, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to coverage under other plans. When we are not primary, our payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event you receive Covered Services from a NetworkBlue Provider or an Out-of-Network Provider who participates in our Traditional Program, "total reasonable expenses" shall mean the amount we are obligated to pay to the Provider pursuant to the applicable agreement we have with such Provider. **In the event that the primary payer's payment exceeds our Allowed Amount, no payment will be made for such Services**.

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

1. When we cover you as a Covered Dependent and the other plan covers you as

other than a dependent, we will be secondary.

2. When we cover a dependent child whose parents are not separated or divorced:

   a) the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or

   b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than us, we will be secondary.

3. When we cover a dependent child whose parents are separated or divorced:

   a) if the parent with custody is not remarried, the plan of the parent with custody is primary;

   b) if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;

   c) 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 primary.

4. When we cover a dependent child and the dependent child is also covered under another plan:

   a) the plan of the parent who is neither laid off nor retired will be primary; or

   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.

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered you the longest shall be primary.

   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.

6. If you are covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, 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.

7. 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.

Facility of Payment

Whenever payments which are payable by us under this Booklet are made by any other person, plan, or organization, we will 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 determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Booklet and, to the extent of such payments, we will be fully discharged from liability.

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Booklet shall not duplicate any benefits to which you or your Covered Dependents are entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 18: Subrogation

If you are injured or become ill as a result of another person's or entity's intentional act, negligence or fault, you must notify us concerning the circumstances under which you were injured or became ill. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. If you recover money to compensate for the cost/expense of Health Care Services to treat your illness or injury, we are legally entitled to recover payments made on your behalf to the doctors, hospitals, or other providers who treated you. Our legal right to recover money we have paid in such cases is called "subrogation". We may recover the amount of any payments we made on your behalf minus our pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. We may subrogate against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although we may, but are not required to, take into consideration any special factors relating to your specific case in resolving our subrogation claim, we will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of the recovery or settlement.

You must do nothing to prejudice our right of subrogation hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 19: Right of Reimbursement

If any payment under this Booklet is made to you or on your behalf with respect to any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, we will have a right to be reimbursed by you (out of any settlement or judgment proceeds you recover) one dollar ($1.00) for each dollar paid under the terms of this Booklet minus a pro rata share for any costs and attorney fees incurred in pursuing and recovering such proceeds.

Our right of reimbursement will be in addition to any subrogation right or claim available to us, and you must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement hereunder. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must do nothing to prejudice our right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 20: Claims Processing

Introduction

This section is intended to:

- help you understand what you or your treating Providers must do, under the terms of this Benefit Booklet, in order to obtain payment for expenses for Covered Services they have rendered or will render 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 your Group Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), your plan administrator 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 your 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 your 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 your 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 your plan sponsor or administrator if you have questions relating to your Group Plan's SPD. We are not your 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 Benefit Booklet, there are three types of claims: 1) Pre-Service Claims; 2) Post-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

We have defined and described the three types of claims that may be submitted to us. Our 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 for Services they render to you. In the event a Provider who renders Services to you does not file a Post-Service Claim for such Services, it is your responsibility to file it with us.

We must receive a Post-Service Claim within 90 days of the date the Health Care 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 Identification Card within one year of the date the Service was rendered unless you were legally incapacitated.

For Post-Service Claims, we must receive an itemized statement from the health care Provider for the Service rendered along with a completed claim form. The itemized statement must contain the following information:

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

The itemized statement and claim form must be received by us at the address indicated on your Identification Card.

Note: If your Group purchased retail pharmacy prescription drug coverage, please refer to the pharmacy program Endorsement for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard® Program (See the "BlueCard® (Out-of-State) Program" section of this Booklet).

The Processing of 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. Post-Service Claims will be paid, contested, or denied within the timeframes described below.

- Payment for Post-Service Claims

When payment is due under the terms of this Benefit 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. 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 or additional information, we may contest 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 Post-Service Claim submitted on a paper claim form, 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. Our notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) 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 additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated 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, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the

claim and the reason(s) for denial. It is your responsibility to ensure that we receive all information determined by us as 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 and appeal procedures described in this section.

Additional Processing Information for Post-Service Claims

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) Post-Service paper 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*.

We will investigate any allegation of improper billing by a Provider upon receipt of written notification from you. If we determine that you were billed for a Service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due solely to the notification from you, we will pay you 20 percent of the amount of the reduction, up to a total of $500.

Pre-Service Claims

How to File A Pre-Service Claim

This Benefit 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 ”What Is Covered?” section and other applicable sections of this Benefit 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 Benefit Booklet require (or condition payment upon) approval by us 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 our 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 your 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 our request. We will use our best efforts to provide notice of the decision on your 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 on 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 your Provider may need to provide; and 3) inform you of the date that we reasonably expect to notify you of our decision. If we request additional information, we must receive it within 45 days of our request for the information. We will use our best efforts to provide notification of the decision on your 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 and appeal procedures described 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:

- 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
- the reduction or termination occurs before the end of such previously approved time or number of Services; and
- the reduction or termination of coverage or benefits by us was not due to an amendment of this Benefit Booklet or termination of your coverage as provided by this Benefit Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures 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 your 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 failed to follow proper procedures in your 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 extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for 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):

- the specific reason or reasons for the Adverse Benefit Determination;
- a reference to the specific Benefit 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;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

If your 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 three days after the oral notification.

How to Appeal an Adverse Benefit Determination

You, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. We will review your appeal through the review process described below. Your appeal must be submitted in writing to us 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:

- We must receive your appeal of an Adverse Benefit Determination in person or in writing;
- You may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, you may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Benefit Booklet to your medical circumstances;
- During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination;
- We may consult with appropriate Physicians, as necessary;
- Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request; and
- If your claim is a Claim Involving Urgent Care, you may request an expedited appeal 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.

Your request for appeal should be sent to the address below:

Blue Cross and Blue Shield of Florida, Inc.
Attention PPO Appeals / DC4
P.O. Box 44197
Jacksonville, Florida 32231-4197

Timing of Our Appeal Review on Adverse Benefit Determinations

We will use our best efforts to review your appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims-- within 30 days of the receipt of your appeal; or
- Post-Service Claims-- within 60 days of the receipt of your appeal; or
- 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 receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

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.

You, or a Provider acting on your behalf, who has had a claim denied as not Medically Necessary has the opportunity to appeal the claim denial. The appeal may be directed to an employee of BCBSF who is a licensed Physician responsible for Medical Necessity reviews. The appeal may be by telephone and the Physician will respond to you, within a reasonable time, not to exceed 15 business days.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

   In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

   In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a health care Provider of our choice as often as is reasonably necessary while a claim is pending. Failure by you to fully cooperate with such examination shall result in a denial of the pending claim and we shall have no liability for such claim.

3. Legal Actions:

   No legal action arising out of or in connection with coverage under this Benefit 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.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

   We rely on the information provided on the itemized statement and the claim form 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.

5. Explanation of Benefits Form:

   All claims decisions, including denial and claims review decisions, will be communicated to you in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

   a) The specific reason or reasons for the Adverse Benefit Determination;

   b) Reference to the specific Benefit 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;

   c) A description of any additional information that would change the initial determination and why that information is necessary;

   d) A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

   e) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. 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 Services, taking into account the impact of the event. For the 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.

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 or your Covered Dependents are entitled, after exhaustion of the appeal procedures provided for 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.

Section 21: Relationships Between the Parties

BCBSF and Health Care Providers

Neither BCBSF nor any of its officers, directors or employees provides Health Care Services to you. Rather, we are engaged in making coverage and benefit decisions under this Booklet. By accepting our coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those 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 we make concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. Neither BCBSF nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and the Group

Neither the Group nor any person covered under this Booklet is our agent or representative, and neither shall be liable for any acts or omissions by our agents, servants, employees, or us. Additionally, we will not be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. We are not your agent, servant, or representative nor are we an agent, servant, or representative of the Group and we will not be liable for any acts or omissions, or those of the Group, its agents, servants, employees, 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.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical Services or supplies, must be made solely by your family 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 procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 22: General Provisions

Access to Information

We have the right to receive, from you and any health care Provider rendering Services to you, information that is reasonably necessary, as determined by us, in order to administer the coverage and benefits we provide, subject to all applicable confidentiality requirements listed below. By accepting coverage, you authorize every health care Provider who renders Services 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.

Right to Receive Necessary Information

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

Amendment

The terms of coverage and benefits to be provided by us may be amended at renewal of the Group Master Policy, without the consent of the Group, you 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 Group Master Policy upon at least ten days prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to Covered Services prior to the date of such amendment. No agent or other person, except a duly authorized officer of BCBSF, has the authority to modify the terms of the Group Master Policy, or to bind us in any manner not expressly described 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 may not be amended by the Group; unless such amendment is evidenced in writing and signed by a duly authorized officer of BCBSF. The Group shall immediately notify you of any such amendment and/or shall assist us in notifying you at our request.

Assignment and Delegation

Your obligations arising hereunder may not be assigned, delegated or otherwise transferred by you without the written consent of BCBSF. We may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without the consent of the Group at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Changes in Premium

We may modify the Rates at any time, without your consent, upon at least 45 days prior notice to the Group. It is the Group's responsibility to immediately notify you if your financial contribution requirement is changed due to a change in Rates.

Right to 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 person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under the Group Master Policy shall be deemed to have been modified 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.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or services under this Booklet**.** Further, 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 arrangements with a Provider may require that we release certain claims and medical information about persons covered under this Booklet to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any such Provider to evaluate your financial responsibility under this Booklet**.**

Evidence of Coverage

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

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

Modification of Provider Network and the Participation Status

NetworkBlue, and the participation status of individual Providers available under this Booklet, are subject to change at any time without prior notice to you or your approval or that of 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, the Group or you. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time the Health Care Service is rendered. Under this Booklet, your financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of You and Your Covered Dependents

You must cooperate with us, and must execute and submit to us any consents, releases, assignments, and other documents we may request in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause by us (See the Termination of an Individual's Coverage for Cause subsection in the "Termination of Coverage" section).

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 described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will 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 Group Master Policy, or this Benefit 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 listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

If to us:

To the address printed on the Group Application and/or the Identification Card.

If to you:

To the latest address provided by you or to your latest address on Enrollment Forms actually delivered to us.

You must notify us immediately of any address change.

If to Group:

To the address indicated on the Group Application.

Our Obligations upon Termination

Upon termination of your coverage for any reason, we will have no further liability or responsibility to you under the Group Master Policy, except as specifically described herein.

ERISA

We are not the plan sponsor or plan administrator, as defined by ERISA. If the group health plan under which you are covered is subject to the Employee Retirement Income Security Act (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.

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.

Florida Agency for Health Care Administration (AHCA) Performance Outcome and Financial Data

The performance outcome and financial data published by AHCA, pursuant to Florida Statute 408.05, or any successor statute, located at the web site address www.floridahealthstat.com, may be accessed through the link provided on Blue Cross and Blue Shield of Florida's corporate web site at www.bcbsfl.com.

Third Party Beneficiary

The Group Master Policy under which this Benefit Booklet was issued was entered into solely and specifically for the benefit of BCBSF and the Group. The terms and provisions of the Group Master Policy shall be binding solely upon, and inure solely to the benefit of, BCBSF and the Group, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. BCBSF and the Group hereby specifically express their intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the Group Master Policy or this Benefit Booklet.

Section 23: Definitions

The following definitions are used in this Benefit Booklet. Other definitions may be found in the particular section or subsection where they are used.

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 (not previously compromised by decay) 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.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Benefit Booklet with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.

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 Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("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® (Out-of-State) Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard® (Out-of-State) Traditional 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® (Out-of-State) Program" section for more details.
5. In the case of Out-of-Network Providers that have not entered into any agreement with BCBSF, or with another Blue Cross and/or Blue Shield organization to provide access to Provider discounts under the BlueCard® Program, the Allowed Amount will be the lesser of the Provider's actual charge or an amount established by BCBSF based on several factors including (but not necessarily limited to): BCBSF's medical, payment, and/or administrative guidelines; pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); payment for such services under the Medicare program; relative value scales; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area

established by BCBSF; and/or the cost of providing the Covered Service.

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular services by calling the customer service telephone number included in this Booklet or on your Identification 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 your Booklet apply. You should refer to the "What Is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much we will pay.

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 of 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 Group Application and subsequent annual anniversaries.

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.

Benefit Booklet or Booklet means the certificate of coverage, which is evidence of coverage under the Group Master Policy.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the Florida Statutes, or a similar applicable law of another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

BlueCard® (Out-of-State) PPO Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the BlueCard® (Out-of-State) PPO Program discounts of other participating Blue Cross and/or Blue Shield plans.

BlueCard® (Out-of-State) PPO Program Provider means a Provider designated as a BlueCard® (Out-of-State) PPO Program Provider by the Host Blue.

BlueCard® (Out-of-State) Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the Provider discounts of other participating Blue Cross and/or Blue Shield plans.

[**BlueCard® (Out-of-State) Traditional Program** means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the BlueCard® (Out-of-State) Traditional Program discounts of other participating Blue Cross and/or Blue Shield plans.]

[**BlueCard® (Out-of-State) Traditional Program Provider** means a Provider designated as a BlueCard® (Out-of-State) Traditional Program Provider by the Host Blue.]

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. 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 Health Care 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 (e.g., Hospital room and board and ancillary services).

Calendar Year begins January 1st and ends December 31st.

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 licensed pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state, as an advanced nurse practitioner 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 registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law 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 BCBSF and you. After your Deductible requirement is met, BCBSF 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.

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 in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management program as described in the “Blueprint For Health Programs” section of this Benefit Booklet.

Condition means a disease, illness, ailment, injury, or pregnancy.

Copayment means the dollar amount established solely by us, which is required to be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Covered Employee (See the Eligibility Requirements for Dependent(s) subsection of the “Eligibility for Coverage” section).

Covered Employee means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Covered Dependent (See Eligibility Requirements for Covered Employees subsection of the “Eligibility for Coverage” section).

Covered Person means a Covered Employee or a Covered Dependent.

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 an individual 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.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services, which you must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Booklet**,** before our payment for Covered Services begins.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual 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 licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law 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 (CMMS) 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.

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) 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 home medical equipment, oxygen therapy services, or dialysis supplies in the patient's home under a Physician's prescription.

Effective Date means, with respect to the Group, 12:01 a.m. on the date specified on the Group Application. With respect to individuals covered under this Group Master Policy, 12:01 a.m. on the date the group specifies that the coverage will commence as further described in the "Enrollment and Effective Date of Coverage" section of this Benefit Booklet.

Eligible Dependent means a Covered Employee's:

1. legal spouse under a legally valid, existing marriage; or
2. natural, newborn, adopted, Foster, or step child(ren); or
3. a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian;

who meets and continues to meet all of the eligibility requirements described in the "Eligibility for Coverage" section in this Benefit Booklet.

Eligible Dependent also includes a newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child. **Refer to the "Eligibility for Coverage" section for limits on eligibility.**

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Covered Employees subsection of the "Eligibility for Coverage" section in this Benefit Booklet and is eligible to enroll as a Covered Employee. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee by us.

Endorsement means an amendment to the Group Master Policy or this Booklet issued by BCBSF.

Enrollment Date means the date of enrollment of the individual under the Group Master Policy or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those BCBSF forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under the Group Master 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; or
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; or
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; or

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; or
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; or
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 in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or
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 and scientific literature published in the United States, Canada, or Great Britain;
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: Health Care Services which are determined by BCBSF to be Experimental or Investigational are excluded (see the "What Is Not Covered?" section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF 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.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with Florida Statutes or by a similar regulatory agency of another state in compliance with that state's applicable laws.

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.

Gestational Surrogate means a woman, regardless of age, who contracts, orally or in writing, to become pregnant by means of assisted reproductive technology without the use of an egg from her body.

Gestational Surrogacy Contract or Arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the Gestational Surrogate and the intended parent or parents.

Group means the employer, labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits are issued by us, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Group Application means the BCBSF form, electronic (where available) or paper, including the underwriting questionnaire form, if any, that the Group must submit to BCBSF when requesting the issuance of the Group Master Policy.

Group Master Policy means the written document, which is the agreement between the Group and us whereby coverage and benefits will be provided to you and any Covered Dependents. The Group Master Policy includes this Benefit Booklet (including the Schedule of Benefits), the Group Application, Enrollment Forms, and any Endorsements to this Benefit Booklet or the Group Master Policy.

Group Plan means the employee welfare benefit plan established by the Group.

Health Care Services or Services includes 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, Providers.

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 a similar applicable law 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 which is duly licensed by the state of Florida under applicable law, or a similar applicable law of 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 persons 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 Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, 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.

Identification (ID) Card means the card(s) we issue to Covered Employees. The card is our property, and is not transferable to another person. Possession of such card in no way verifies that a particular individual is eligible for, or covered under, the Group Master Policy.

Independent Clinical Laboratory means a laboratory 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 Facility 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 Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida law or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an Independent Diagnostic Testing Facility.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on the Schedule of Benefits under the heading “In-Network”. Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Benefit Booklet.

In-Network Provider means any health care Provider who, at the time Covered Services were rendered to you, was under contract with BCBSF to participate in BCBSF’s NetworkBlue and included in the panel of providers designated by BCBSF as “In-Network” for your specific plan. (Please refer to your Schedule of Benefits). For payment purposes under this Benefit Booklet only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard® (Out-of-State) PPO Program Provider under the Blue Cross Blue Shield Association’s BlueCard® (Out-of-State) Program.

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 the woman's uterus.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statues, or a similar applicable law of another state.

Massage Therapist means a person properly licensed to practice Massage, pursuant to Chapter 480 of the Florida Statutes, or a similar applicable law of another state.

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 Benefit 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.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means, in accordance with our guidelines and criteria then in effect, for coverage and payment purposes only, that a Health Care Service is required for the identification, treatment, or management of a Condition, and is, in the opinion of BCBSF:

1. consistent with the symptom, diagnosis, and treatment of the Condition being treated;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. universally accepted in clinical use such that omission of the service in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not Experimental or Investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of, the Covered Person's family, the Physician or other provider;
7. the most appropriate level of service or care which can safely be provided to the Covered Person; and
8. in the case of inpatient care, the Health Care Service(s) cannot be provided safely in an alternative setting.

Note: It is important to remember that any review of Medical Necessity by us is solely for the purposes 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.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

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

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state.

Morbid Obesity is a Condition where an individual is 100 pounds over their ideal body weight and/or Body Mass Index (BMI) of equal to or greater than 40.

NetworkBlue means, or refers to, the preferred provider network established and so designated by BCBSF, which is available to BlueOptions members under this Benefit Booklet. Please note that BCBSF's Preferred Patient Care (PPC) preferred provider network is not available to BlueOptions members under this Benefit Booklet.

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 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.

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 means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on the Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of this Benefit Booklet.

Out-of-Network Provider means a Provider who, at the time Health Care Services were rendered:

1. [did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or]
2. [did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard® (Out-of-State) PPO Program but was participating, for purposes of the BlueCard® (Out-of-State) Program, as a BlueCard® (Out-of-State) Traditional Program Provider; or]
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue [or our Traditional Program; or]
5. [did not have a contract with a Host Blue to participate for purposes of the BlueCard® (Out-of-State) Program as a BlueCard® (Out-of-State) Traditional Program Provider.]

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; outpatient cardiac rehabilitation therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet our criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, 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 rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III “specialty rehabilitation hospital” described in Chapter 59A, Florida Administrative Code or the similar law or laws of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring 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 seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Physical Therapy means 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 heat therapy.

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.

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 pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

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.

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 Benefit 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 Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Premium means the amount required to be paid by the Group to BCBSF in order for there to be coverage under the Group Master Policy.

Prior/Concurrent Coverage Affidavit means the form that an Eligible Employee can submit to us as proof of the amount of time the Eligible Employee was covered under Creditable Coverage.

Prosthetist/Orthotist means a person or entity that is properly licensed, 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.

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 malfunctioning body part or organ.

Provider means any facility, person or entity recognized for payment by BCBSF 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 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.

Rate means the amount BCBSF charges the Group for each type of coverage under the Group Master Policy (e.g., Employee Only Coverage).

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 (RNFA) 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.

Rehabilitation Services means Services for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to cardiac rehabilitation, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage Therapy.

Rehabilitative Therapies means therapies the primary purpose of which is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

Skilled Nursing Facility means an institution or part thereof which meets BCBSF's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations 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 BCBSF.

Speech Therapy means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy services.

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.

Standard Reference Compendium means: 1) the United States Pharmacopoeia Drug Information; 2) the American Medical Association Drug Evaluation; 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 the 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.

[2][**Traditional Program** means, or refers to, BCBSF 's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS).]

[8][**Traditional Program Providers** means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, have entered into a contract, then in effect, to participate in BCBSF's Traditional Program as applicable in Florida or in certain counties outside of Florida when such programs exist.]

Urgent Care Center means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (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 Physicians and Registered Nurses (RNs) 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 Rehabilitation Facility.

Waiting Period means the length of time specified on the Group Application, which must be met by an individual before that individual becomes eligible for coverage under this Benefit Booklet.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the resulting 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.

[2] This definition will not be included for groups who do not have access to Traditional Program Providers as part of their benefits.