# BlueOptions

## Schedule of Benefits – Plan 5462

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, access the most recent provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".

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

### Deductible, Coinsurance and Out-of-Pocket Maximum

| Benefit Description | In-Network (INN) | Out-of-Network (OON) |
|---|---|---|
| **Deductible (DED)** | | |
| Per Individual per Benefit Period | $500 | $1,000 |
| Per Family per Benefit Period | $1,500 | $3,000 |
| **Coinsurance** (The percentage of the Allowed Amount **you pay** for Covered Services) | 20% | 50% |
| **Out-of-Pocket Maximums** | | |
| Per Individual per Benefit Period | $2,500 | $5,000 |
| Per Family per Benefit Period | $5,000 | $10,000 |
| **Medical Pharmacy** per individual, per calendar month | $200 | Not Applicable |

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise specified within this Schedule of Benefits. This includes the DED and Out-of-Pocket Maximum amounts.

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What **applies** to out-of-pocket maximums?

- DED
- Coinsurance
- Copayments

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

- Non-covered charges
- Charges in excess of the Allowed Amount
- Any Prescription Drug Cost Share amounts (except for Medical Pharmacy Services)

## Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- Copayments listed in this Schedule of Benefits appear as a dollar amount only and apply per visit.

## Preventive Health Services

| Benefit Description | In-Network (INN) | Out-of-Network (OON) |
|---|---|---|
| **Adult Wellness Services**<br>Physician's Office and all other locations | $0 | 50% |
| **Adult Well Woman Services**<br>Physician's Office and all other locations | $0 | 50% |
| **Child Health Supervision Services**<br>Physician's Office and all other locations | $0 | 50% |
| **Mammograms** | $0 | $0 |
| **Routine Colonoscopy** | $0 | $0 |

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## Office Services

A Primary Care Provider is a Physician whose primary specialty, according to our records, is one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

| Benefit Description | In-Network (INN) | Out-of-Network (OON) |
|---|---|---|
| **Office visits rendered by** | | |
| Primary Care Providers | $15 | DED + 50% |
| Other health care professionals licensed to perform such Services | $35 | DED + 50% |
| **Advanced Imaging Services** (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by: | | |
| Primary Care Providers | $150 | DED + 50% |
| Other health care professionals licensed to perform such Services | $150 | DED + 50% |
| **Allergy Injections rendered by** | | |
| Primary Care Providers | $10 | DED + 50% |
| Other health care professionals licensed to perform such Services | $10 | DED + 50% |
| **Convenient Care Centers** | $15 | DED + 50% |
| **Medical Pharmacy Services -** Prescription Drugs administered by: | | |
| Primary Care Providers | 20% | DED + 50% |
| Other health care professionals licensed to perform such Services | 20% | DED + 50% |

**Important** – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections and Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.

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## Virtual Health

| Benefit Description | You Pay |
|---|---|
| **Virtual Visits**<br>General Medicine and Urgent Care rendered by a designated Virtual Care Provider | $0 |
| Specialized Care rendered by a designated Virtual Care Provider | $35 |
| Behavioral Health rendered by a designated Virtual Care Provider | $0 |

Please visit https://www.floridablue.com/virtual-health for more information.

## Outpatient Diagnostic Services

| Benefit Description | In-Network (INN) | Out-of-Network (OON) |
|---|---|---|
| **Independent Clinical Lab** | $0 | DED + 50% |
| **Independent Diagnostic Testing Facility**<br>Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | $150 | DED + 50% |
| All other diagnostic Services (e.g., X-rays) | $50 | DED + 50% |
| **Outpatient Hospital Facility** | See **Hospital Services Outpatient** | |

## Emergency and Urgent Care Services

| Benefit Description | In-Network (INN) | Out-of-Network (OON) |
|---|---|---|
| **Ambulance Services** | DED + 20% | INN DED + 20% |
| **Emergency Room Visits** | See **Hospital Services Emergency Room Visits** | |
| **Urgent Care Center** | $40 | DED + $40 |

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## Surgical Services

| Benefit Description | In-Network (INN) | Out-of-Network (OON) |
|---|---|---|
| **Ambulatory Surgical Center** | | |
| Facility | $100 | DED + 50% |
| Primary Care Providers | $15 | DED + 50% |
| Radiologists, Anesthesiologists, and Pathologists | $35 | $35 |
| Physician and other health care professional Services rendered by all other Providers | $35 | DED + 50% |
| **Outpatient Hospital Facility** | See **Hospital Services Outpatient** | |

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## Hospital Services

| Benefit Description | In-Network (INN) | | Out-of-Network (OON) |
|---|---|---|---|
| | Option 1* | Option 2* | |
| **Inpatient** | | | |
| Facility (per admission) | $600 | $1,000 | **DED + 50% |
| Physician and other health care professional Services | $50 | $50 | $50 |
| **Outpatient** | | | |
| Facility | $250 | $350 | DED + 50% |
| Physician and other health care professional Services | $50 | $50 | $50 |
| Therapy Services | $40 | $50 | DED + 50% |
| **Emergency Room Visits** | | | |
| Facility | $100 | $100 | $100 |
| Physician and other health care professional Services | $50 | $50 | $50 |

**Important:**

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room Physicians. We will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the INN benefit level. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital. Option 2 includes Out-of-State BlueCard Participating Providers.

** If you are admitted to an Out-of-Network Hospital as an inpatient at the time of an emergency room visit to the same facility, the In-Network Option 1 inpatient Cost Share will apply to that admission.

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## Benefit Maximums

**Home Health Care** visits per Benefit Period ..... 20

**Inpatient Rehabilitation** days per Benefit Period ..... 21

**Mental Health Services -- Inpatient** days/visits or combination of inpatient and Partial Hospitalization days, per Benefit Period ..... 30

**Mental Health Services -- Outpatient** visits per Benefit Period ..... 20

**Outpatient Therapies and Spinal Manipulations** visits per Benefit Period ..... 35

**Note**: Refer to the Benefit Booklet for reimbursement guidelines.

**Skilled Nursing Facility** days per Benefit Period ..... 60

## Benefit Maximum Carryover

If, immediately before the Effective Date of the Small Employer, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or HOI to the Small Employer, amounts applied to your Benefit Period maximums under the prior BCBSF or HOI policy, will be applied toward your Benefit Period maximums under this Benefit Booklet.

## Prescription Drug Program

Please refer to the Pharmacy Program Endorsement for details regarding your pharmacy coverage.

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# BlueScript® Pharmacy Program

## Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueScript Pharmacy Program described in the BlueScript Pharmacy Program Endorsement, both of which should be reviewed carefully. To find a Participating Pharmacy, access the provider directory on our website at www.floridablue.com or call the customer service phone number on your ID Card.

**Pharmacy Deductible (DED) per Benefit Period** ..... $0

| **RETAIL PHARMACY**<br>(for each One-Month Supply) | ***Participating Pharmacy** | ***Non-Participating Pharmacy** |
|---|---|---|
| Preferred Generic Prescription Drugs and Supplies and Covered OTC Drugs | $10 | 50% |
| Preferred Brand Name Prescription Drugs and Supplies | $30 | 50% |
| Non-Preferred Prescription Drugs and Supplies | $50 | 50% |

| **HOME DELIVERY PHARMACY**<br>(up to a Three-Month Supply) | ***Participating Pharmacy** | ***Non-Participating Pharmacy** |
|---|---|---|
| Preferred Generic Prescription Drugs and Supplies and Covered OTC Drugs | $25 | 50% |
| Preferred Brand Name Prescription Drugs and Supplies | $75 | 50% |
| Non-Preferred Prescription Drugs and Supplies | $125 | 50% |

* Our payment for Covered Prescription Drugs is based on the **Participating Pharmacy Allowance**

** Our payment for Covered Prescription Drugs is based on the **Non-Participating Pharmacy Allowance** and may be less than the cost of the Drug or Supply. You are responsible for any charges in excess of the Non-Participating Pharmacy Allowance for purchases at Non-Participating Pharmacies.

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## Important information affecting the amount you will pay for Prescription Drugs:

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the Cost Share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

  **Note:** The difference in cost described in number 2 above is a benefit penalty and therefore does not help to satisfy your Deductible or Out-of-Pocket Maximums.

- You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) from a retail Participating Pharmacy, if the Prescription is written for a Three-Month Supply.
- Specialty Drugs are only covered when purchased from the Specialty Pharmacy and only up to a One-Month Supply. Certain Specialty Pharmacy products may have unique quantity limits. Specialty Drugs may be dispensed in lesser or greater quantities due to manufacturer package size or FDA-approved dosage requirements for a course of therapy. These unique quantity limits will be indicated in the Medication Guide.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Home Delivery Pharmacy.

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# BlueOptions

Benefit Booklet

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# BlueOptions

Benefit Booklet

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Patrick J. Geraghty
Chief Executive Officer

For Customer Assistance : 800-FLA-BLUE

This Benefit Booklet Contains Deductible Provisions

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# 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 to determine how much you have to pay for particular Health Care Services.

### When reading your Booklet, please remember:

1. You should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
2. 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.
3. References to "you" or "your" throughout refer to you as the Covered Employee and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Covered Employee or solely to your Covered Dependent(s) will be noted as such.
4. 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."
5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section or defined within the particular section where it is used.

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| Where do I find information on… | …go to: |
|---|---|
| What is **covered?** | The **"What Is Covered?"** section. |
| What is **not covered?** | The **"What Is Covered?"** and **"What Is Not Covered?"** sections. |
| How do I know what **Providers** I can use, and how the Providers I use will affect my **Cost Share** amount? | The **"Health Care Provider Options"** section, along with the current **BlueOptions Provider Directory**. |
| **How much do I pay** for Health Care Services? | The **"Understanding Your Share of Health Care Expenses"** section along with the **Schedule of Benefits**. |
| How do I access Services when I'm **out-of-state?** | The **"BlueCard® (Out-of-State) Program"** section. |
| How do I **add or remove a Dependent?** | The **"Enrollment and Effective Date of Coverage"** section. |
| What if I am covered under **BlueOptions** and **another health plan?** | The **"Duplication of Coverage"** section. |
| What happens when **my coverage ends?** | The **"Termination of Coverage"** section. |
| What do the **terms used** throughout this Booklet **mean?** | The **"Definitions"** section. |
| Who do I call if I have **questions?** | Call our **customer service** department at **800-352-2583** (this phone number can also be found on your **ID Card)**. |

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# 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 1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, 2) the applicable Allowed Amount, 3) any limitations and exclusions, as well as any other provisions contained in this Booklet, and any Endorsement(s) that are part of your Booklet, and 4) 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 and in any Endorsement(s) that are part of this Benefit Booklet. 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 Covered Services Categories in this "What Is Covered?" section;
2. actually rendered to you (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 in this section;
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 such Services are rendered. For example, we may determine whether a proposed transplant would be 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 unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

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, the Small Employer, nor any health care Provider or other person should rely on any such written or verbal representation.

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## 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 a Condition 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

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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 per-day maximums for Ambulance Services.

**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 at an Ambulatory Surgical Center (except for take home drugs);
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration and cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (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 include both the CRNA and the Physician's Services at the lower directed Services Allowed Amount in accordance with our payment program then in effect for such Covered Services.

<u>Exclusion:</u>

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**

Health Care 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. The Speech Therapy coverage provided herein is subject to the limitations set forth on your Schedule of Benefits for Outpatient Therapies and Spinal Manipulation Services. For additional information on coverage and limitations that apply to Speech Therapy, refer to the Outpatient Therapies

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and Spinal Manipulation Services category in this section. 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: 1) the additional Physician actively participates in your treatment; 2) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and 3) the Physicians have different specialties or have the same specialty with different 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**

Contraceptive 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.

**Dental Services**

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care 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.

<u>Exclusion:</u>

1. Dental Services provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such Services could have been rendered within 62 days; and
2. Dental implants.

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**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, are covered if your treating Physician or a Physician who specializes in the treatment of diabetes certifies that such Services are Medically Necessary. 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.

**Note:** Diabetes equipment and supplies will not be covered under this category if such equipment and supplies are covered under a BCBSF Pharmacy Program Endorsement to this Booklet. The terms and conditions of such Pharmacy Program Endorsement will apply to diabetes equipment and supplies.

**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.

Exclusion:

Oversight of a medical laboratory by a Physician or other health care Provider, as described in the “What Is Not Covered?” section.

**Dialysis Services**

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

**Durable Medical Equipment**

Durable Medical Equipment is covered 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.

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. Coverage 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)

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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: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

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 are covered 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.

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

Please refer to your Schedule of Benefits for any applicable enteral formula benefit maximums or limitations.

**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 that 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 not covered. 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 not covered.

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**Home Health Care**

The Home Health Care Services listed below are covered when all of 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 at least every 30 days until benefits are exhausted. (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); and
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 an Occupational Therapist, and Speech Therapy by a Speech Therapist.

<u>Exclusion:</u>

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.

Please refer to your Schedule of Benefits for any applicable Home Health Care benefit maximums or limitations.

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**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. Your Physician may be required to certify your life expectancy in writing.

**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 by the Hospital (except for take-home drugs);
7. intravenous solutions;
8. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. chemotherapy and radiation treatment for proven malignant disease;
14. Physical, Speech, Occupational, and Cardiac Therapies; and
15. transplants as described in the Transplant Services category.

<u>Exclusion:</u>

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.

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;

SAMPLE

5. guest meals or gourmet menus; and
6. admission kits.

**Inpatient Rehabilitation**

Inpatient Rehabilitation Services are covered when all of the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is 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. you 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 your 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 you to receive Services in a less intensive setting.

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

Exclusion:

All Inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Substance Dependency category), 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.

**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 rendered 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.

SAMPLE

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.

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

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. This exclusion applies to all expenses for prenatal, intra-partal (care provided during delivery and childbirth), and post-partal (care for the mother following childbirth) 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.

**Medical Pharmacy**

Physician-administered Prescription Drugs which are rendered in a Physician's office are subject to a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to the Prescription Drug and does not include the administration of the Prescription Drug.

Your plan may also include a maximum monthly amount you will be required to pay out-of-pocket for Medical Pharmacy, when such Services are provided by an In-Network Provider or Specialty Pharmacy. If your plan includes a Medical Pharmacy out-of-pocket maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

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

**Note:** For purposes of this benefit, allergy injections and immunizations are not considered Medical Pharmacy.

**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.

SAMPLE

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 diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder;
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 diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.
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. inpatient (overnight) mental health Services received in a residential treatment facility.

Please refer to your Schedule of Benefits for any applicable Mental Health Services benefit maximums or limitations.

**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 illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment:

An assessment of the newborn child is covered when the Services are rendered at a Hospital, 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 Deductible.

SAMPLE

Ambulance Services are covered 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.

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

**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 one splint in a six-month period unless a more frequent replacement is determined by us to be Medically Necessary.

Exclusion:

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

**Osteoporosis Screening, Diagnosis, and Treatment**

Screening, diagnosis, and treatment of osteoporosis are covered for high-risk individuals, 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;

SAMPLE

4. individuals who have primary hyperparathyroidism; and
5. individuals who have a family history of osteoporosis.

**Outpatient Therapies and Spinal Manipulation Services**

1. The outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The only outpatient therapies covered under this Booklet are those specifically listed below. 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 in this section.

   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.

   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 rendered by a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition.

   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.

   e) Massage Therapy Services provided by a Physician, Massage Therapist, or Physical Therapist are covered 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.

      Exclusion:

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

   Payment Guidelines for Massage and Physical Therapy

   a) Payment for covered Massage Therapy Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Therapies and Spinal Manipulations benefit maximum listed in your Schedule of Benefits.

   b) Payment for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Therapies and Spinal Manipulations benefit maximum listed on your Schedule of Benefits.

SAMPLE

c) Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day not to exceed fifteen (15) minutes in length.

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

   Payment Guidelines for Spinal Manipulation

   a) Payment for covered spinal manipulation is limited to no more than 26 spinal manipulations per Benefit Period, or the maximum benefit listed in your Schedule of Benefits, whichever occurs first.

   b) Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

Your Schedule of Benefits sets forth the maximum dollar amount that we will pay for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if you may have only been administered two (2) of your spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy dollar maximum with other Services.

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

The term "established patient," as used in this category, 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.

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Exclusion:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet other than through a health care communication services vendor that has entered into a contract with BCBSF are not covered. 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**

Preventive adult wellness Services are covered. For purposes of this benefit, an adult is 17 years or older. Preventive adult wellness Services include:

1. annual physical and/or gynecological exam, including family planning/contraceptive Services; and
2. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory Services, and immunizations.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Adult Health Care of the U.S. Preventive Services Task Force, or the Advisory Committee on Immunization Practices established under the Public Health Service Act.

Exclusion:

Routine vision and hearing examinations and screenings are not covered.

Please refer to your Schedule of Benefits for any applicable benefit maximums or limitations on preventive adult wellness Services.

**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, the U.S. Preventive Services Task Force, or the Advisory Committee on Immunization Practices established under the Public Health Service Act.

Expenses for these Services are not subject to the 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:

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

Covered Prosthetic Devices (except cardiac pacemakers, and Prosthetic Devices incident to Mastectomy) are limited to the first 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.

Exclusion:

1. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g. C-legs); and
2. Expenses for cosmetic enhancements to artificial limbs.

**Self-Administered Prescription Drugs**

Unless otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet, only Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

**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 and cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the “What Is Not Covered?” section);
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (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.

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Exclusion:

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other Service primarily for your convenience, that of your family members and/or the Provider are excluded. Expenses for any inpatient days beyond the per person maximum listed on your Schedule of Benefits are also excluded.

**Substance Dependency**

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 your Schedule of Benefits.

Exclusion:

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

**Surgical Assistant Services**

Services are covered when 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.

**Surgical Procedures**

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

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;

   Exclusion:

   Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies is excluded.
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.

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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 is subject to the Cost Share amount (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 for the surgical procedure.

**Transplant Services**

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to us, and are 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-12.001 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 transplant;

SAMPLE

8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung 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 ID Card in order to determine which Bone Marrow Transplants are covered under this Booklet.

Exclusion:

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-12.001 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.

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# Section 3: What Is Not Covered?

## Introduction

Your Booklet expressly excludes expenses for 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 or any other section of the Benefit Booklet.

**Abortions** which are elective.

**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, and appliances, or other Health Care Services, except as 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 and preparation of any form and/or medical information.

SAMPLE

**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 purpose 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 dental Services covered under the Dental Services and Child Cleft Lip and Cleft Palate Treatment Services categories of 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. Drugs prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also 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 to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required).
   d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit.
   e. defined by, and covered under, a BCBSF Pharmacy Program Endorsement to this Booklet.
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.

SAMPLE

4. Any drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject,). The exception described in exclusion number one does not apply to sexual dysfunction drugs excluded under this paragraph.
5. Any Self-Administered Prescription Drug which is otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet except for a Self-Administered Prescription Drug indicated as covered in the "What Is Covered?" section of this Benefit Booklet.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
   a. emergency stabilization;
   b. during a covered inpatient stay, or
   c. when proximately related to a surgical procedure.
7. The exceptions to the exclusion for drugs purchased or dispensed by a pharmacy described in exclusion number two do not apply to hemophilia drugs excluded under this subparagraph.
8. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.

**Experimental or Investigational Services**, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category in the "What Is Covered?" section.

**Food and Food Products** whether prescribed or not, except as covered in the Enteral Formulas category of the "What Is Covered?" section.

**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. This exclusion does not apply to Services otherwise covered under the Diabetes Outpatient Self-Management category of the "What Is Covered?" section of this Booklet.

**General Exclusions** include, but are not limited to:

1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. any Health Care Service not within the Covered Services Categories described in the "What Is Covered?" section, or any Endorsement attached hereto, unless such Services are specifically required to be covered by applicable law;
3. any Health Care Service 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 defined in this Booklet and determined by us. The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service;
5. any Health Care Service rendered at no charge;
6. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;

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7. any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a. war or an act of war, whether declared or not;
    b. your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes riot, or rebellion;
    c. your engaging in an illegal occupation;
    d. Services received at military or government facilities;
    e. Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or
    f. Services that are not patient-specific, as determined solely by us.
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 Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

**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 (care provided during delivery and childbirth), and post-partal (care provided to the mother following delivery and childbirth) 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.

**Immunizations** except those covered under the Preventive Child Health Supervision Services or Preventive Adult Wellness Services categories of the “What Is Covered?” section.

**Oral Surgery** except as provided under the “What Is Covered?” section.

**Orthomolecular Therapy** including nutrients, vitamins, and food supplements.

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

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

SAMPLE

**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 set forth in the "What Is Covered?" section.

**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 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 Service 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.

SAMPLE

**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 any applicable Cost Share 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.

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# 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 purpose 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 judgment 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. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service. Please refer to the "Definitions" section for the definition of "Medically Necessary or Medical Necessity".**

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# 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.

## Deductible Requirements

### Individual Deductible

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

### Family Deductible

If your plan includes a family Deductible, after the family Deductible has been met by your family, neither you nor your Covered Dependents will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward the individual Deductible, if applicable. Please see your Schedule of Benefits for more information.

**Note:** Please see your Schedule of Benefits for more information on your Cost Share amounts.

## Copayment Requirements

Covered Services rendered by certain Providers or at certain locations or settings may 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 that are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your plan. In some cases, when our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you may be responsible for the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

### Office Services Copayment

If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office must be paid by you, for each office visit before any payment will be made by us. The office Services Copayment applies regardless of the reason for the office visit and applies to all Covered Services rendered during that visit, with the exception of Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Office Services Copayment, as set forth on your Schedule of Benefits.

### Inpatient Facility Services Copayment

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

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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 your Schedule of Benefits for more information.

**Outpatient Facility Services Copayment**

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 and the Services received. Please see your Schedule of Benefits for more information.

**Emergency Room Facility Services Copayment**

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 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 your 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.

For example, if the In-Network Coinsurance for your plan were 80%, the Coinsurance percentage that would be used as a base for Covered Services as described above would be between 70% and 80% of the Allowed Amount. In this example, the Coinsurance percentage used as the basis for payment would not be less than 70% of the Allowed Amount.

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## Out-of-Pocket Maximums

### Individual Out-of-Pocket Benefit Period Maximum

Once you have reached the individual out-of-pocket maximum amount listed in your Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period.

### Family Out-of-Pocket Benefit Period Maximum

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

**Note:** The Deductible, any applicable Copayments and Coinsurance amounts will accumulate toward the out-of-pocket Benefit Period maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket Benefit Period maximums. Any applicable Cost Share amounts under the Prescription Drug coverage, will not apply to the Deductible or the out-of-pocket maximums under this Booklet. Amounts applied to the Out-of-Network out-of-pocket maximum will not be applied to the In-Network out-of-pocket maximums.

## Prior Coverage Credit

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

### Prior Coverage Credit for Deductible

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

### Prior Coverage Credit for Coinsurance

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

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

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

## 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 your Schedule of Benefits (e.g., the lifetime maximums and Benefit Period 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 the Small Employer.

## How we will Credit Benefit Maximums

Except as described below, only the amounts actually paid by us for Covered Services will be credited toward applicable benefit maximums (e.g., Benefit Period maximums and lifetime maximum). The amounts we pay that are credited toward your Benefit Period maximums and your lifetime maximum will be based on our Allowed Amount for the Covered Services provided.

If your Booklet is amended by a BCBSF Pharmacy Program Endorsement, all amounts paid under such BCBSF Pharmacy Program Endorsement will also be applied to your lifetime maximum, if applicable.

Under certain agreements we have with Providers, we may pay the Provider a set monthly amount per individual to cover the cost of providing Covered Services to you, whether or not care is actually provided during that month. This form of payment is called “capitation”. In these instances, when you receive Covered Services from such a Provider, the amounts we will credit toward any applicable benefit maximums, and the lifetime maximum, will be the amount we would have paid (based on our Allowed Amount then in effect) had the Provider not been paid on a capitated basis

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# Section 6: Health Care 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 your Schedule of Benefits and the BlueOptions 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 Deductible and/or Coinsurance amounts for Covered Services.

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

## 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. 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.

## 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 your 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.

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 Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians):

- Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs.

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- 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.
- 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-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.

## 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 on our website at www.bcbsfl.com; and/or
3. call the customer service phone number in this Contract or on your ID Card.

## 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.

## 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.

### Physicians

When you receive Covered Services from a Physician you will be responsible for the applicable Cost Share amount set forth in your Schedule of Benefits. Several factors will determine your out-of-pocket expenses including whether the Physician is In-Network or Out-of-Network, the location of service, the type of Service rendered, and the Physician's specialty (as determined by us).

Refer to your Schedule of Benefits to determine the applicable Cost Share amount you are responsible for paying for Physician Services.

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| | In-Network | Out-of-Network |
|---|---|---|
| **What expenses are you responsible for paying?** | • Any applicable Copayments, Deductible(s) and/or Coinsurance requirements;<br>• Expenses for Services which are not covered;<br>• Expenses for Services in excess of any benefit maximum limitations;<br>• 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<br>• 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

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rendered. You are also responsible for determining the corresponding payment options, if any, at the time the Health Care Services are rendered.

**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.

In-Network Hospitals have been divided into two groups, which are referred to as “options” on your 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 Cost Share amount you are responsible for paying for Hospital Services.

**Specialty Pharmacy**

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

Using the Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications, while helping to preserve your benefits. Please refer to the Medication Guide for a list of Specialty Pharmacies.

**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.

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.

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## 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 Small Employer Master Policy.

We will, when applicable honor an assignment of your right to receive payment for Covered Services to a Provider in accordance with Section 627.638(2) *Florida Statutes* or other applicable statute then in effect. A written attestation of the assignment of benefits may be required.

SAMPLE

# 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.

SAMPLE

# 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, Substance Abuse, Hospice, Inpatient Rehabilitation, Long Term Acute Care (LTAC) 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 website at www.bcbsfl.com; and/or
3. call the customer service phone number in this Booklet or on your ID 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 Hospital, Psychiatric, Substance Abuse, Hospice, Inpatient Rehabilitation, LTAC and 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 facility if we have been notified of your admission. For an admission outside of Florida, you or the facility 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 facility may notify us of your admission by calling the customer service phone number on your ID Card.

### Out-of-Network

For admissions to an Out-of-Network Hospital, Psychiatric, Substance Abuse, Hospice, Inpatient Rehabilitation, LTAC or Skilled Nursing Facility, you or the 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 facility may notify us of your admission by calling the customer service phone number on your ID Card.

## Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, Hospice, Inpatient Rehabilitation, LTAC and Skilled Nursing Facility 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, after your

SAMPLE

discharge, or as part of a review of an episode of care when you are transferred from one level of inpatient care to another for ongoing treatment. 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, including in advance of a transfer from one inpatient facility to another for ongoing treatment. We will provide notification to your Physician, when inpatient coverage criteria are 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. These 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 a specific Health Care Service if:

1. they fail to submit the Health Care Service for a focused prospective review when required under the terms of their agreement with us; **or**
2. we perform a focused review under the focused utilization management program and we determine that a Health Care Service is not Medically Necessary in accordance with our Medical Necessity criteria or inconsistent with our benefit guidelines then in effect unless the following exception applies.

   <u>Exception for Certain NetworkBlue Physicians</u>

   Certain NetworkBlue Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only may bill you for Services determined to be not Medically Necessary by BCBSF under this focused utilization management program if, before you receive the Service:

   a. they give you a written estimate of your financial obligation for the Service;
   b. they specifically identify the proposed Service that BCBSF has determined not to be Medically Necessary; and
   c. you agree to assume financial responsibility for such Service.

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## Prior Coverage Authorization/ Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you are responsible for paying under this Benefit Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for:

1. certain **Provider-administered drugs**, as denoted with a special symbol in the Medication Guide;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging; and
3. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by us.

Prior coverage authorization requirements vary, depending on whether Services are rendered by an In-Network Provider or an Out-of-Network Provider, as described below:

**In-Network Providers**

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

**Out-of-Network Providers**

1. In the case of **Provider-administered drugs**, it is your sole responsibility to comply with our prior coverage authorization requirements when you use an Out-of-Network Provider **before** the drug is purchased or administered. **Your failure to obtain prior coverage authorization will result in denial of coverage for such drug, including any Service related to the drug or its administration.**

   For additional details on how to obtain prior coverage authorization, and for a list of Provider-administered drugs that require prior coverage authorization, please refer to the Medication Guide.

2. In the case of **advanced diagnostic imaging Services** such as CT scans, MRIs, MRA and nuclear imaging, it is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** the advanced diagnostic imaging Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

   For additional details on how to obtain prior coverage authorization for advanced diagnostic imaging Services, please call the customer service phone number on the back of your ID Card.

3. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. Failure to obtain prior coverage authorization or provide pre-service notification may result in denial of the claim or application of a financial penalty assessed at

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the time the claim is presented for payment to us. The penalty applied will be the lesser of $500 or 20% of the total Allowed Amount of the claim. The decision to apply a penalty or deny the claim will be made uniformly and will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

Once the necessary medical documentation has been received from you and/or the Out-of-Network Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

BCBSF will provide you information for any Out-of-Network Health Care Service subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Out-of-Network Services becoming subject to a prior coverage authorization or pre-service notification program.

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

**Note:** Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

## 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 primarily on members who suffer from a catastrophic illness or injury. In the event you meet our case management guidelines, we may, in our sole discretion, assign a Personal Case Manager to you to help you coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the personal case management program, we may 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.

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**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 customer service phone number on your ID 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 Small Employer.

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# Section 9: Pre-existing Condition Exclusion Period

## Definitions

The following definitions will be referred to for purposes of this Pre-existing Condition Exclusion Period section. You should pay particular attention to the definition of Pre-existing Condition because it will vary depending upon the size of the group and whether you have Creditable Coverage that will reduce the Pre-existing Condition exclusionary period.

**For Small Employers with two or more employees or with one employee that has Creditable Coverage that will reduce the Pre-existing Condition exclusion period:**

**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 the Waiting Period for initial enrollees; or
2. your Effective Date of coverage under the Small Employer Master Policy for special and annual enrollees.

**For a Small Employer with one employee who does not have Creditable Coverage that will reduce the Pre-existing Condition exclusion period:**

**Pre-existing Condition** means any Condition that, during the 24-month period immediately preceding your Effective Date of coverage, has manifested itself in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received for that Condition. Pregnancy is a Pre-existing Condition when inception of the pregnancy preceded the Effective Date of your coverage regardless of whether you knew you were pregnant prior to the Effective Date.

**Definition Applicable to All Small Employers:**

**Genetic Information** 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 Exclusion Period

The Pre-existing Condition exclusionary period will vary based upon the size of the Small Employer and whether or not you have Creditable Coverage.

**For Small Employers with two or more employees or with one employee with Creditable Coverage that will reduce the Pre-existing Condition exclusion period:**

There is no coverage under this Small Employer Master Policy 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 Policy for a 12-month period. This 12-month Pre-existing Condition exclusion period

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begins on the first day of the Waiting Period (your Enrollment Date) if you are an initial enrollee, or on your Effective Date of coverage if you are a special or annual enrollee.

**For a Small Employer with one employee who does not have Creditable Coverage that will reduce the Pre-existing Condition exclusion period:**

There is no coverage under this Small Employer Master Policy 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 Small Employer Master Policy for a 24-month period. This 24-month Pre-existing Condition exclusionary period begins on your Effective Date of coverage.

### Pre-existing Conditions Differences by Small Employer Size At a Glance

| **Small Employers with…** | **two** or more employees | **one** employee **with** Creditable Coverage | **one** employee **without** Creditable Coverage |
|---|---|---|---|
| **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:<br>1. the first day of the Waiting Period for initial enrollees; or<br>2. your Effective Date of coverage under the Small Employer Master Policy for special and annual enrollees. | | any Condition that during the 24-month period immediately preceding your Effective Date of coverage, has manifested itself in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received for that Condition. Pregnancy is a Pre-existing Condition when inception of the pregnancy preceded the Effective Date of your coverage regardless of whether you knew you were pregnant prior to the Effective Date. |
| **Duration of Exclusionary Period…** | 12 months | | 24 months |
| **Exclusionary Period begins on…** | • the first day of the Waiting Period (your Enrollment Date) if you are an initial enrollee, or<br>• your Effective Date of coverage if you are a special or annual enrollee. | | • your Effective Date of coverage. |

## Exceptions to the Pre-existing Condition Exclusion Period

The Pre-existing Condition exclusion period does not apply to:

1. a newborn child or an Adopted newborn child;

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2. an Adopted child or child placed for Adoption;
3. Genetic Information in the absence of a diagnosis of the Condition;
4. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
5. Conditions arising from domestic violence;
6. you, if you were covered under the Small Employer's prior medical plan on the date immediately preceding the Effective Date of coverage under the Small Employer Master Policy;
7. Drugs that are covered and payable under a BCBSF Pharmacy Program Endorsement issued with and part of this Benefit Booklet.

The term Drug used above shall have the same definition as that set forth in any retail pharmacy Endorsement issued with and part of this Benefit Booklet.

In addition to the above list, the Pre-existing Condition exclusion period does not apply to pregnancy for:

1. a Small Employer with two or more employees or one employee who has Creditable Coverage; or
2. a Small Employer with one employee who has Creditable Coverage that will reduce the Pre-existing Condition exclusionary period.

## Reducing the Pre-existing Condition Exclusion Period

You may be able to reduce or even eliminate the Pre-existing Condition exclusion period if you have prior Creditable Coverage.

If you are enrolling when you are first eligible for coverage, or during an Annual Enrollment Period or Special Enrollment Period, and you have no more than a 63-day break in Creditable Coverage as of your Enrollment Date under this Small Employer Master Policy, your Pre-existing Condition exclusion period will be reduced by the amount of prior Creditable Coverage you have.

If you have no Creditable Coverage, or if you have a break in coverage of 63 days or more between your Creditable Coverage and your Enrollment Date, then the full Pre-existing Condition exclusion period will apply.

## Proving Creditable Coverage

You may provide certification of Creditable Coverage or a Prior/Concurrent Coverage Affidavit to prove the amount of time you were covered under Creditable Coverage. Prior health insurers and/or group health plans are required to provide you with certification of Creditable Coverage 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, you must provide us some other evidence of Creditable Coverage such as a copy of an identification card or health insurance bill from a prior carrier and attest to the amount of time you were covered under the Creditable Coverage.

The Small Employer must notify you of your right to show that you had prior Creditable Coverage to reduce the Pre-existing Condition exclusion period. You may ask that your Small Employer assist you in obtaining a certificate from any prior plan, such as by a telephone call from your Small Employer to a prior employer or insurer verifying Creditable Coverage.

SAMPLE

# 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 Small Employer. 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 Small Employer Application;
3. The employee must have completed any applicable Waiting Period identified on the Small Employer Application; and
4. The employee must meet any additional eligibility requirements identified on the Small Employer 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 Small Employer, provided such companies and the Small Employer are under common control; and
4. other individuals as determined by us and the Small Employer (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 Small Employer prior to such expansion, and may be subject to different Rates.

## Eligibility Requirements for Dependents

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 Domestic Partner when the Covered Employee has completed and submitted any required forms to the Small Employer and the Small Employer has determined the Domestic Partnership eligibility requirements have been met;

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3. 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) who:
    a. is under the age of 25 or has not reached the end of the Calendar Year in which he or she reaches age 25 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program); and
        i. is dependent upon the Covered Employee for financial support; and
            1. living in the household of the Covered Employee or a full-time or part-time student; or
            2. 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. has reached the end of the Calendar Year in which he or she becomes 25, but has not reached the end of the Calendar Year in which he or she becomes 30, and who:
        i. is unmarried and does not have a dependent;
        ii. is a Florida resident or a full-time or part-time student;
        iii. is not enrolled in any other health coverage policy or plan; and
        iv. is not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.
    c. in the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 30, as a Covered Dependent if the dependent child is:
        i. otherwise eligible for coverage under the Small Employer 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 30th birthday.

    This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

    Or

4. the Covered Domestic Partner's dependent child(ren), who meets all of the following eligibility requirements, and the eligibility requirements for Eligible Dependents listed in item number 3 of this subsection, who:
    a. resides regularly with the Covered Employee and the Domestic Partner, or the Domestic Partner is required to provide coverage for the Eligible Dependent child(ren) by court order; or
    b. qualifies as the Domestic Partner's dependent(s) for tax purposes under the federal guidelines; and
    c. meets and continues to meet the eligibility requirements as outlined in this section.

SAMPLE

5. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 25. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

**Note:** If a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 25, obtains a dependent of their own (e.g., through birth or adoption), such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage. 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.

Covered Domestic Partners and/or Covered Dependents of Domestic Partners are not entitled to continuing coverage but, may be entitled to apply for a conversion policy as set forth in the "Conversion Privilege" section of this Benefit Booklet.

**Exception for Students on Medical Leave of Absence from School**

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a Physician-certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes under this Booklet for the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Booklet.

SAMPLE

# 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 Small Employer.
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 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 to us on a timely basis. 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 the Small Employer, 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 the Small Employer, 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 the Small Employer's program. Such types may include:

| Coverage Type | Provides Coverage for: |
|---|---|
| **Employee Only** | the Eligible Employee only |
| **Employee/ Spouse** | the Eligible Employee and the employee's spouse under a legally valid existing marriage |
| **Employee/ Child(ren)** | the Eligible Employee and the employee's eligible children only |
| **Employee/ Family** | 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 Small Employer.

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## 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 Small Employer'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 Small Employer. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for Eligible Dependents will be the same as the Covered Employee's Effective Date.
2. An individual who becomes an Eligible Employee after the Small Employer'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 Small Employer 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 Small Employer. The Effective Date of coverage for a newborn child shall 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.

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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.

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 who has not reached the end of the Calendar Year in which he or she becomes 25 will automatically terminate 18 months after the birth of the newborn child. For a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 25, if the Covered Dependent child obtains a dependent of their own (e.g., through birth or Adoption) such newborn child will not be eligible for this coverage and cannot enroll. Further, the Covered Dependent child will also lose his or her eligibility for this coverage.

**Adopted Newborn Child** – To enroll an Adopted newborn child, the Covered Employee must submit any Enrollment Form through the Small Employer to us. The Effective Date of coverage for an Adopted newborn child eligible for coverage, shall 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. We must be notified, in writing, and 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.

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

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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 (other than an Adopted newborn 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 or Foster Child (other than an Adopted newborn child) shall be the date such Adopted or Foster Child is placed in the residence of the Covered Employee pursuant to Florida law. If timely notice is given, no additional Premium will be charged for coverage of the Adopted child or Foster Child for the duration of the notice period. Any Pre-existing Condition exclusion 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 deemed necessary by us 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 Small Employer, 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 your responsibility as the Covered Employee to notify us if the Adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child 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 your responsibility as the Covered Employee to notify us in writing that the Foster Child is no longer in your care. Upon receipt of this notification, we will terminate the coverage of the child on the date provided by the Small Employer 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 and submit the Enrollment Form through the Small Employer 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 by you for a minor child under their plan. To apply for coverage, the Covered Employee must complete and submit an Enrollment Form through the Small Employer and forward it to us. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of

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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 Dependents 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 Dependent(s) 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 Dependent(s) must complete the applicable Enrollment Form and forward it to the Small Employer within the time periods noted below for each special enrollment event.

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage if one of the following special enrollment events occurs and the applicable Enrollment Form is submitted to the Small Employer within the indicated time periods:

1. If you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Program (CHIP) or Medicaid, see #3 below), or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:
    - 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
    - you lost your other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) 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; and
    - you submit the applicable Enrollment Form to the Small Employer within 30 days of the date your coverage was terminated

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**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.

or

2. If 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 you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption and you submit the applicable Enrollment Form to the Small Employer within 30 days of the date of the event.

   or

3. If you or your Eligible Dependent(s) lose coverage under a CHIP or Medicaid due to loss of eligibility for such coverage or become eligible for the optional state premium assistance program and you submit the applicable Enrollment Form to the Small Employer within 60 days of the date such coverage was terminated or the date you become eligible for the optional state premium assistance program.

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

### Rehired Employees

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

### 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 Small Employer of such amount. In no event shall an individual be covered under this Small Employer Master Policy if we do not receive the applicable Premium payment within such time period.

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# 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 Small Employer 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 Small Employer 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 Small Employer 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;
    a. as further clarification for purposes of this subsection, a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 25, but who has not reached the end of the Calendar Year when the Covered Dependent child becomes 30, will lose coverage if the Covered Dependent child incurs any of the following:
        i. marriage;
        ii. no longer resides in Florida or is no longer a full-time or part-time student;
        iii. obtains a dependent (e.g. through birth or adoption); or
        iv. obtains other coverage.
5. on the date specified by the Small Employer 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 Small Employer.

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 Small Employer, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

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## 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 you or on your behalf; or
3. misuse of the ID 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 Small Employer's responsibility to immediately notify you of termination of the Small Employer 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 exclusion 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. You may call the customer service phone number indicated in this Booklet or on your ID Card to request the certification.

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).

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# Section 13: Continuing Coverage

## Introduction

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

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

This section provides a description of both federal and Florida law continuation of coverage requirements. Contact your Small Employer to determine what continuation law is applicable to you.

Covered Domestic Partners and/or Covered Dependents of Domestic Partners are not entitled to continuing coverage but, may be entitled to apply for one of our conversion policies as set forth in the "Conversion Privilege" section of this Benefit Booklet.

## Federal Continuation of Coverage Law

A federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to the Small Employer. If COBRA applies to the Small Employer, 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 Small Employer to determine if you or your Covered Dependents are entitled to COBRA continuation of coverage. The Small Employer 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 Small Employer or you fail to meet your obligations under COBRA and this Small Employer Master Policy, we will not be liable for any claims incurred by you or your Covered Dependents after your 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 Small Employer are met by the purchase of the Small Employer Master Policy; the duty to meet such obligations remains with the Small Employer.

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

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

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***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. You must supply notice of the disability determination to the Small Employer 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 Covered Dependent child may elect the 36-month extension if the Covered Dependent child ceases to be an Eligible Dependent under the terms of the Small Employer Master Policy.

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

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

1. The Small Employer must notify you of your continuation of coverage rights under COBRA within 14 days of the event that creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify the Small Employer, in writing, within 60 days of any of these events. The Small Employer'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 Small Employer.
3. COBRA coverage will terminate if you become covered under any other group health plan. However, COBRA coverage may continue if the new group health 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 SSA that you are no longer disabled. You must inform the Small Employer of the SSA's determination within 30 days of such determination.
6. You must meet all Premium payment requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, as described in the Small Employer Master Policy.

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7. The Small Employer must continue to provide group health coverage to its employees.

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

**Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Small Employer 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 Small Employer.**

## Florida Continuation of Coverage Law

Section 627.6692, *Florida Statutes,* known as the Florida Health Insurance Coverage Continuation Act, requires that a Small Employer, who does not qualify for COBRA coverage, offer you the opportunity for a temporary extension of health coverage (called "continuation of coverage") in certain instances where coverage under the Small Employer Master Policy would otherwise end. The Small Employer may not qualify for COBRA coverage for many reasons, including, but not limited to, the Small Employer employs fewer than 20 employees or is a state or local government plan, or church plan.

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

**Initial Notice to Choose Continuation of Coverage:**

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

**Types of Qualifying Events**

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

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

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

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

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

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1. the death of the Covered Employee;
2. the termination of the Covered Employee employment (for reasons other than gross misconduct) or a reduction in the Covered Employee's hours of employment;
3. parents' divorce or legal separation;
4. the Covered Employee becomes entitled to Medicare; or
5. the dependent ceases to be a Covered Dependent under the terms of the Small Employer Master Policy.

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

**Notice Requirements**

You must inform Coverage Continuation Service (CCS) of any qualifying event under the Small Employer Master Policy. **This notification must be postmarked no later than 63 days after the date of the qualifying event that would cause a loss of coverage.**

The notice must be in writing and include:

1. the name and address of the qualified beneficiary;
2. the social security number of the qualified beneficiary;
3. the name of the Small Employer;
4. the insurance carrier's name;
5. one of the applicable qualifying event as listed above;
6. the date of the qualifying event;
7. the daytime telephone number of the qualified beneficiary;
8. the Covered Employee's social security number;
9. the Small Employer Master Policy number; and
10. the name and address of all other qualified beneficiaries.

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

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

If you chose continuation of coverage, the coverage will be identical to the coverage provided under the Small Employer Master Policy to similarly situated individuals. The law requires that you be given the

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opportunity to maintain continuation coverage for 18 months. However, the law also provides that your continuation of coverage may be terminated for any of the following reasons:

1. the Small Employer no longer provides group health coverage to any of its employees;
2. the premium for your continuation of coverage is not paid within 30 days;
3. after electing continuation of coverage, you become covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any Pre-existing Condition; or
4. after electing continuation of coverage, you are approved for Medicare.

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

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

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

Coverage Continuation Service (CCS)
P. O. Box 534088
St. Petersburg, Florida 33747-4088
Telephone: 888-342-5888
Fax: 727-865-3649

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

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# 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 Small Employer Master Policy, and/or under another group policy with your Small Employer, that provided similar benefits immediately prior to the Small Employer Master Policy; and
2. your coverage was terminated for any reason, including discontinuance of the Small Employer 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 Cost Share 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 coverage under the Small Employer Master Policy terminated. If coverage has been terminated due to the non-payment of premium by the Small Employer, 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 Small Employer 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 the contribution required by the Small Employer for coverage under the Small Employer Master Policy on a timely basis;
3. the Small Employer 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. any of the following apply to you:
    a. 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 that are similar to the benefits provided under this Booklet; or
    b. 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

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c. 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

The benefits provided under the sources referred to in paragraph 4.a. or the benefits provided or available under the source referred to in paragraph 4.b. and 4.c. 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.

## Other Provisions Regarding Conversion

1. 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.
2. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under the Small Employer Master Policy terminated.
3. Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws.
4. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Booklet.
5. When applying for our converted policy, you have two options:
   a. a converted policy providing major medical coverage meeting the requirements of 627.6675(10) *Florida Statutes*; or
   b. 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*.
6. In any event, we will not be required to issue a converted policy unless required to do so by Florida law, however we may have other options available to you. Call the phone number on your ID card for more information.

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# Section 15: Extension of Benefits

## Extension of Benefits

In the event the Small Employer 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 Small Employer Master Policy is terminated. The extension of benefits described in this section does not apply when your coverage terminates and the Small Employer 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 Small Employer 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 Small Employer 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 Small Employer 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 Small Employer 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 Small Employer 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 Small Employer 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.

SAMPLE

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

3. In the event you are pregnant as of the termination date of the Small Employer Master Policy, we will provide a limited extension of the maternity expense benefits covered under this Booklet, provided the pregnancy commenced while the pregnant individual was covered under the Small Employer 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.

SAMPLE

# Section 16: Medicare Secondary Payer Provisions

When you become covered under Medicare and continue to be eligible and covered under the Small Employer 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. If we are the primary payer, claims for Covered Services should be filed with us first.

Under Medicare, your Small Employer MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, your Small Employer 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 Small Employer.

## 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.

## 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 Small Employer Master Policy.
2. We will not be liable to the Small Employer or to any individual covered under the Small Employer Master Policy on account of any nonpayment of primary benefits resulting from any failure of performance of the Small Employer '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 Small Employer to reimburse us for such payments. Alternatively, we may require the Small Employer to pay the Rate differential that resulted from the Small Employer's failure to provide us with the required information in a timely manner.

SAMPLE

# Section 17: Duplication of Coverage

## 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 organizations;
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage with which the law permits us to coordinate benefits;
4. Medicare, as described in the "Medicare Secondary Payer" 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.

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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.

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## 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.

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# Section 18: Subrogation and Right of Reimbursement

## 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 out of such money any payments we 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 motorist coverage and Workers' Compensation. 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.

## 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.

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# Section 19: 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.

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## Types of Claims

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

## Post-Service Claims

### How to File a Post-Service Claim

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.

NetworkBlue Providers and Traditional Insurance 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 codes;
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis codes;
5. the Provider's name and address;
6. the name of the individual who received the Service; and
7. 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 the Small Employer purchased retail pharmacy Prescription Drug coverage, please refer to the Pharmacy Program Endorsement for information on the processing of Prescription Drug claims. 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 for additional information.

**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 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 reasons for contesting the claim or a portion of the claim; and 3) the date we reasonably expect to notify you of the decision. The notice may also indicate whether additional information is

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needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request. **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 or portions of the claim and the reasons 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 *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 phone 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.

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### 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 given to provide the 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. 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:

1. we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
2. the reduction or termination occurs before the end of such previously approved time or number of Services; and
3. 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 in this section. In no event shall we

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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 we need additional information; or 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:

1. the specific reason or reasons for the Adverse Benefit Determination;
2. 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;
3. a description of any additional information that might change the determination and why that information is necessary;
4. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
5. 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

Except as described below, only you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the review process described below. Your appeal must be submitted to us in writing for an internal appeal within 365 days of the original Adverse Benefit Determination, except in the case of

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Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. We must receive your appeal of an Adverse Benefit Determination in person or in writing;
2. 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;
3. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request, 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.
4. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination;
5. We may consult with appropriate Physicians, as necessary;
6. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request; and
7. 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.
8. If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.bcbsfl.com or by calling the number on the back of your ID Card.
9. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service, or the Experimental or Investigational nature of a Service, you have the right to an independent external review through the External Review Organization designated in the How to Request External Review of Our Appeal Decision subsection. Your right to an External Review applies only when the Service is actually rendered by Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.).

<u>Your request for appeal should be sent to the address below:</u>

Blue Cross and Blue Shield of Florida, Inc.
Attention Member Appeals
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:

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1. Pre-Service Claims: within 30 days of our receipt of your appeal; or
2. Post-Service Claims: within 60 days of the receipt of your appeal; or
3. Claims Involving Urgent Care: (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of our receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested 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.

## Your Rights under Florida Statute 627.6141

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.

## How to Request External Review of Our Appeal Decision

If you are not satisfied with our internal review of your appeal of an Adverse Benefit Determination based on the lack of Medical Necessity or Experimental or Investigational nature of a Service you received from Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.), you may appeal our decision through an External Review Organization. Our denial letter will provide information regarding this External Review Organization.

Only Adverse Benefit Determinations based on the lack of Medical Necessity or Experimental or Investigational nature of a Service you actually received will be reviewed by the External Review Organization.

The External Review Organization's determination with respect to your appeal shall be binding upon you, your Physician, and us.

## Additional Claims Processing Provisions

### Release of Information/Cooperation

In order to process claims, we may need certain information, including information regarding other health care coverage you may have. 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.

### 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.

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### 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.

### 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.

### 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:

1. The specific reason or reasons for the Adverse Benefit Determination;
2. 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;
3. A description of any additional information that would change the initial determination and why that information is necessary;
4. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
5. 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.

### 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.

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# Section 20: 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 Small Employer will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

## BCBSF and the Small Employer

Neither the Small Employer 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 Small Employer and we will not be liable for any acts or omissions, or those of the Small Employer, its agents, servants, employees, or any person or organization with which the Small Employer 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 you, 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.

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# Section 21: 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 in this section. 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.

## Amendment

The terms of coverage and benefits to be provided by us may be amended at renewal of the Small Employer Master Policy, without the consent of the Small Employer, you or any other person, upon 45 days prior written notice to the Small Employer. In the event the amendment is unacceptable to the Small Employer, the Small Employer may terminate the Small Employer 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 Small Employer 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 Small Employer unless such amendment is evidenced in writing and signed by a duly authorized officer of BCBSF. The Small Employer 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 our written consent. We may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without the consent of the Small Employer 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 Small Employer. Payments submitted to us following receipt of any such written notice of modification constitutes acceptance by the Contractholder of any such modification.

## Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under the Small Employer 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.

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## 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.

## 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).

## Customer Rewards Programs

From time to time, we may offer programs to our customers that provide rewards for following the terms of the program. We will tell you about any available rewards programs in general mailings, member newsletters and/or on our website. Your participation in these programs is completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $25 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

## Evidence of Coverage

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

## 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 website address www.FloridaHealthFinder.gov, may be accessed through the link provided on Blue Cross and Blue Shield of Florida's website at www.bcbsfl.com.

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## Governing Law

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

## Identification Cards

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

## Modification of Provider Networks and Participation Status

The Provider networks, 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 Small Employer. 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 Small Employer 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.

## 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 Small Employer 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.

<u>If to us:</u>

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

<u>If to you:</u>

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

You must notify us immediately of any address change.

<u>If to the Small Employer:</u>

To the address indicated on the Small Employer Application.

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## Our Obligations upon Termination

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

## ERISA

We are not the plan sponsor or plan administrator of your Group Plan, as defined by ERISA. If the Group Plan under which you are covered is subject to the Employee Retirement Income Security Act (ERISA), the Small Employer, 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.

## 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.

## 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.

## Third Party Beneficiary

The Small Employer Master Policy under which this Benefit Booklet was issued was entered into solely and specifically for the benefit of BCBSF and the Small Employer. The terms and provisions of the Small Employer Master Policy shall be binding solely upon, and inure solely to the benefit of BCBSF and the Small Employer, and no other person shall have any rights, interest or claims hereunder or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. BCBSF and the Small Employer 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 Small Employer Master Policy or this Benefit Booklet.

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# Section 22: Definitions

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

**Adoption or Adopt(ed)** means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as otherwise defined by Florida law or similar applicable laws of another state.

**Adverse Benefit Determination** means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this 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 the "Claims Processing" 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 an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services

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provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by BCBSF that may be based on several factors including (but not necessarily limited to): (i) payment for such Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by BCBSF, with BCBSF's provider network strategies (e.g., does not result in payment that encourages Providers participating in a BCBSF network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard (Out-of-State) Program, the Allowed Amount for the specific Covered Services provided to you may be based upon the amount provided to BCBSF by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating Providers in its geographic area for such Services.

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 phone 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 this Booklet apply. You should refer to the "What Is Covered?" section of this Booklet and the Schedule of Benefits to determine what is covered and how much we will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between such Allowed Amount and the amount billed for such Services by any such Out-of-Network Provider.

**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 Small Employer 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.

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

**Benefit Period** means a consecutive period of time, specified by BCBSF and the Small Employer, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your Benefit Period is listed on your Schedule of Benefits, and will not be less than 12 months.

**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 or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider 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).

**Breast Reconstructive Surgery** means surgery to reestablish symmetry between the two breasts.

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**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, we will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

**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.

**Convenient Care Center** means a properly licensed ambulatory center that: 1) treats a limited number of common, low-intensity illnesses when ready access to the patient's primary Physician is not possible; 2) shares clinical information about the treatment with the patient's primary Physician; 3) is usually housed in a retail business; and 4) is staffed by at least one master’s level nurse (ARNP) who operates under a set of clinical protocols that strictly circumscribe the Conditions the ARNP can treat. Although no Physician is present at the Convenient Care Center, medical oversight is based on a written collaborative agreement between a supervising Physician and the ARNP.

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

**Cost Share** means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost Share may

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include, but is not limited to Coinsurance, Copayment, Deductible amounts. Applicable Cost Share amounts are identified in your Schedule of Benefits.

**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 Small Employer Master Policy other than as a Covered Employee (See the Eligibility Requirements for Dependents 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 Small Employer 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.

**Creditable Coverage** means health care coverage which is continuous to a date within 63 days of your Enrollment Date. Such health care coverage 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. Children's Health Insurance Program (CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

**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.

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**Deductible** means the amount of charges, up to the Allowed Amount, for Covered Services, which you must actually pay to an appropriately 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.

**Domestic Partner** means a person of the same or opposite gender with whom the Covered Employee (employee only) has established a Domestic Partnership.

**Domestic Partnership** means a relationship between a Covered Employee (employee only) and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent and have resided together continuously in the same residence for at least 12 months prior to applying for coverage under this Benefit Booklet and intend to continue to reside together indefinitely;
5. the Covered Employee has submitted to the Small Employer acceptable proof of evidence of common residence and joint financial responsibility; and
6. the Covered Employee has completed and submitted any required forms to the Small Employer and the Small Employer has determined the Domestic Partnership eligibility requirements have been met.

**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.

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**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 Small Employer, 12:01 a.m. on the date specified on the Small Employer Application. With respect to individuals covered under this Small Employer Master Policy, 12:01 a.m. on the date the Small Employer 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 an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependents subsection of the "Eligibility for Coverage" section in this Benefit Booklet and is eligible to enroll as a Covered Dependent.

**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 Small Employer Master Policy or this Booklet issued by BCBSF. Endorsements are also sometimes referred to as amendments.

**Enrollment Date** means the date of enrollment of the individual under the Small Employer 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 Small Employer 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. credible scientific 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

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5. credible scientific 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. credible scientific 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.

"Credible scientific 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.**

**External Review Organization** means an external organization that is chosen by BCBSF in its sole discretion to conduct external reviews as described herein.

**FDA** means the United States Food and Drug Administration.

SAMPLE

**Foster Child** means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health and Rehabilitative Services in compliance with *Florida Statutes* or by a similar 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.

**Generally Accepted Standards of Medical Practice** means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**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 Plan** means the employee welfare benefit plan established by the Small Employer.

**Health Care Service or Services** includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services actually rendered or supplied, by or at the direction of, a licensed Provider, to a specific individual covered under this Booklet.

**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.

SAMPLE

**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 cards 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 Small Employer Master Policy.

**Independent Clinical Laboratory** means a laboratory, independent of a Hospital or Physician's office, which is a fixed location, properly licensed pursuant to Chapter 483 of the *Florida Statutes*, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

**Independent Diagnostic Testing 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 laws or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an Independent Diagnostic Testing 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.

SAMPLE

**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 Emergency** means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

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

**Medically Necessary** or **Medical Necessity** means that, with respect to a Health Care Service, a Physician, exercising prudent clinical judgment, provided the Health Care Service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was:

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and
3. not primarily for your convenience, or that of your Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness.

**Note:** It is important to remember that any review of Medical Necessity by us is solely for the purpose of determining coverage or benefits under this Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

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

**Medication Guide** for purposes of this Booklet means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

**Note:** The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service phone number on your Identification Card.

SAMPLE

**Mental Health Professional** means a person properly licensed to provide Mental Health Services, pursuant to Chapter 491 of the *Florida Statutes*, or a similar applicable law of another state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling Services.

**Mental and Nervous Disorder** means any disorder listed in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

**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

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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 59-A, *Florida Administrative Code* or a 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 Therapist** means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the *Florida Statutes*, or a similar applicable law of another state.

**Physical Therapy** means 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.

**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.

**Physician Specialty Society** means a United States medical specialty society that represents diplomates certified by a board recognized by the American Board of Medical Specialties.

**Post-Service Claim** means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the "Claims Processing" section.

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

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**Premium** means the total amount required to be paid by the Small Employer to BCBSF in order for there to be coverage under the Small Employer Master Policy.

**Prescription** means an order for drugs, Services or supplies by a Physician or other health care professional authorized by law to prescribe such drugs, Services or supplies.

**Prescription Drug** means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".

**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.

**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.

**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.

**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(s)** means the amount BCBSF charges the Small Employer for each type of coverage under the Small Employer 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 function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

**Self-Administered Prescription Drug** means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

**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

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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.

**Small Employer** means any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employs an average of at least one but not more than 50 Eligible Employees on business days during the preceding Calendar Year the majority of whom are employed in the state of Florida, and employs at least one employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance, through which coverage and/or benefits are issued by us, and through which Eligible Employees and Eligible Dependents become entitled to the Covered Services described herein. In determining the number of Eligible Employees, companies that are an affiliated group as defined in s. 1504 (a) of the Internal Revenue Code of 1986, as amended, are considered a single employer.

**Small Employer Application** means the BCBSF application form, including the underwriting questionnaire form, if any, that the Small Employer must submit to BCBSF when requesting the issuance of the Small Employer Master Policy.

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

**Sound Natural Teeth** means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

**Specialty Drug** means an FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs are identified with a special symbol in the Medication Guide.

**Specialty Pharmacy** means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to provide specific Prescription Drug products, as determined by us. In-Network Specialty Pharmacies are listed in the Medication Guide.

The fact that a pharmacy is a participating pharmacy does not mean that it is a Specialty Pharmacy.

**Speech Therapist** means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the *Florida Statutes*, or a similar applicable law of another state.

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

**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.

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**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.

**Traditional Program** means, or refers to, BCBSF 's Provider contracting programs called Payment for Professional Services (PPS) and Payment for Hospital Services (PHS).

**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 Small Employer 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.

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# BlueScript® Pharmacy Program Endorsement

This Endorsement and the BlueScript Pharmacy Program Schedule of Benefits are to be attached to, and made a part of, your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet. The Benefit Booklet is hereby amended by adding the following BlueScript Pharmacy Program provisions.

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

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 reference that refers 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 BCBSF.

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## Introduction

Under this Endorsement, we provide coverage to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this Endorsement, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as applicable, indicated on the BlueScript Pharmacy Program Schedule of Benefits.

In the Medication Guide, you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. You may be able to reduce your out-of-pocket expenses by: 1) using Participating Pharmacies; 2) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.bcbsfl.com, call the customer service phone number on your ID Card, or refer to the Pharmacy Program Provider Directory then in effect.

## Covered Prescription Drugs and Supplies and Covered OTC Drugs

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

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license;
2. dispensed by a Pharmacist;
3. Medically Necessary;
4. in the case of a Self-Administered Injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a Covered Self-Administered Injectable Prescription Drug;

5. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide;
6. a Prescription Drug contained in an anaphylactic kit (e.g., Epi-Pen, Epi-Pen Jr., Ana-Kit);
7. authorized for coverage by us, if prior coverage authorization is required by us as indicated with a unique identifier in the Medication Guide, then in effect;
8. not specifically or generally limited or excluded herein or by the Benefit Booklet; and
9. approved by the FDA, and assigned a National Drug Code.

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

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

## Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs

In providing benefits under this Endorsement, we may apply the benefit guidelines set forth below, as well as any other applicable reimbursement rules specific to particular Covered Services listed in the Benefit Booklet.

**Contraceptive Coverage**

Prescription diaphragms, oral contraceptives and contraceptive patches will be covered under this Endorsement.

Exclusion

Contraceptive injectable Prescription Drugs and implants (e.g., Norplant, IUD) inserted for any purpose, are excluded from coverage under this Endorsement.

**Covered Over-the-Counter (OTC) Drugs**

Select OTC Drugs, listed in the Medication Guide, may be covered when you obtain a Prescription for the OTC Drug from your Physician. Only those OTC Drugs listed in the Medication Guide are covered.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed on our website at www.bcbsfl.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

**Diabetic Coverage**

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this Endorsement. Insulin is **only** covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting insulin are covered only when prescribed in conjunction with insulin.

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

Exclusion

All Supplies used in the treatment of diabetes except those that are Covered Prescription Supplies are excluded from coverage under this Endorsement.

**Mineral Supplements, Fluoride or Vitamins**

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

1. prenatal vitamins;
2. oral single-product fluoride (non-vitamin supplementation);
3. sustained release niacin;
4. folic acid;
5. oral hematinic agents;
6. dihydrotachysterol; or
7. calcitriol.

Exclusion

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

## Limitations and Exclusions

**Limitations**

Coverage and benefits for Covered Prescription Drugs and Supplies and Covered OTC Drugs are subject to the following limitations in addition to all other provisions and exclusions of your Benefit Booklet:

1. We will not cover more than the Maximum supply, as set forth in the BlueScript Pharmacy Program Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs.
2. We will not cover amounts in excess of the lifetime maximum for your health plan, as indicated in your Schedule of Benefits.
3. Prescription refills beyond the time limit specified by state and/or federal law are not covered.
4. Certain Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
5. Specialty Drugs (self-administered and provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

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6. Retin-A or it's generic or therapeutic equivalent is excluded after age 26.

**Exclusions**

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific subsection of the "What Is Covered?" section of your Benefit Booklet, which this Endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a Hospital).
2. Except as covered in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for insulin and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this Endorsement.
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes); regardless of the intended use (except for Covered Prescription Supplies).
7. Prescription Drugs and Supplies and OTC Drugs that are:
   a. in excess of the limitations specified in this Endorsement or on the BlueScript Pharmacy Program Schedule of Benefits;
   b. furnished to you without cost;
   c. Experimental or Investigational;
   d. indicated or used for the treatment of infertility;
   e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova;
   f. prescribed by a Pharmacist;
   g. used for smoking cessation (e.g., Chantix, Nicorette, Zyban);
   h. listed in the Homeopathic Pharmacopoeia;
   i. not Medically Necessary;
   j. indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number 11 does not apply to sexual dysfunction drugs excluded under this paragraph;
   k. purchased from any source (including a pharmacy) outside of the United States;
   l. prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America;

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m. OTC Drugs not listed in the Medication Guide; and

n. Self-Administered Injectable Prescription Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependant peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses. Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.

9. Any appetite suppressant, Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control.

10. Immunization agents, biological sera, blood and blood plasma.

11. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. This exclusion also 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 cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce.

13. Drugs that do not have a valid National Drug Code.

14. Drugs that are compounded except those that have at least one active ingredient that is an FDA-approved Prescription Drug with a valid National Drug Code.

15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:

    a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

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b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by: 1) American Medical Association; 2) National Heart Lung and Blood Institute; 3) American Cancer Society; 4) American Heart Association; 5) National Institutes of Health; 6) American Gastroenterological Association; 7) Agency for Health Care Policy and Research; or

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

16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by:

    a. American Medical Association;

    b. National Heart Lung and Blood Institute;

    c. American Cancer Society;

    d. American Heart Association;

    e. National Institutes of Health;

    f. American Gastroenterological Association;

    g. Agency for Health Care Policy and Research;

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

17. Any amount you are required to pay under this Endorsement as indicated on the BlueScript Pharmacy Program Schedule of Benefits.

18. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance.

19. Self-prescribed Drugs or Supplies and Drugs or Supplies prescribed by any person related to you by blood or marriage.

20. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.

21. Food or medical food products, whether prescribed or not.

22. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a. the Drug is no longer marketed;

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

    c. the Drug is available Over-the-Counter (OTC);

    d. the Drug has a preferred formulary alternative;

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

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

g. the number of members affected by the change.

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

## Payment Rules

Under this Endorsement, the amount you must pay for Covered Prescription Drugs and Supplies or Covered OTC Drugs may vary depending on:

1. the participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. the terms of our agreement with the Pharmacy selected;
3. whether you have satisfied the Pharmacy Deductible, if any, and the amount of Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance set forth in the BlueScript Pharmacy Program Schedule of Benefits;
4. whether the Prescription Drug is a Generic Prescription Drug or a Brand Name Prescription Drug or Covered OTC Drug;
5. whether the Prescription Drug is on the Preferred Medication List;
6. whether the Prescription Drug is purchased from the Mail Order Pharmacy;
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and
8. If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
   a. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the Cost Share amount that applies to Non-Preferred Prescription Drugs, as indicated in your BlueScript Pharmacy Program Schedule of Benefits; **and**
   b. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Non-Preferred Prescription Drugs are subject to a higher Cost Share amount, as set forth in the BlueScript Pharmacy Program Schedule of Benefits.

We reserve the right to add, remove or reclassify any Prescription Drug in the Medication Guide at any time.

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## Pharmacy Alternatives

For purposes of this Endorsement, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

**Participating Pharmacies**

Participating Pharmacies are Pharmacies participating in our BlueScript Pharmacy Program, or a National Network Pharmacy belonging to our Pharmacy Benefit Manager, at the time you purchase Covered Prescription Drugs and Supplies and/or Covered OTC Drugs. Participating Pharmacies have agreed not to charge, or collect from you, for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug more than the amount set forth in the BlueScript Pharmacy Program Schedule of Benefits.

With BlueScript, there are four types of Participating Pharmacies:

1. Pharmacies in Florida that have signed a BlueScript Participating Pharmacy Provider Agreement with us;
2. National Network Pharmacies;
3. Specialty Pharmacies; and
4. the Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.bcbsfl.com, call the customer service phone number included in your Benefit Booklet or on your ID Card, or refer to the Pharmacy Program Provider Directory then in effect.

Prior to purchase, you must present your BCBSF ID Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that we, in fact, cover you.

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by a Participating Pharmacy are less than the required Copayment, the amount you will pay depends on the agreement then in effect between the Pharmacy and us and will be one of the following:

1. The usual and customary charge of such Pharmacy as if it were not a Participating Pharmacy;
2. The charge under the Pharmacy's agreement with us; or
3. The Copayment if less than the usual and customary charge of such Pharmacy.

**Specialty Pharmacy**

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

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications, while helping to preserve your benefits.

The Specialty Pharmacies designated, solely by us, are the only "In-Network" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any

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Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueScript Pharmacy Program.

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

**Mail Order Pharmacy**

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

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

**Non-Participating Pharmacies**

A Non-Participating Pharmacy is a Pharmacy that has not agreed to participate in our BlueScript Participating Pharmacy Program and that is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Our payment to you for Covered Prescription Drugs and Supplies and Covered OTC Drugs is based upon our Non-Participating Pharmacy Allowance. Non-Participating Pharmacies have **not** agreed to accept our Participating Pharmacy Allowance or our Pharmacy Benefit Manager's Participating Pharmacy Allowance as payment in full less any applicable Cost Share amounts due from you.

You may be responsible for paying the full cost of the Covered Prescription Drugs and Supplies and Covered OTC Drugs at the time of purchase and must submit a claim to us for reimbursement. Our reimbursement for Covered Prescription Drugs and Supplies will be based on the Non-Participating Pharmacy Allowance less the Pharmacy Deductible, if any, and the Copayment or percentage of the Non-Participating Pharmacy Allowance set forth in the Out-of-Network Cost Share column in the BlueScript Pharmacy Program Schedule of Benefits.

In order to obtain reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs purchased at a Non-Participating Pharmacy, you must obtain an itemized paid receipt and submit it with a properly completed claim form (with any required documentation) to:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Prescription Drug Program
P. O. Box 1798
Jacksonville, Florida 32231

## Pharmacy Utilization Review Programs

Our pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and Supplies and OTC Drugs.

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

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**Note**: If coverage is not available, or is limited, this does not mean that you cannot obtain the Prescription Drug, Supply or OTC Drug from the Pharmacy. It only means that we will not cover or pay for the Prescription Drug, Supply or OTC Drug. You are always free to purchase the Prescription Drug, Supply or OTC Drug at your sole expense.

Our pharmacy utilization review programs include the following:

**Responsible Steps**

Under this program, we may exclude from coverage certain Prescription Drugs and OTC Drugs unless you have first tried designated Drug(s) identified in the Medication Guide in the order indicated. In order for there to be coverage for such Prescription Drugs and OTC Drugs prescribed by your Physician, we must receive written documentation from you and your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Prior to filling your Prescription, your Physician may, but is not required to, contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

**Dose Optimization Program**

Under this program, we may exclude from coverage any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

**Prior Coverage Authorization Program**

You are required to obtain prior coverage authorization from us in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **Failure to obtain authorization will result in denial of coverage.** Prescription Drugs and Supplies and OTC Drugs requiring prior coverage authorization are designated in the Medication Guide.

For additional details on how to obtain prior coverage authorization refer to the Medication Guide.

Information on our pharmacy utilization review programs is published in the Medication Guide at www.bcbsfl.com, or you may call the customer service phone number on your ID Card. Your Pharmacist may also advise you if a Prescription Drug requires prior coverage authorization.

## Ultimate Responsibility for Medical Decisions

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

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug, Supply or OTC Drug, must be made solely by you and your treating

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Physician in accordance with the patient/physician relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug, Supply or OTC Drug is needed, appropriate, or desirable, even though such Prescription Drug, Supply or OTC Drug may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if we have indicated that coverage and payment will not be made for such Prescription Drug, Supply or OTC Drug.

## Definitions

Certain important terms applicable to this Endorsement are set forth below. For additional applicable definitions, please refer to the definitions in the Benefit Booklet that this Endorsement amends.

**Average Wholesale Price ("AWP")** means the average wholesale price of a Prescription Drug at the time a claim is processed as established by BCBSF based upon its utilization of a national drug database as determined by BCBSF, provided that any such national drug database must be accepted in the industry as a provider of average wholesale price, or similar pricing, data on a national scale.

**Brand Name Prescription Drug** means a Prescription Drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer drug, or a drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the drug under a generic or other non-proprietary name.

**Covered OTC Drug** means an Over-the-Counter Drug that is designated in the Medication Guide as a Covered OTC Drug.

**Covered Prescription Drug** means a Drug, which, under federal or state law, requires a Prescription and which is covered by this Endorsement.

**Covered Prescription Drug(s) and Supply(ies)** means Covered Prescription Drugs and Covered Prescription Supplies.

**Covered Prescription Supply(ies)** means only the following Supplies:

1. syringes and needles prescribed in conjunction with insulin, or a covered Self-Administered Injectable Prescription Drug which is authorized for coverage by us;
2. syringes and needles prescribed in conjunction with a Prescription Drug authorized for coverage by us;
3. syringes and needles which are contained in anaphylactic kits (e.g., Epi-Pen, Epi-Pen, Jr., Ana Kit); or
4. Prescription Supplies used in the treatment of diabetes limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

**Day Supply** means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

**Dispensing Fee** means the fee a Pharmacy is paid for filling a Prescription in addition to payment for the Drug.

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**Drug** means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

**FDA** means the United States Food and Drug Administration.

**Generic Prescription Drug** means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either 1) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or 2) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of BCBSF, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic Drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Prescription Drug.

**Mail Order Copayment** means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug and Covered Prescription Supply as set forth in the BlueScript Pharmacy Program Schedule of Benefits.

**Mail Order Pharmacy** means the Pharmacy that has signed a Mail Services Prescription Drug Agreement with us.

**Maximum** means the amount designated in our Medication Guide as the Maximum, including but not limited to, frequency, dosage and duration of therapy.

**Medication Guide** means the guide then in effect issued by us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Preferred Brand Name Prescription Drugs; and Non-Preferred Prescription Drugs. The Medication Guide does not list all Non-Preferred Prescription Drugs due to space limitations, but some Non-Preferred Prescription Drugs and potential alternatives are provided for your information. The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service phone number on your ID Card for current information.

**National Drug Code (NDC)** means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

**National Network Pharmacy** means a Pharmacy located outside of Florida that is part of the national network of Pharmacies established by our contracting Pharmacy Benefit Manager.

**Non-Participating Pharmacy** means a Pharmacy that has not agreed to participate in our BlueScript Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

**Non-Participating Pharmacy Allowance** means the amount upon which payment in such situations will be based for Covered Prescription Drugs and Supplies and Covered OTC Drugs:

1. In the case of Generic Prescription Drugs and Supplies and OTC Drugs, the Non-Participating Pharmacy Allowance shall be approximately 33 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable drug is less, the amount billed.

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2. In the case of Brand Name Prescription Drugs and Supplies, the Non-Participating Pharmacy Allowance shall be approximately 82 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable drug is less, the amount billed.

It is further provided, however, that if either: 1) a national drug database then used by BCBSF makes a "material modification" to its AWP data (as determined by BCBSF), or; 2) BCBSF elects to utilize a new national drug database, BCBSF may modify the 33 percent of AWP figure and/or the 82 percent of AWP figure set out above so that the applicable modified figure sets out a replacement percent figure that is between: 1) the percent figure calculated to approximate the applicable Non-Participating Pharmacy Allowance in effect immediately prior to the applicable AWP database change, and; 2) the 33 percent of AWP figure or the 82 percent of AWP figure, whichever is applicable.

**Non-Preferred Prescription Drug** means a Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect.

**One-Month Supply** means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's dosing recommendations. Certain Drugs, e.g. Specialty Drugs, may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

**Over-the-Counter (OTC) Drug** means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

**Participating Pharmacy** means, as to Pharmacies located in Florida, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to participate in the BlueScript Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

**Participating Pharmacy Allowance** means the maximum amount allowed to be charged by a Participating Pharmacy per Prescription for Covered Prescription Drug, Covered Prescription Supply or Covered OTC Drug under this Endorsement.

**Pharmacist** means a person properly licensed to practice the profession of Pharmacy pursuant to Chapter 465 of the *Florida Statutes*, or a similar law of another state that regulates the profession of Pharmacy.

**Pharmacy** means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the *Florida Statutes,* or a similar law of another state, where Pharmacist dispenses Prescription Drugs.

**Pharmacy Benefit Manager** means an organization that has established, and manages, a pharmacy network and other pharmacy management programs for third party payers and employers which has entered into an arrangement with us to make such a network and/or programs available to you.

**Pharmacy Deductible** means the amount of allowed charges for Covered Prescription Drugs and Supplies and Covered OTC Drugs that you must actually pay per Calendar Year, in addition to any applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, to a Pharmacy, who is recognized for payment under this Endorsement, before our payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs begins.

**Pharmacy Out-of-Pocket Maximum** means the maximum amount you will be required to pay per Calendar Year for Covered Prescription Drugs and Supplies and Covered OTC Drugs. Any benefit penalty reductions, non-covered charges or any charges in excess of the Participating Pharmacy

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Allowance or Non-Participating Pharmacy Allowance will not accumulate toward the pharmacy out-of-pocket maximum.

**Preferred Brand Name Prescription Drug** means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug.

**Preferred Generic Prescription Drug** means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide.

**Preferred Medication List** means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which we provide coverage and benefits, subject to the exclusions of this Endorsement. The Preferred Medication List is contained within the Medication Guide.

**Preferred Prescription Drug** means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained within the Medication Guide.

**Prescription** means an order for Drugs, or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or supplies.

**Prescription Drug** means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of this Endorsement, insulin is considered a Prescription Drug because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

**Self-Administered Injectable Prescription Drug** means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding insulin. Covered Self-Administered Injectable Prescription Drugs are denoted with a symbol in the Medication Guide.

**Specialty Drug** means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy. Specialty Drugs are identified with a special symbol in the Medication Guide.

**Specialty Pharmacy** means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to participate in the BlueScript Pharmacy Program, to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

**Supply(ies)** means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, bandages, cotton swabs, and similar items.

**Three-Month Supply** means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer's dosing recommendations.

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This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

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# BlueOptions Self-Administered Prescription Drugs Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

## SCHEDULE OF BENEFITS

The **Schedule of Benefits** is amended by adding the following benefit maximum:

Self-Administered Specialty Drugs (Out-of- Network only) per Benefit Period..... $1,000

## WHAT IS COVERED?

The **Self-Administered Prescription Drugs** category is deleted in its entirety and replaced with the following:

**Self-Administered Prescription Drugs**

The Following Self-Administered Drugs are covered:

1. Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g., anaphylaxis), or in the administration of dialysis; and
2. Self-Administered Prescription Drugs identified as Specialty Drugs with a special symbol in the Medication Guide when delivered to you at home and purchased at a Specialty Pharmacy or an Out-of-Network Provider that provides Specialty Drugs.

   Specialty Drugs used to increase height or bone growth (e.g., growth hormone), must meet the following criteria in order to be covered:

   a. Must be prescribed for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   b. Continuation of growth hormone therapy only covered for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth

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hormone dependent peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses. Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

**Note:** Specialty Drugs purchased from an Out-of-Network Provider for delivery to you at home will be subject to the benefit maximum set forth in the Schedule of Benefits.

## WHAT IS NOT COVERED?

The **Drugs** exclusion is amended as follows:

Exclusion number five is deleted in its entirety and replaced with the following:

5. Any Self-Administered Prescription Drug except when indicated as covered in the "What Is Covered?" section of this Benefit Booklet.

The following **exclusion** is added:

8. Specialty Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. (See "What is Covered?" section for additional information.)

## BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/Pre-Service Notification Programs** subsection is amended as follows:

The second paragraph is deleted in its entirety and replaced with the following:

You or your Provider will be required to obtain prior coverage authorization from us for:

1. certain **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging; and
3. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by us.

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The **Out-of-Network** category is amended by deleting item #1 in its entirety and replacing it with the following:

1. In the case of **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization, it is your sole responsibility to comply with our prior coverage authorization requirements when you use an Out-of-Network Provider **before** the Prescription Drug is purchased or administered. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Prescription Drug, including any Service related to the Prescription Drug or its administration.**

   **Exception:** Self-Administered Prescription Drugs, identified as Specialty Drugs with a special symbol in the Medication Guide, do not require prior authorization when purchased from an Out-of-Network Provider for delivery to you at home.

   For additional details on how to obtain prior coverage authorization, and for a list of Prescription Drugs that require prior coverage authorization, please refer to the Medication Guide.

The **Out-of-Network** category is amended by adding the following note after the last paragraph:

**Note:** Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

## DEFINITIONS

The **Definitions** section is amended as follows:

The following definition is added:

**Medical Emergency** means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

The "Specialty Drug" definition is deleted in its entirety and replaced with the following:

**Specialty Drug** means an FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

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This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Benefit Booklet including any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

The Benefit Booklet is amended as described below to comply with the Patient Protection and Affordable Care Act (PPACA), H.R. 3590, otherwise known as the Affordable Care Act.

This Endorsement is effective at your group plan's initial effective date occurring on or after **September 23, 2010** or first Anniversary Date occurring on or after **September 23, 2010** whichever occurs first.

## WHAT IS COVERED?

The following **new** category is added:

**Emergency Services**

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

When Emergency Services for an Emergency Medical Condition are rendered by an Out-of-Network Provider, any Copayment and/or Coinsurance amount applicable to In-Network Providers for Emergency Services will also apply to such Out-of-Network Provider.

Special Payment Rules for Non-grandfathered Plans

The Patient Protection and Affordable Care Act (PPACA) requires that non-grandfathered health plans apply a specific method for determining the allowed amount for Emergency Services rendered for an Emergency Medical Condition by Providers who do not have contract with us.

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider will be the greater of:

1. the amount equal to the median amount negotiated with all BCBSF In-Network Providers for the same Services;
2. the Allowed Amount as defined in this Booklet;
3. the usual and customary Provider charges for similar Services in the community where the Services were provided; or
4. what Medicare would have paid for the Services rendered.

In no event will Out-of-Network Providers be paid more than their charges for the Services rendered. **If your plan is a grandfathered health plan under PPACA, these payment guidelines do not apply to your plan.** If you are not sure whether or not your health plan is grandfathered, please contact your

SAMPLE

Group. If your plan is not grandfathered, payment will be based on the Allowed Amount as defined in the "Definitions" section.

The **Hospice Services** category is deleted in its entirety and replaced with the following:

**Hospice Services**

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

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

Recertification is required every six months.

The **Outpatient Therapies and Spinal Manipulation Services** subsection is amended by deleting the last paragraph of the Payment Guidelines for Spinal Manipulation subsection in its entirety and replacing it with the following:

Your Schedule of Benefits sets forth the maximum number of visits covered under this plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if you may have only been administered two (2) of your spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy visit maximum with other Services.

The **Preventive Adult Wellness Services** category, if included in your Benefit Booklet, is deleted in its entirety and replaced with the following. If the **Preventive Adult Wellness Services** category is not included in your Benefit Booklet, the following category is added.

**Preventive Adult Wellness Services**

Preventive adult wellness Services are covered under your plan. For purposes of this benefit, an adult is 17 years or older.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

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

SAMPLE

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph number one above.

The **Preventive Child Health Supervision Services** category is deleted in its entirety and replaced with the following:

**Preventive Child Health Supervision Services**

Preventive Child Health Supervision Services from the moment of birth up to the 17th birthday are covered.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

## WHAT IS NOT COVERED?

The **Drugs** exclusion is amended by deleting number three in its entirety and replacing it with the following:

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, except as described in the Preventive Adult Wellness Services and Preventive Child Health Supervision Services categories of the "What Is Covered?" section.

The **Genetic Screening** exclusion is deleted in its entirety and replaced with the following:

**Genetic screening**, including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition, except as provided under the Preventive Adult Wellness Services category of the "What Is Covered?" section.

SAMPLE

# BLUEPRINT FOR HEALTH PROGRAMS

The following new subsection is added:

### Prior Coverage Authorization/Pre-Service Notification Programs for Mental Health and Substance Dependency Care and Treatment Services

You or your Physician will be required to obtain prior coverage authorization from us for Mental Health and Substance Dependency Care and Treatment Services.

**In-Network Providers**

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

**Out-of-Network Providers**

It is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** Mental Health and Substance Dependency Care and Treatment Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

For additional details on how to obtain prior coverage authorization for Mental Health and Substance Dependency Care and Treatment Services, please call the customer service phone number on your ID Card.

Once the necessary medical documentation has been received from you and/or the Out-of-Network Provider, BCBSF will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

**Note:** Prior coverage authorization is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

# PRE-EXISTING CONDITIONS EXCLUSION PERIOD

The list of **Exceptions to the Pre-existing Condition Exclusionary Period** is deleted in its entirety and replaced with the following:

The Pre-existing Condition exclusion period does not apply to:

1. a Covered Person who is under the age of 19 as of the effective date of this Endorsement, or if enrolled thereafter, is under the age of 19 at the time of enrollment;

SAMPLE

2. Genetic Information in the absence of a diagnosis of the Condition;
3. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
4. Conditions arising from domestic violence;
5. you, if you were covered under the Small Employer's prior medical plan on the date immediately preceding the Effective Date of coverage under the Small Employer Master Policy; or
6. Drugs that are covered and payable under a BCBSF Pharmacy Program Endorsement issued with and part of this Booklet.

# ELIGIBILITY FOR COVERAGE

The **Eligibility Requirements for Dependents** subsection is deleted in its entirety and replaced with the following:

**Eligibility Requirements for Dependents**

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 Domestic Partner when the Covered Employee has completed and submitted any required forms to the Small Employer and the Small Employer has determined the Domestic Partnership eligibility requirements have been met;
3. The Covered Employee's or Covered Domestic Partner's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee or Covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan.
   a. in the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 30, as a Covered Dependent if the dependent child is:
      i. otherwise eligible for coverage under the Small Employer 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 30th birthday.

      This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

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

SAMPLE

**Note:** It is your sole responsibility as the Covered Employee to establish that a child meets the applicable requirements for eligibility.

# ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

The **Dependent Enrollment** subsection is amended by deleting the note at the end of the Newborn Child subsection in its entirety and replacing it with the following:

**Note:** Coverage for a newborn child of a Covered Dependent child who has not reached the limiting age will automatically terminate 18 months after the birth of the newborn child.

# TERMINATION OF COVERAGE

The **Termination of a Covered Dependent's Coverage** subsection is deleted in its entirety and replaced with the following:

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

1. on the date the Small Employer Master Policy terminates;
2. on the date Covered Employee's coverage terminates for any reason;
3. on the last day of the Calendar Year that the Covered Dependent child no longer meets the eligibility requirements;
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 Small Employer 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 Small Employer.

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 Small Employer, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

The following **new** subsection is added:

## Rescission of Coverage

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

BCBSF may only Rescind the coverage of an individual covered under the Booklet if you or another person on your behalf commit fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

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

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure described in the "Claims Processing" section of your Booklet.

SAMPLE

# CLAIMS PROCESSING

The **Standards for Adverse Benefit Determinations** subsection is amended by deleting the numbered list under **Manner and Content of a Notification of an Adverse Benefit Determination** in its entirety and replacing it with the following:

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

The **How to Appeal an Adverse Benefit Determination** is amended by deleting number nine in its entirety and replacing it with the following:

9. You have the right to an independent external review through an external review organization for certain appeals, as provided in the Patient Protection and Affordable Care Act of 2010.

The **How to Request External Review of Our Appeal Decision** is deleted in its entirety and replaced with the following:

**How to Request External Review of Our Appeal Decision**

If you are not satisfied with our internal review of your appeal of an Adverse Benefit Determination, you should refer to the Adverse Benefit Determination notice or call the customer phone number on your ID Card for information on how to request an external review.

SAMPLE

# DEFINITIONS

The definition of **Adverse Benefit Determination** is deleted in its entirety and replaced with the following:

**Adverse Benefit Determination** means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Benefit Booklet in connection with:

1. a Pre-Service Claim or a Post-Service Claim;
2. a Concurrent Care Decision, as described in the "Claims Processing" section; or
3. Rescission of coverage, as described in the "Termination of Coverage" section.

The definition of **Medical Emergency** is in its entirety and replaced with the following:

**Emergency Medical Condition** means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

The following **new** definitions are added:

**Emergency Services** means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient.

**Rescission or Rescind** refers to BCBSF's action to retroactively cancel or discontinue coverage under the Benefit Booklet. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premiums.

**Stabilize** shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2012 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Benefit Booklet including any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

Except as otherwise noted, your Booklet is amended as described below to comply with the Patient Protection and Affordable Care Act (PPACA), H.R. 3590, otherwise known as the Affordable Care Act. The provisions contained in this Endorsement are effective at your Group's initial effective date occurring on or after **August 1, 2012** or first Anniversary Date occurring on or after **August 1, 2012,** whichever occurs first.

All references to the "**Preventive Adult Wellness Services**" and "**Preventive Child Health Supervision Services**" categories throughout the Booklet are hereby replaced with **"Preventive Health Services"**.

## WHAT IS COVERED?

The **Preventive Adult Wellness Services** and **Preventive Child Health Supervision Services** categories are hereby deleted in their entirety and replaced with the following:

**Preventive Health Services**

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

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

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

SAMPLE

a. well-woman visits;

b. screening for gestational diabetes;

c. human papillomavirus testing;

d. counseling for sexually transmitted infections;

e. counseling and screening for human immune-deficiency virus;

f. contraceptive methods and counseling unless indicated as covered under a BlueScript Pharmacy Program Endorsement section;

g. screening and counseling for interpersonal and domestic violence; and

h. breastfeeding support, supplies and counseling. Breastfeeding supplies are limited to one manual breast pump per pregnancy.

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph number one above. Sterilization procedures covered under this section are limited to tubal ligations only. Contraceptive implants are limited to Intra-uterine devices (IUD) only, including insertion and removal.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® Contraceptive Amendment

This amendment is to be attached to, and made a part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet ("Booklet"). Your BlueScript® Pharmacy Program Endorsement is amended as described below.

This amendment is effective at your Group plan's initial effective date occurring on or after **August 1, 2012** or first Anniversary Date occurring on or after **August 1, 2012** whichever occurs first.

If you have any questions concerning this amendment, please call us toll free at 800-FLA-BLUE.

## COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

**Number 1** is deleted in its entirety and replaced with the following:

1. Prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;

## COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Contraceptive Coverage** category is deleted in its entirety and replaced with the following:

**Contraceptive Coverage**

Prescription diaphragms, oral contraceptives and contraceptive patches will be covered under this Endorsement.

The following are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

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

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

2. Diaphragms indicated as covered in the Medication Guide; and
3. Emergency contraceptives indicated as covered in the Medication Guide.

SAMPLE

Exclusion

Contraceptive injectable Prescription Drugs, and implants (e.g., Norplant, IUD, etc.) inserted for any purpose are excluded from coverage under this Endorsement.

## LIMITATIONS AND EXCLUSIONS

The **Limitations** subsection is amended by deleting exclusion number 6 in its entirety and replacing it with the following: (this change is not related to the Affordable Care Act)

6. Retinoids (e.g., Retin-A) and their generic or therapeutic equivalents are excluded after age 26.

The **Exclusions** subsection is amended by deleting exclusions 3, 10 and 22 in their entirety and replacing them with the following:

3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (i.e., Drugs which do not require a Prescription) except for emergency contraceptives, insulin and Covered OTC Drugs listed in the Medication Guide.
10. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.
22. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:
    a. the Drug is a Repackaged Drug;
    b. the Drug is no longer marketed;
    c. the Drug has been shown to have excessive adverse effects and/or safer alternatives;
    d. the Drug is available Over-the-Counter (OTC);
    e. the Drug has a preferred formulary alternative;
    f. the Drug has a widely available/ distributed AB rated generic equivalent formulation;
    g. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or
    h. the number of members affected by the change.

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

## DEFINITIONS

The **Covered Prescription Supply(ies)** definition is deleted in its entirety and replaced with the following:

**Covered Prescription Supply(ies)** means only the following Supplies:

1. Prescription diaphragms indicated as covered in the Medication Guide;
2. syringes and needles prescribed in conjunction with Insulin, or a covered Self-Administered Injectable Prescription Drug which is authorized for coverage by us;

SAMPLE

3. syringes and needles prescribed in conjunction with a Prescription Drug authorized for coverage by us; or
4. Prescription Supplies used in the treatment of diabetes limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets (unless indicated as not covered on the BlueScript® Pharmacy Program Schedule of Benefits).

The **Non-Preferred Prescription Drug** definition is deleted in its entirety and replaced with the following:

**Non-Preferred Prescription Drug** means a compound drug or Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect.

The **Prescription Drug** definition is deleted in its entirety and replaced with the following:

**Prescription Drug** means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of this Endorsement, emergency contraceptives and insulin are considered a Prescription Drug because, in order to be covered, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

The following **new** definition is added:

**Repackaged Drug(s)** means a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2014 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 1, 2014** or first Anniversary Date occurring on or after **January 1, 2014** whichever occurs first.

The **Table of Contents** is amended by deleting **Pre-Existing Condition Exclusion Period** in its entirety.

## WHAT IS COVERED?

The **Introduction** is amended as follows:

Item number six is deleted in its entirety and replaced with the following:

6. not specifically or generally limited or excluded under this Booklet.

The **Mental Health Services** category is amended by deleting it in its entirety and replacing it with the following:

**Mental Health Services**

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

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

**Exclusion**

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation or diagnosis of learning disabilities or for mental retardation;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;

SAMPLE

8. Services to test aptitude, ability, intelligence or interest;
9. Services required to maintain employment;
10. Services for cognitive remediation;
11. inpatient stays that are primarily intended as a change of environment; and
12. inpatient (overnight) mental health Services received in a residential treatment facility.

The **Preventive Health Services** category is amended by deleting the exclusion in its entirety and replacing it with the following:

**Exclusion**

Routine vision and hearing examinations and screenings are not covered as Preventive Health Services, except as required under paragraph number one and/or number three above. Sterilization procedures covered under this category are limited to tubal ligations rendered in an outpatient setting only. Contraceptive implants are limited to Intra-uterine devices (IUD) indicated as covered in the Medication Guide only, including insertion and removal.

## PRE-EXISTING CONDITION EXCLUSION PERIOD

The **Pre-Existing Condition Exclusion Period** Section is deleted in its entirety.

## ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

The **Dependent Enrollment** subsection is amended by deleting the first paragraph of the **Adopted/Foster Children** subsection in its entirety and replacing it with the following:

**Adopted/Foster Children** – To enroll an Adopted child (other than an Adopted newborn 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 or Foster Child (other than an Adopted newborn child) shall be the date such Adopted or Foster Child is placed in the residence of the Covered Employee pursuant to Florida law. If timely notice is given, no additional Premium will be charged for coverage of the Adopted child or Foster Child for the duration of the notice period. We may require the Covered Employee to provide any information and/or documents deemed necessary by us in order to properly administer this section.

The **Other Provisions Regarding Enrollment and Effective Date of Coverage** category is amended by deleting the **Rehired Employees** subcategory in its entirely and replacing it with the following:

**Rehired Employees**

Individuals who are rehired as employees of the Small Employer are considered newly-hired employees for purposes of this section. The provisions of the Small Employer Master Policy (which includes this Booklet), applicable to newly-hired employees and their Eligible Dependents (e.g., enrollment, Effective

SAMPLE

Dates of coverage and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

## CLAIMS PROCESSING

The **Standards for Adverse Benefit Determinations** subsection is amended by deleting **How to Request External Review of Our Appeal Decision** in its entirety and replacing with the following:

**How to Request External Review of Our Appeal Decision**

If we deny your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational, you are entitled to request an independent, external review of our decision. Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

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

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

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

SAMPLE

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

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

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

# GENERAL PROVISIONS

The following **subsection** is added:

## Care Profile Program – A Payer-Based Health Record Program

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

1. All authorized treating Physicians will have a consolidated view – or history – of your Health Care Services, assisting them in improved decision-making in the delivery of health care.
2. In times of catastrophic events or Emergency Services, the care profile will be accessible from any location by authorized Physicians so that appropriate treatment and Service can still be delivered.
3. Safe and secure transmission of claim information. Only authorized health care Providers or authorized members of the Provider's staff will have access to your information.
4. Coordination of care among your authorized treating health care Providers.
5. More efficient health care delivery for you.

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

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

SAMPLE

# DEFINITIONS

The definition of **Domestic Partnership** is deleted in its entirety and replaced with the following:

**Domestic Partnership** means a relationship between a Covered Employee (employee only) and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent and intend to continue to reside together indefinitely;
5. the Covered Employee has submitted to the Small Employer acceptable proof of evidence of common residence and joint financial responsibility; and
6. the Covered Employee has completed and submitted any required forms to the Small Employer and the Small Employer has determined the Domestic Partnership eligibility requirements have been met.

The definition of **Intensive Outpatient Treatment** is added:

**Intensive Outpatient Treatment** means treatment in which an individual receives at least 3 clinical hours of institutional care per day (24-hour period) for at least 3 days a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

The definition of **Mental and Nervous Disorder** is deleted in its entirety and replaced with the following:

**Mental and Nervous Disorder** means any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD-10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

The definition of **Partial Hospitalization** is deleted in its entirety and replaced with the following:

**Partial Hospitalization** means treatment in which an individual receives at least 6 clinical hours of institutional care per day (24-hour period) for at least 5 days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® Specialty Pharmacy Split Fill Option Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript® Pharmacy Program Endorsement is amended as described below.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **January 1, 2014** or first Anniversary Date occurring on or after **January 1, 2014** whichever occurs first.

If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

## COVERGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The following subcategory is added:

**Specialty Pharmacy: Split Fill Option**

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

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2014 Compliance Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

## WHAT IS COVERED?

The **Preventive Health Services** category is amended by deleting number h under item number 4 in its entirety and replacing it with the following:

h. breastfeeding support, supplies and counseling. Breastfeeding supplies are limited to breast pumps. **You must obtain prior coverage authorization from us before you get the breast pump**. Breast pumps must be obtained through a Durable Medical Equipment Provider who must be able to verify that you are either scheduled for delivery or have delivered within 9 months. In-Network benefits are only available through our preferred Durable Medical Equipment Provider. If you do not obtain prior coverage authorization we will not make any payment for such Service.

The following **Note** is added after number h:

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

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

The **Exclusion** is deleted in its entirety and replaced with following:

Routine vision and hearing examinations and screenings are not covered as Preventive Services, except as required under paragraph number one and/or number three above. Sterilization procedures covered under this category are limited to those procedures indicated as covered in the Medication Guide only. Contraceptive implants are limited to Intra-uterine devices (IUD) indicated as covered in the Medication Guide only, including insertion and removal.

The following limitations are added after the **Exclusion**:

**Limitations**

Breast pumps are limited to:

a. one manual or electric breast pump per pregnancy, in connection with childbirth;

SAMPLE

b. the most cost-effective pump, as determined by us (please see the Durable Medical Equipment category in this section for additional information);

c. hospital-grade breast pumps are not covered except when Medically Necessary during an inpatient stay, in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® Oral Chemotherapy Drug Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"), including any Endorsements attached thereto. This document specifically amends the BlueScript® Pharmacy Program Endorsement is amended as described below.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **July 1, 2014** or first Anniversary Date occurring on or after **July 1, 2014** whichever occurs first.

If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

## COVERGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The following subcategory is added:

**Oral Chemotherapy Drugs**

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed $50 per One-Month when purchased from a Participating Pharmacy.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions COBRA Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective on **December 1, 2014**.

## TERMINATION OF COVERAGE

The **Certification of Creditable Coverage** subsection is deleted in its entirety.

## CONTINUING COVERAGE

All references to Coverage Continuation Services (CCS) are being replaced with BCBSF.

The **Florida Continuation of Coverage Law** subsection is amended by deleting the second paragraph and the address under **Notice Requirements** in their entirety and replacing them with the following.

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

BCBSF
FHICCA/COBRA
P.O. Box 45272
Jacksonville, Florida 32232-5272
Toll Free (855) 509-1678

SAMPLE

## DEFINITIONS

The **Creditable Coverage** definition is deleted in its entirety.

The **Prior/Concurrent Coverage Affidavit** definition is deleted in its entirety.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2016 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2016**.

## WHAT IS COVERED?

**The Emergency Services** category is amended by deleting item number 3 in its entirety.

The **Medical Pharmacy** category is amended by deleting the first paragraph in its entirety and replacing it with the following:

Physician-administered Prescription Drugs which are rendered in a Physician's office may be subject to a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug and does not include the administration of the Prescription Drug.

The **Preventive Health Services** category is amended by deleting the last sentence in item number 4 and items number "a – h" in their entirety, then adding the following after item number 4:

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

The **Exclusion** is deleted in its entirety and replaced with the following:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph one above.

The **Limitations** are deleted in their entirety.

## WHAT IS NOT COVERED?

The **General Exclusions** subsection is amended by deleting item number 3 in its entirety and replacing it with the following:

3. Any Health Care Service you render to yourself or those renedered by a Physician or other health care Provider related to you by blood or marriage.

SAMPLE

It is further amended by deleting items number “b - d” under item number 7 in their entirety and replacing them with the following:

b. your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical condition;

c. your engaging in an illegal occupation; except for an injury resulting from an act of domestic violence or a medical condition;

d. Services received at military or government facilities to treat a condition arising out of your service in the armed forces, reserves and/or National Guard; or

The following **Exclusion** is added:

**Motor Vehicle Accidents** including any costs you incur due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

## UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Emergency Room Facility Services Copayment** section is deleted in its entirety and replaced with the following:

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 your plan includes a Copayment for emergency room Services and you are admitted to an In-Network Hospital as an inpatient at the time of the emergency room visit, this Copayment will be waived, and you will pay the Cost Share that applies to inpatient facility Services.
- If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, please see your Schedule of Benefits for the applicable Cost Share that will apply to that admission.

## DUPLICATION OF COVERAGE

The **Coordination of Benefits** subsection is amended by deleting the fifth paragraph and subsequent numbered list in their entirety and replacing them with the following:

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

1. This plan always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile policy available to you.

SAMPLE

2. When we cover you as a Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
   a. the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;
   b. if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.
4. When we cover you as a dependent child whose parents are not married, or are separated or divorced:
   a. 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 is last;
   c. regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When we cover you as a dependent child and the other plan covers you as a dependent child:
   a. the plan of the parent who is neither laid off nor retired will be primary;
   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini-COBRA), COBRA or FHICCA 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. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary, unless you are age 65 or older and covered under Medicare Parts A and B. In that case, this Booklet will be secondary to Medicare.
8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

SAMPLE

# SUBROGATION AND RIGHT OF REIMBURSEMENT

The **Subrogation and Right of Reimbursement** section is deleted in its entirety and is replaced with the following:

## Subrogation and Right of Reimbursement

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

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

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

By accepting benefits under this Booklet, you specifically acknowledge our right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an accident), and we pay benefits under this Booklet as a result of those injuries, we will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits we have paid. This means that we have the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits we have paid. In order to secure our recovery rights, you agree to assign to us any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of our subrogation and reimbursement claims. This assignment allows us to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this Booklet, you also specifically acknowledge our right of reimbursement. This right of reimbursement attaches when we have paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Booklet, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided under this Booklet. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

By accepting benefits under this Booklet, you or your representatives further agree to:

SAMPLE

- Notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
- Cooperate with us and do whatever is necessary to secure our right of subrogation and reimbursement under this Booklet;
- Give us a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided under this Booklet (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due to us as reimbursement for the full cost of all benefits associated with Third Party Injuries paid under this Booklet (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing;
- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid under this Booklet; and
- Serve as a constructive trustee for the benefits under this Booklet over any settlement.

We may recover the full cost of all benefits paid by us under this Booklet without regard to any claim of fault on your part, whether by comparative negligence or otherwise. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits provided by us under this Booklet in addition to costs and attorney's fees incurred by us in obtaining repayment.

## DEFINITIONS

The following definition is added:

**Preventive Services Guide** means the guide then in effect issued by us that contains a listing of Preventive Services covered under your plan. **Note**: The Preventive Services Guide is subject to change Please refer to our website at www.FloridaBlue.com/healthresources for the most current guide.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® Pharmacy Program New Drug Addition Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2016**.

## COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Covered Prescription Drugs and Supplies and Covered OTC Drugs** section is amended by deleting item number 9 in its entirety and replacing it, then adding item number 10 as follows:

9. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs; and
10. reviewed by our Pharmacy and Therapeutics Committee.

## COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The following subsection is added:

**Preventive Medications**

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

## LIMITATIONS AND EXCLUSIONS

The **Limitations and Exclusions** section is amended by adding the following to the numbered list.

23. New Prescription Drugs.
24. Prescription Drugs used to treat Hepatitis C, except when treating for advanced liver disease as documented by liver fibrosis score of Metavir F3 or F4.

SAMPLE

# DEFINITIONS

The **Definitions** section is amended by adding and/or replacing the following definitions:

**New Prescription Drug(s)** means an FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee resulting in a final coverage determination. New Prescription Drugs includes a new dosage form of a previously FDA approved Prescription Drug. All New Prescription Drugs will be reviewed by the Pharmacy and Therapeutics Committee within 6 months of FDA approval.

**Non-Preferred Prescription Drug** means a Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect. New Prescription Drugs are not a Non-Preferred Prescription Drug.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2017 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2017**.

## WHAT IS COVERED?

The **Ambulance Services** category is amended by deleting it in its entirety and replacing it with the following:

**Ambulance Services**

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

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

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

SAMPLE

Limitations:

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

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

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

Exclusions:

Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

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

The **Dental** category is amended by deleting item number 3b) its entirety and replacing it with the following:

3b) you or your Covered Dependent has 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.

SAMPLE

**The Maternity Services category** is amended by deleting the **Exclusion** in its entirety.

The **Surgical Procedures** category is amended by adding item number 6. as follows:

6. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

Exclusions:

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

a. reduction thyroid chondroplasty;

b. liposuction;

c. rhinoplasty;

d. facial bone reconstruction;

e. face lift;

f. blepharoplasty;

g. voice modification surgery;

h. hair removal/hairplasty; or

i. breast augmentation.

## WHAT IS NOT COVERED?

The **General Exclusions** subsection is amended by deleting item number 7b) in its entirety and replacing it with the following:

7b) your participation in, or commission of, any act punishable by law as a felony whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical condition;

The following **Exclusions** are deleted in their entirety and replaced with the following:

**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,or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, breast augmentation.

**Costs** related to telephone consultations (except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section), failure to keep a scheduled appointment, or completion of any form and/or medical information.

SAMPLE

**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.),except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section.

**Weight Control Services** including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

The **Motor Vehicle Accidents Exclusion** is deleted in its entirety and replaced with the following:

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

The following **Exclusions** are deleted in their entirety: **Maternity Services** and **Sexual Reassignment, or Modification Services**.

## UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Understanding Your Share of Health Care Expenses** section has been amended by adding the following after the first paragraph:

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

## DEFINITIONS

The following definitions are deleted in their entirety: **Gestational Surrogate** and the **Gestational Surrogacy Contract or Arrangement**.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® Pharmacy Program 2017 Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2017**.

## COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Covered Prescription Drugs and Supplies and Covered OTC Drugs** section is amended by deleting the following numbered items in their entirety and replacing them with the following:

3. Medically Necessary, as defined in this Endorsment and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;

6. a Prescription Drug contained in an anaphylactic kit;

The following is added to the numbered list:

11. within the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs section listed in this Endorsement.

## COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs** section is amended by deleting the first paragraph under **Contraceptive Coverage** in its entirety and replacing it with the following:

**Contraceptive Coverage**

Prescription diaphragms, oral contraceptives and contraceptive patches are covered under this Endorsement unless indicated as not covered on the BlueScript® Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Endorsement.

SAMPLE

## LIMITATIONS AND EXCLUSIONS

The **Limitations and Exclusions** section is amended by deleting the following numbered items in their entirety and replacing them with the following:

7g. used for smoking cessation, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section;

19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage;

22d. The Drug, or an effective alternative, is available Over-the-Counter (OTC);

Exclusion number 24. is deleted in its entirety

## DEFINITIONS

The **Definitions** subsection is amended by deleting the following definition in its entirety and replacing it with the following:

**New Prescription Drug(s)** means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee. Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee, resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee, or
2. December 31st of the following Calendar Year.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2018 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2018**.

## WHAT IS COVERED?

The **Ambulance Services** category is deleted in its entirety and replaced with the following:

**Ambulance Services**

Ground Ambulance

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

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

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

SAMPLE

Air and Water Ambulance

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

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

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

**Exclusion**

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

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

The **Emergency Services** category is deleted in its entirety and replaced with the following:

**Emergency Services and Urgent Care Services**

Emergency Services

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

SAMPLE

Urgent Care Services

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

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

The **Physician Services** category is deleted in its entirety and replaced with the following:

**Physician Services**

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility. Certain Physician Services can be rendered electronically through a computer via the Internet (E-Visits). E-Visits are covered when rendered in accordance with the Payment Rules below.

Payment Rules for E-Visits

Expenses for E-Visits are covered only if:

1. you are an established patient of the Physician rendering the Services at the time the Services are provided; and
2. the Services are provided in response to an online inquiry you sent to the Physician.

The term "established patient", as used in this category, shall mean that the covered individual has received professional Services from the Physician who provided the E-Visit, or another Physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

**Exclusion**

1. Expenses for failure to keep a scheduled appointment or scheduled E-visit and for telephone consultations (except as indicated as covered under the Preventive Services category of this section).
2. Telemedicine Services, as defined in this Benefit Booklet.
3. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

The **Prosthetic Devices** category is amended by deleting the exclusion in its entirety and replacing it with the following:

Exclusion

Expenses for cosmetic enhancements to artificial limbs.

SAMPLE

## WHAT IS NOT COVERED?

The **Drugs** exclusion is amended by adding the following:

9. New Prescription Drug(s), as defined in the DEFINITIONS section.
10. Convenience Kits as defined in the DEFINITIONS section.
11. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

The following exclusion is added:

**Telemedicine Services**, as defined in this Benefit Booklet.

## UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Additional Expenses You Must Pay** subsection is amended by adding the following:

**Special Payment Rules**

Emergency Services in an Emergency Room

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

Additionally, payments for Emergency Services by an Out-of-Network Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center; and
- you do not have the ability and opportunity to choose an In-Network Provider at the In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center who is available to treat you; and,
- section 627.64194(3) of the Florida Statutes is applicable to the Services rendered.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

SAMPLE

# BLUEPRINT FOR HEALTH

The **Note** at the end of the **Prior Coverage Authorization /Pre-Service Notification Programs** section is deleted in its entirety and replaced with the following:

**Note:**

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
   a. the termination date of your plan, or
   b. the period authorized by us, as indicated in the letter you receive from us.

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

# DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

The **Coordination of Benefits** subsection is amended by deleting list numbers 4 through 7 of the second numbered list in the section and replacing them with the following:

4. When we cover a dependent child whose parents are not married, or are separated or divorced:
   a. the plan of the parent with custody is primary;
   b. the plan of the remarried parent with custody is primary; the step-parent's plan is secondary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; and
   c. the plan of the parent without custody is last;
   d. regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:
   a. the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

SAMPLE

6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:
   a. first, the plan covering the person as an employee, or as the employee's dependent; and
   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.
7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.

# DEFINITIONS

The following definitions are added:

**Convenience Kits** are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

**E-Visit**, for purposes of the Benefit Booklet, means online assessment and management Services provided to an established patient by a Physician or other qualified health care professional; that does not originate from a related Physician Service rendered within the previous 7 days; using the internet or similar electronic communications network.

**New Prescription Drug(s) means:**An FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

**Telemedicine** means the practice of medicine by a licensed Florida Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® 2018 Pharmacy Program Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below.

If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2018**.

## PHARMACY ALTERNATIVES

The **Participating Pharmacies** subsection is deleted in its entirety and replaced with the following:

**Participating Pharmacies**

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

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

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

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

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

The first paragraph in the **Non-Participating Pharmacies** subsection is deleted in its entirety.

SAMPLE

# PHARMACY UTILIZATION REVIEW PROGRAMS

The **Prior Coverage Authorization Program** subsection is amended by adding the following Note after the first paragraph:

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

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

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

# DEFINITIONS

The following definitions are deleted in their entirety and replaced with the following:

**Mail Order Pharmacy** means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

**New Prescription Drug(s)** means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

**Non-Participating Pharmacy** means a Pharmacy that has not agreed to participate in the network for this Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

**Participating Pharmacy** means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

SAMPLE

**Pharmacy Benefit Manager** means an organization that has established, and manages, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

**Specialty Pharmacy** means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program, to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueCard® Program Endorsement

This Endorsement is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's first Anniversary Date occurring on or after **January 1, 2018**.

## BLUECARD® PROGRAM

The Benefit Booklet is hereby amended by deleting the BlueCard (Out-of-State) Program section in its entirety and replacing it with the following:

### Out-of-Area Services

**Overview**

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

**Inter-Plan Arrangements Eligibility – Claim Types**

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

**BlueCard Program**

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

SAMPLE

When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

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

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

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

**Special Cases: Value-Based Programs**

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

**Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

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

**Nonparticipating Providers Outside Florida**

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

**BCBS Global™ Core Program**

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the BCBS Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

SAMPLE

**Inpatient Services**

In most cases, if you contact the BCBS Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the BCBS Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

**Outpatient Services**

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

**Submitting a BCBS Global Core Claim**

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

## DEFINITIONS

The following definitions are added:

**Care Coordination** means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

**Care Coordinator Fee** means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

**Provider Incentive** means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

**Value-Based Program** means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2019 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2019**.

## WHAT IS COVERED?

The **Transplant Services** subsection is amended by deleting item number 3 in the first numbered list in its entirety and replacing it with the following:

3. heart transplant;

List items 2 and 4 of the Exclusions under the **Transplant Services** subsection are deleted in their entirety and replaced as follows:

2. transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect;

List item **9** of the Exclusions under the **Transplant Services** subsection is deleted in its entirety.

## WHAT IS NOT COVERED?

The **Complications of Non-Covered Services** subsection is deleted in its entirety.

The **Services to Treat Complications of Non-Covered Services** subsection is added as follows:

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

SAMPLE

The **Weight Control Services** subsection is deleted in its entirety and replaced with the following:

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

# UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The following subsection is added before the **Additional Expenses You Must Pay** subsection as follows:

## Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

# ELIGIBILITY FOR COVERAGE

The **Eligibility Requirements for Dependents** is amended by deleting list item numbers 1 and 2 in their entirety and replacing them as follows:

1. The Covered Employee's present Domestic Partner when the Covered Employee has completed and submitted any required forms to the Small Employer and the Small Employer has determined the Domestic Partnership eligibility requirements have been met;
2. The Covered Employee's or covered Domestic Partner's natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Covered Employee or covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan.
    a. in the case of a dependent child with an intellectual or physical disability, such child is eligible to continue coverage, beyond the limiting age of 30, as a Covered Dependent if the dependent child is:
        1) otherwise eligible for coverage under the Small Employer Master Policy;

SAMPLE

2) incapable of self-sustaining employment by reason of intellectual or physical disability; and

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

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

# CLAIMS PROCESSING

The **How to Appeal an Adverse Benefit Determination** subsection is amended by adding the following **new** list item below item number 2 as follows:

3. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.

The **new** subsection, **Exhaustion of Internal Appeals Process** is added below the **Timing of Our Appeal Review on Adverse Benefit Determination** as follows:

## Exhaustion of Internal Appeals Process

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

# DEFINITIONS

The following definition is replaced:

**Small Employer Application** means the BCBSF application form that a Small Employer must submit to BCBSF when requesting the issuance of the Small Employer Master Policy.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript® Pharmacy Program 2019 Changes Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2019** or first Anniversary Date occurring on or after January 01, 2019 whichever occurs first.

## INTRODUCTION

The **Introduction** is amended by deleting the first sentence of the third paragraph in its entirety and replacing it with the following:

The Medication Guide contains a listing of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs.

## COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Covered Over-the-Counter (OTC) Drugs** category is amended by deleting the second paragraph in its entirety and replacing it with the following:

Covered OTC Drugs are listed in the Medication Guide which can be viewed on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

The **Oral Chemotherapy Drugs** category is deleted in its entirety and replaced with the following:

**Oral Chemotherapy Drugs**

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

## LIMITATIONS AND EXCLUSIONS

**Exclusion** number 7.n. is deleted in its entirety.

SAMPLE

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2020 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2020**.

## WHAT IS COVERED?

The **Physician Services** category is deleted it in its entirety and replaced with the following:

**Physician Services**

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

Exclusion

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

The following **new** category is added in alphabetical order:

**Virtual Visits**

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

- Virtual Visits between you and a Virtual Care Provider that is designated by us and has a contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

  Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion

Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.

SAMPLE

## WHAT IS NOT COVERED?

The **Telemedicine** exclusion is deleted in its entirety.

The following **new** exclusions are added in alphabetical order:

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

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

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

## BLUECARD® PROGRAM

The **BCBS Global™ Core Program** subsection is amended as follows:

The **heading** is deleted in its entirety and replaced with the following:

**Blue Cross Blue Shield Global® Core Program**

References to **"BCBS"** throughout the subsection are deleted in their entirety and replaced with **"Blue Cross Blue Shield"**.

## TERMINATION OF INDIVIDUAL COVERAGE

The **Termination of a Covered Dependent's Coverage** subsection is amended by deleting the second to last paragraph in its entirety and replacing with the following:

If you as the Covered Employee wish to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to to us through the Small Employer prior to the termination date requested.

## GENERAL PROVISIONS

The **Customer Rewards Program** provision is deleted in its entirety and replaced with the following:

**Customer Rewards Program**

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any

SAMPLE

available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

## DEFINITIONS

The definitions of **Certified Nurse Midwife, Certified Registered Nurse Anesthetist** and **Convenient Care Center** are deleted it in their entirety and replaced with the following:

**Certified Nurse Midwife** means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

**Certified Registered Nurse Anesthetist** means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

**Convenient Care Center** means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one master's level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

The **E-Visit** and **Telemedicine** definitions are deleted it in their entirety.

The following **new** definitions are added in alphabetical order:

**Virtual Care Provider** is a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered. A Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

**Virtual Visit**, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2021 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2021**.

## WHAT IS COVERED?

The **Transplant Services** category is deleted in its entirety and replaced with the following:

**Transplant Services**

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

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

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

Lodging and Transportation

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

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1. the transplant recipient is a Covered Person at the time Services are rendered;
2. Covered Services are performed at a Designated Transplant Facility;
3. lodging and transportation to and from the Designated Transplant Facility are booked through a travel agency designated by us;
4. the transplant has been approved by us in advance; and
5. the facility where the transplant will be performed is 50 miles or more away from the recipient's home.

The lodging and transportation benefit is limited to $10,000 per transplant.

Exclusion:

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

SAMPLE

# WHAT IS NOT COVERED?

The following **new** exclusion is added in alphabetical order:

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

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

SAMPLE

# HEALTH CARE PROVIDER OPTIONS

The **Location of Services** subsection is amended by adding the following before the **Other Providers** category:

**Value Choice Providers**

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

| Value Choice Provider Type | Services Included | Cost Share |
|---|---|---|
| Primary Care Physician | • Office Visits*<br>• Diagnostic Testing (such as lab work and x-rays done in the office)<br>• Allergy Testing and Injections | $0 |
| Specialist Physician | • Office Visits*<br>• Diagnostic Testing (such as lab work and x-rays done in the office) | $20** |
| Dietician / Nutritionist | Covered Services such as Diabetic Education | $0 |
| Urgent Care Center | Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period | $0<br>for first 2 visits*** |

* Advanced imaging, maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

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

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

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

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# BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/Pre-Service Notification Programs** subsection is deleted in its entirety and replaced with the following:

**Prior Coverage Authorization/Pre-Service Notification Programs**

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these rules and ultimately how much you will have to pay under this Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for Covered Services listed below. You are solely responsible for getting any required authorization before Services

are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider. For details on how to obtain prior coverage authorization for these Services, please call the customer service phone number on your ID Card.

**Services that Require Prior Authorization**

Advanced Diagnostic Imaging Services

You must obtain an authorization for advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, when rendered or referred by a Provider **before** the advanced diagnostic imaging Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Mental Health and Substance Dependency Care and Treatment Services

You must obtain an authorization for mental health and Substance Dependency treatment, when rendered or referred by a Provider **before** the mental health and Substance Dependency treatment Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Prescription Drugs

In the case of Prescription Drugs, it is your sole responsibility to obtain prior coverage authorization **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, this plan will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

All Prescription Drugs covered under the Medical Pharmacy category in the WHAT IS COVERED? section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

Transplant Services

You must obtain an authorization for all Transplant Services, including the pre-transplant evaluation **before** the transplant evaluation is scheduled. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Other Health Care Services

In the case of other Health Care Services under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

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**Additional Information**

Once the necessary medical documentation has been received from you and/or the Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

**Note:**

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:
   a. the termination date of your policy, or
   b. the period authorized by us, as indicated in the letter you receive from us.

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

See the CLAIMS PROCESSING section for information on what you can do if prior coverage authorization is denied.

# TERMINATION OF COVERAGE

The **Termination of an Individual's Coverage for Cause** subsection is amended by deleting the numbered list in its entirety and replacing it with the following:

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

# GENERAL PROVISIONS

The **Customer Rewards Program** provision is deleted in its entirety and replaced with the following:

## Customer Rewards and Incentive Programs

From time to time we may offer you rewards or incentives for participating in certain activities and programs. These may be one-time rewards, available periodically or related to completing activities under a particular program. This includes but is not limited to shared savings incentive programs as defined under Florida law.

**Types of Rewards or Incentives**

The rewards and incentives available to you may exceed $100 per year and may include things like Premium credits, reduced Copayments, Coinsurance or Deductibles, cash equivalents or other incentives

SAMPLE

such as gift cards, debit cards, free or low cost transportation for medical Services, discounts, contributions to a health savings account and memberships to gyms or other programs.

**Types of Programs**

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

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

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

Transportation Program

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

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

## DEFINITIONS

The following **new** definition is added in alphabetical order:

**Designated Transplant Facility** is a licensed facility that is designated by us and has a contract with us to provide covered transplant Services at the time the Services are rendered. Designated transplant facilities may or may not be located in the service area. The fact that a Hospital is an In-Network Hospital does not mean that it is a designated facility.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript 2021 Pharmacy Program Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2021**.

## COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Contraceptive Coverage** exclusion is deleted in its entirety and replaced with the following:

Exclusion

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants such as Norplant and IUD are not covered.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2022 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2022**.

## WHAT IS COVERED?

The **Surgical Procedures** category is amended as follows:

**List item 6** is deleted in its entirety and replaced with the following:

6. Gender reassignment surgery and Services, including breast augmentation and reduction mammoplasty, related to gender dysphoria or gender transition.

**Exclusion i** is deleted in its entirety and replaced with the following:

   i. breast augmentation and reduction mammoplasty, except as specifically indicated as a Covered Service elsewhere in this Booklet.

The **Transplant Services** category is amended as follows:

The **Lodging and Transportation** subsection is deleted in its entirety and replaced with the following:

**Lodging and Transportation**

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

1. the transplant recipient is a Covered Person at the time Services are rendered;
2. the transplant is a Covered Service at the time Services are rendered and is designated by us as eligible for lodging and transportation assistance. Please note that only certain types of transplants are eligible for lodging and transportation assistance; the fact that a transplant is a Covered Service under this Booklet, does not mean such transplant is eligible for lodging and transportation assistance;
3. Covered Services are performed at a Designated Transplant Facility;
4. lodging and transportation arrangements to and from the Designated Transplant Facility are coordinated through us;
5. the transplant, including pre-transplant evaluation, has been approved by us in advance; and
6. the facility where the transplant will be performed is 50 miles or more away from the recipient's home, unless a shorter distance is Medically Necessary, as determined by us.

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

**Exclusions 2 and 12** are deleted in their entirety and replaced with the following:

SAMPLE

2. Transplant evaluations for transplants designated by us as eligible for lodging and transportation assistance, rendered **before** we are contacted for authorization.

12. Travel expenses that are not authorized by us in advance and those associated with:

    a. transplants that are not covered under this Booklet;

    b. evaluation for registration at more than one transplant center (dual listing); or

    c. costs considered taxable income under IRS regulations.

The **Virtual Visits** category is deleted in its entirety and replaced with the following:

**Virtual Visits**

Your plan covers Virtual Visits between you and a Virtual Care Provider when rendered consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered. Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

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

**Exclusion**

1. Expenses for failure to keep a scheduled Virtual Visit.

2. Virtual Visits rendered by any Provider other than a Virtual Care Provider, as defined in the DEFINITIONS section.

## WHAT IS NOT COVERED?

The **Cosmetic Services** exclusion is deleted in its entirety and replaced with the following:

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

The **Transplant Services** exclusion is amended by deleting **Exclusions 2 and 12** in their entirety and replacing them with the following:

2. Transplant evaluations for transplants designated by us as eligible for lodging and transportation assistance, rendered **before** we are contacted for authorization.

12. Travel expenses that are not authorized by us in advance and those associated with:

    a. transplants that are not covered under this Booklet;

    b. evaluation for registration at more than one transplant center (dual listing); or

SAMPLE

c. costs considered taxable income under IRS regulations.

The **Virtual Visits** exclusion is deleted in its entirety and replaced with the following:

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

# UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Emergency Room Facility Services Copayment** subsection is deleted in its entirety and replaced with the following:

**Emergency Room Facility Services Copayment**

The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit and is in addition to any applicable Coinsurance amount. 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, you will pay the Cost Share that applies to inpatient facility Services, as listed in your Schedule of Benefits.

The **Special Payment Rules** subsection is amended as follows:

The two paragraphs under **Emergency Services in an Emergency Room** are deleted in their entirety and replaced with the following:

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

The first paragraph under **Non-Emergency Services** is deleted in its entirety and replaced with the following:

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

# HEALTH CARE PROVIDER OPTIONS

The **Value Choice Providers** subsection is deleted in its entirety and replaced with the following:

**Value Choice Providers**

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

SAMPLE

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

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

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

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

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

# BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/ Pre-Service Notification Programs** subsection is amended by deleting the **Transplant Services** provision under Services that Require Prior Authorization, in its entirety and replacing it with the following:

Transplant Services

1. In the case of **Transplant Services**, you must obtain an authorization for the transplant **before** the transplant is scheduled.



SAMPLE

2. In the case of **Transplant Services designated by us as eligible for lodging and transportation assistance**, you must obtain an authorization for all Services, including the pre-transplant evaluation **before** the transplant evaluation is scheduled.

**If you do not obtain prior coverage authorization, we will deny coverage for the Services and not make any payment for such Services**.

For details on how to obtain prior coverage authorization for transplant evaluation and procedures, please call the customer service phone number on your ID Card.

## EXTENSION OF BENEFITS

The subsection heading is changed to **Extension of Benefits and Continuity of Care**; and the following is added at the end:

**Continuity of Care**

We will provide benefits for continuing care patients as required by the federal No Surprises Act (H.R. 133, P.L. 116-260).

## DEFINITIONS

The following **new** definition is added in alphabetical order:

**Transplant Travel Benefit Period** begins with pre-evaluation testing and ends when post-transplant Services are complete, but not to exceed 12 months after organ transplantation.

The **Virtual Care Provider** definition is deleted in its entirety and replaced with the following:

**Virtual Care Provider** means (1) an In-Network Provider that is designated by us and that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2023 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2023**.

## WHAT IS COVERED?

The **Mammograms** category is deleted in its entirety and replaced with the following:

**Mammograms**

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

In accordance with the Florida Statute 627.6613, coverage is available under the following circumstances:

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

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## BLUESCRIPT® PHARMACY PROGRAM

The **Responsible Steps** subcategory is deleted in its entirety and replaced with the following:

**Responsible Steps Program**

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

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

Coverage Protocol Exemption

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

# WHAT IS NOT COVERED?

The **Complementary or Alternative Medicine** exclusion is deleted in its entirety and replaced with the following:

**Complementary or Alternative Medicine** including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; prayer and mental healing; 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.

# UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Special Payment Rule** provision is deleted in its entirety and replaced with he following:

**Special Payment Rules**

**Emergency Services in an Emergency Room**

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered. If the No Surprises Act applies but section 627.64194(4) of the Florida Statute does not apply, then payment under this section will comply with the qualifying payment amount (QPA) rules of the federal No Surprises Act (H.R. 133, P.L. 116-260).

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

**Non-Emergency Services**

If you receive Services from an Out-of-Network Provider in an In-Network Health Care Facility (as defined below) and you did not have the ability and opportunity to choose an In-Network Provider that is available to treat you, then payment will be determined in accordance with either: (1) 627.64194(4) of the Florida Statutes or (2) the qualifying payment amount (QPA) rules of the federal No Surprises Act (H.R. 133, P.L.

SAMPLE

116-260), as applicable. The Out-of-Network Provider in such case, should only bill you for the applicable In-Network Cost Share.

For purposes of this subsection, an In-Network Health Care Facility means an In-Network Ambulatory Surgical Center, Hospital, Hospital outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act) or Urgent Care Center.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

**Air Ambulance**

If an Out-of-Network air Ambulance Provider renders Covered Services under this Booklet, the In-Network Cost Share will apply and the payment will be determined in accordance with the provisions of the federal No Surprises Act (H.R. 133, P.L. 116-260) applicable to air Ambulance Providers.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

## BLUEPRINT FOR HEALTH PROGRAMS

The following **new** subsection is added at the end of the section:

**Coverage Protocol Exemption Request**

In some cases, Services under this Booklet require you to complete use of another Prescription Drug, medical procedure, or course of treatment other than the one requested by your treating Physician, before coverage will be authorized/granted. Florida Statute 627.42393 permits you to request a protocol exemption in order to receive coverage without completing our coverage protocol for the Prescription Drug, medical procedure, or course of treatment. If we deny the coverage protocol exemption request, we will provide you with a written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure for appealing the denial. In some instances, the process for appealing a denied coverage protocol exemption request will be your formal appeal of an Adverse Benefit Determination process as outlined in the CLAIMS PROCESSING section of this Booklet.

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

## CLAIMS PROCESSING

The **How to Request External Review of Our Appeal Decision** subsection is amended as follows:

The **heading** is hereby changed to **External Review**.

The **first paragraph** is deleted in its entirety and replaced with the following:

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

SAMPLE

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

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

## DEFINITIONS

The **Allowed Amount** definition is amended by adding number 6 below:

6. In the case of Covered Services rendered by an Out-of-Network Provider where the Services are subject to either the federal No Surprises Act (H.R. 133, P.L. 116-260) or 627.64194(4) F.S., then the allowed amount will be calculated in accordance with the applicable statute. For clarity, if the Provider is located in Florida and 627.64194(4) F.S. applies, then the allowed amount calculated under 5. above is presumed to meet the requirements 627.64194(4) F.S.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueScript 2023 Pharmacy Program Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2023**.

## PHARMACY UTILIZATION REVIEW PROGRAMS

The **Responsible Steps** subsection is deleted in its entirety and replaced with the following:

**Responsible Steps Program**

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

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

Coverage Protocol Exemption

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

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This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2024 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2024**.

## HOW TO USE YOUR BENEFIT BOOKLET

The following **new row** is added to the **Where do I find information on…** table:

| | |
|---|---|
| What happens if **I receive a surprise bill?** | The **Surprise Billing** subsection in the **YOUR SHARE OF HEALTH CARE EXPENSES** section. |

## WHAT IS COVERED?

The **Home Health Care** category is amended by deleting the first numbered list in its entirety and replacing it with the following:

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; and
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 as documented in the clinical progress notes.

The **Inpatient Rehabilitation** category is amended by deleting **item number 4** in its entirety and replacing it with the following:

4. the individual must be able to actively participate in at least two Rehabilitative Therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five days a week; and

SAMPLE

The **Mental Health Services** category is amended by deleting the **Exclusion** in its entirety and replacing it with the following:

**Exclusion**

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation or diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability, except for Services that meet the definition of Medical Necessity for the Condition;
4. Services for educational purposes, except for Services that meet the definition of Medical Necessity for the Condition;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation, except for Services that meet the definition of Medical Necessity for the Condition;
8. Services to test aptitude, ability, intelligence or interest;
9. Services required to maintain employment;
10. Services for cognitive remediation;
11. inpatient stays for Custodial Care, convalescent care, change of environment or any other Service primarily for your convenience or that of your family members or the Provider; and
12. inpatient (overnight) mental health Services received in a residential treatment facility.

The following **new** category is added in alphabetical order:

**Nutrition Counseling**

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

# UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Special Payment Rule** provision is deleted in its entirety and replaced with the following:

## Surprise Billing

Sometimes you may receive Covered Services from Out-of-Network Providers who will not accept our payment as payment in full. Out-of-Network Providers in the specific situations described below are

SAMPLE

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

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

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

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

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

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

**Facility**, as used above means:

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

**How Much we will Pay Out-of-Network Providers**

Generally, Florida state law prohibits Out-of-Network Providers rendering Covered Services subject to this Surprise Billing section from balance billing you. If section 627.64194(4), Florida Statutes applies, then the Allowed Amount (i.e., the amount we base payment on) will generally be calculated in accordance with the definition within this Benefit Booklet. In certain circumstances, the Allowed Amount will be calculated for Out-of-Network Providers, including all Covered Services rendered by Out-of-Network Air

SAMPLE

Ambulance Providers, based upon the Median Contracted Rate. The term "Median Contracted Rate" as used here means, generally:

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

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

**Calculating Your Share of the Cost**

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

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

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

## HEALTH CARE PROVIDER OPTIONS

The **In-Network Providers** subsection is amended by deleting the paragraphs and bulleted list after the first paragraph and replacing them with the following:

**Primary Care Providers**

We encourage you to select and develop a relationship with an In-Network Primary Care Provider ("PCP"). There are several advantages to selecting a PCP (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians):

- PCPs 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 PCP allows the Provider to become knowledgeable about you and your family's health history.
- A PCP 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.
- Care rendered by PCPs usually results in lower out-of-pocket expenses for you.

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Whether you select a PCP or another type of Physician to render Health Care Services, please remember that using In-Network Providers will result in lower out-of-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.

The **Value Choice Providers** subsection is deleted in its entirety and replaced with the following:

**Value Choice Providers**

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

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

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

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

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

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

The following **new** subsection is added before the **Assignment of Benefits to Providers** subsection:

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

Federal law (42 U.S. Code § 300gg –113) provides for continuity of Services for enrollees of health plans when there is a change in the plans’ Provider network resulting in a Provider no longer being In-Network for the enrollee’s benefit plan. These protections extend to individuals defined as a “Continuing Care Patient” and include patients who are undergoing a course of treatment for:

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

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

## EXTENSION OF BENEFITS

The **Extension of Benefits and Continuity of Care** subsection is deleted in its entirety and replaced with the following:

## Extension of Benefits and Continuity of Care

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

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

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

1. a serious or complex Condition,

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a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or

b) in the case of a chronic illness or Condition, a Condition that:

   i. is life-threatening, degenerative, potentially disabling, or congenital; and

   ii. requires specialized medical care over a prolonged period of time.

2. institutional or inpatient care;

3. a scheduled non-elective surgery including postoperative care;

4. pregnancy; or

5. a terminal illness.

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

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

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

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

**Extension of Benefits**

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

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

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

3. If you are receiving covered dental treatment on the termination date of the Group Plan, we will provide a limited extension of such covered dental treatment as long as the course of dental treatment or dental procedures were recommended in writing and started while you were covered by us. Additionally, the dental procedures must be for Services other than routine examinations,

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prophylaxis, x-rays, sealants, or orthodontic Services and performed within 90 days after the Group Plan terminated.

**Note**: 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 Plan 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 Services category of the "What Is Covered?" section for a description of the dental Services covered under this Booklet.

# CLAIMS PROCESSING

The **Post-Service Claims** subsection is amended by deleting the **Payment for Post-Service Claims** provision in its entirety and replacing it with the following:

**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 , however all claims subject to the No Surprises Act will be paid or denied within 30 days as stated in the Surprise Billing subsection of the UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES section of this Booklet. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need additional information, we may contest the claim within the timeframes set forth below.

# GENERAL PROVISIONS

The following **new** subsection is added at the end of the section:

## Your Rights and Responsibilities

We are committed to providing quality health care coverage at a reasonable cost while maintaining your dignity and integrity. Consistent with our commitment and recognizing that In-Network Providers are independent contractors and not our agents, the following statement of your Rights and Responsibilities has been adopted.

**Rights**

1. To be provided with information about our services, coverage and benefits, the In-Network Providers delivering care and members' rights and responsibilities.
2. To receive medical care and treatment from In-Network Providers who have met our credentialing standards.
3. To expect In-Network Providers to:

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a) discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage;

b) permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.

c) advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments; and

d) inform you about any medications you are told to take, how to take them, and their possible side effects

4. To expect courteous service from us and considerate care from our In-Network Providers with respect and concern for your dignity and privacy.

5. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures found in this Booklet.

6. To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision. In the event, members are encouraged (but not required) to:

   a) complete an advance directive, such as a living will and provide it to In-Network Providers; and

   b) have someone help make decisions, or to give another person the legal responsibility to make decisions about medical care on a member's behalf.

7. To have access to your medical records and to be assured that the confidentiality of your medical records is maintained in accordance with applicable law.

8. To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding our rights and responsibilities policies. Please call the phone number on your ID Card or write to us at the address on your ID Card.

**Responsibilities**

1. To cooperate with anyone providing your care and treatment.

2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.

3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about your care and to ask questions if you do not understand or need an explanation.

4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.

5. To pay your Cost Share amounts and be financially responsible for non-covered Services and to provide current information concerning your coverage status to any In-Network Provider.

6. To follow the process for filing an appeal about medical or administrative decisions that you feel were made in error.

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7. To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
8. To review information regarding Covered Services, policies and procedures as stated in this Booklet.

## DEFINITIONS

The following **new** definition is added:

**Continuing Care Patient** means a patient who is undergoing a course of treatment for:

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

The **Dietitian** definition is deleted in its entirety and replaced with the following:

**Dietitian** means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services and appropriate behavioral health Conditions covered under this plan.

The following **new** definition is added:

**Primary Care Provider** or **Family Physician (PCP)** means a Provider who, at the time Covered Services are rendered, was under a primary care Provider contract with us. A primary care Provider may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist, or APRN may elect to contract with us as a primary care Provider.

The definition of **Skilled Nursing Facility** is deleted in its entirety and replaced with the following:

**Skilled Nursing Facility** means a facility or part thereof which is properly licensed under Florida law, or a similar applicable law of another state, to provide care and treatment of medical Conditions and meets all of the following requirements:

1. is accredited as a Skilled Nursing Facility by The Joint Commission or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us;
2. has nursing staff on-site 24 hours per day and 7 days per week;

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3. provides access to necessary medical Services 24 hours per day and 7 days per week;
4. provides appropriate access to any Physician-ordered Services required for treatment of your Condition on at least a daily basis (and likely multiple times per day). These Services may consist of skilled nursing Services, (e.g., intravenous fluids and medication administration, wound care, etc.) and therapy Services (i.e., physical, occupational and speech);
5. has individualized active treatment plan (e.g., skilled nursing and therapy Services) directed toward the management and improvement of the Condition that caused the admission; and
6. provides a level of skilled care consistent with your Condition and care needs.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

SAMPLE

# BlueOptions 2025 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2025**.

## WHAT IS COVERED?

The **Transplant Services** category is amended by deleting the **Lodging and Transportation** subcategory in its entirety and replacing it with the following:

Lodging and Transportation

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

1. the transplant recipient is a Covered Person at the time Services are rendered;
2. the transplant is a Covered Service at the time Services are rendered and is designated by us as eligible for lodging and transportation assistance. Please note that only certain types of transplants are eligible for lodging and transportation assistance; the fact that a transplant is a Covered Service under this Booklet, does not mean such transplant is eligible for lodging and transportation assistance;
3. Covered Services are performed at a Designated Transplant Facility;
4. the transplant, including pre-transplant evaluation, has been approved by us in advance; and
5. the facility where the transplant will be performed is 50 miles or more away from the recipient's home, or, in the case of the living donor, 50 miles or more away from the living donor's home, unless a shorter distance is Medically Necessary, as determined by us.

The lodging and transportation benefit is limited to a combined total of $10,000 per Transplant Travel Benefit Period for all covered expenses from the transplant recipient, the living donor and their companions.

## HEALTH CARE PROVIDER OPTIONS

The **Value Choice Providers** subsection is amended by deleting the last paragraph in its entirety and replacing it with the following:

Value Choice Providers are available in certain Florida counties only and not all Services are available at all locations. To find a Value Choice Provider, access our website at www.floridablue.com and click on

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“find a doctor” and search for a doctor near you. When using the filter options, click on “Programs” and select “Value Choice Providers”.

## DEFINITIONS

The **Emergency Services** definition is deleted in its entirety and replaced with the following:

**Emergency Services** means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition;
2. within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient: and
3. items and Services that are furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the Hospital in which such items or Services are furnished) after the patient is stabilized and as part of the outpatient observation or an inpatient or outpatient stay with respect to the visit in which the medical screening examination Services described in number 1 are furnished.

The **Virtual Care Provider** definition is deleted in its entirety and replaced with the following:

**Virtual Care Provider** means (1) an In-Network Provider that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time the Services are rendered.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

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# BlueScript 2025 Pharmacy Program Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA_BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2025**.

The term **Mail Order** is hereby replaced with the term **Home Delivery** throughout the Endorsement.

## DEFINITIONS

The **One-Month Supply** definition is deleted in its entirety and replaced with the following:

**One-Month Supply** means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's daily dosing recommendations. Certain Drugs (such as Specialty Drugs) may be dispensed in lesser or greater quantities due to manufacturer package size or FDA-approved dosage requirements for a course of therapy.

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This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

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# BlueOptions 2026 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2026**.

## WHAT IS COVERED?

The **Surgical Procedures** category is amended as follows:

The **exclusion** is amended by deleting the paragraph before the list in its entirety and replacing it with the following:

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

The **Transplant Services** category is amended by adding the following before the **Lodging and Transportation** provision:

Organ Donor

Donor costs in connection with a covered transplant that has been authorized by us, may be covered to the extent the donor does not have health benefits available from any other source, and include:

1. Evaluation and testing: medical exams and tests to determine the donor's suitability for donation;
2. Surgery and Hospital stay: donor's surgery, Hospital stay and post-operative care;
3. Follow-up care: immediate acute post-operative care, rendered within 3 months post-surgery; and
4. Travel and lodging: as described in the Lodging and Transportation provision below.

## WHAT IS NOT COVERED?

The **Assisted Reproductive Therapy (Infertility)** exclusion is deleted in its entirety.

The **Cosmetic Services** exclusion is deleted in its entirety and replaced with the following:

**Cosmetic Services**, including any Service to improve the appearance or self-perception of an individual, including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling, such as Minoxidil, Rogaine, Retin-A, and hair implants/transplants, breast augmentation and reduction mammoplasty, except as specifically indicated as a Covered Service elsewhere in this Booklet, reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery and hair removal/hairplasty.

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The following is added to the **Drugs** exclusion in numerical order:

12. Drugs approved through the FDA's expedited/accelerated approval process (found in Title 21 U.S. Code §356 and enabling regulations or similar statute then in effect) are excluded from coverage for 18 months from the date of approval. These Drugs are usually approved by the FDA based on early evidence that they may be better than existing treatments. The 18-month exclusion will be extended until any FDA-required studies, pursuant to Title 21 U.S. Code §356(c)(2), are completed to confirm the Drug's clinical benefit. After 18 months and upon completion of any required studies, we may review the Drug for coverage under the terms of this Benefit Booklet. We reserve the right to, in our sole discretion, but are not required to, review and provide coverage for the accelerated approval Drug prior to the end of the 18-month exclusionary period as determined by our Pharmacy and Therapeutics Committee or clinical committees. This exclusion does not apply to accelerated approval Drugs prescribed for the treatment of cancer.

The **Hearing Aids** exclusion is deleted in its entirety and replaced with the following:

**Hearing Aids** (external) and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries and repair costs.

The **Infertility Treatment** exclusion is added in alphabetical order:

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

1. Services provided to treat infertility;
2. reversal of previous surgical sterilization procedures;
3. all infertility treatment medications;
4. assisted reproductive therapy including, but not limited to, Artificial Insemination (AI); In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); and any Services associated with these procedures;
5. expenses associated with the donation or purchase of sperm; and
6. expenses for a person not covered under this Booklet, in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

## HEALTH CARE PROVIDER OPTIONS

The **Value Choice Providers** provision is deleted it in its entirety and replaced with the following:

**Value Choice Providers**

Some Providers, designated by us, may provide Services other than Advanced Imaging Services, maternity and Medical Pharmacy Services at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office. The chart below lists Services that may be included and the Cost Share amounts, where available.

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| Value Choice Provider Type | Services Included | Cost Share |
|---|---|---|
| Primary Care Provider | • Office Visits*<br>• Allergy Testing and Injections<br>• Diagnostic Testing (such as lab work and x-rays done in the office)<br>• Occupational Therapy and Physical Therapy | $0 |
| Dietitian / Nutritionist | Covered Services such as Diabetic Education | $0 |
| Urgent Care Center | Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period | $0<br>for first 2 visits** |

* Advanced Imaging Services, maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

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

Value Choice Providers are available in certain Florida counties only and not all Services are available at all locations. To find a Value Choice Provider, access our website at www.floridablue.com and click on "find a doctor" and search for a doctor near you. When using the filter options, click on "Programs" and select "Value Choice Providers".

## BLUEPRINT FOR HEALTH PROGRAMS

The **Coverage Protocol Exemption Request** subsection is amended by deleting the last paragraph in its entirety and replacing it with the following:

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

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer



SAMPLE

# BlueScript 2026 Pharmacy Program Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2026**.

## COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

**Item number 1** is deleted in its entirety and replaced with the following:

1. Prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license, except:
   a. vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration; and
   b. HIV preexposure prophylaxis Drugs, when prescribed by a Pharmacist in accordance with section 465.1861 of the Florida Statutes;

## LIMITATIONS AND EXCLUSIONS

The **Exclusions** subsection is amended as follows:

**Exclusion number 7.f.** is deleted in its entirety and replaced with the following:

f. prescribed by a Pharmacist acting within the scope of his or her license, except:
   i. vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
   ii. HIV preexposure prophylaxis Drugs, when prescribed by a Pharmacist in accordance with section 465.1861 of the Florida Statutes;

The following new **Exclusion** is added in numerical order.

24. Drugs approved through the FDA's expedited/accelerated approval process (found in Title 21 U.S. Code §356 and enabling regulations or similar statute then in effect) are excluded from coverage for 18 months from the date of approval. These Drugs are usually approved by the FDA based on early evidence that they may be better than existing treatments. The 18-month exclusion will be extended until any FDA-required studies, pursuant to Title 21 U.S. Code §356(c)(2), are completed to confirm the Drug's clinical benefit. After 18 months and upon completion of any required studies, we may review the Drug for coverage under the terms of this Benefit Booklet. We reserve the right to, in our sole discretion, but are not required to, review and provide coverage for the accelerated approval

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Drug prior to the end of the 18-month exclusionary period as determined by our Pharmacy and Therapeutics Committee or clinical committees. This exclusion does not apply to accelerated approval Drugs prescribed for the treatment of cancer.

## PHARMACY UTILIZATION REVIEW PROGRAMS

The **Coverage Protocol Exemption** provision under the **Responsible Steps Program** is deleted in its entirety and replaced with following:

Coverage Protocol Exemption

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

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This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

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# BlueCard® Program Endorsement

This Endorsement is replacing the BlueCard Program Endorsement, form number 24978 R0523 and is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's first Anniversary Date occurring on or after **January 1, 2024**.

The **BlueCard Program** section is deleted in its entirety and replaced with the following:

## BLUECARD® PROGRAM

### Out-of-Area Services

**Overview**

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Programs". These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described generally below.

When you receive care outside of Florida, you generally obtain care from health care Providers that have a contractual agreement. ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from health care Providers in the Host Blue geographic area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. A Nonparticipating Provider is a healthcare provider that does not have a contractual agreement with the applicable Host Blue plan in the geographic area where services are received, regardless of whether such provider may be described as "in-network" or "out-of-network" elsewhere in this Benefit Booklet. We explain below how we pay both kinds of Providers.

**Inter-Plan Programs Eligibility – Claim Types**

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

### BlueCard® Program

Under the BlueCard Program, when you access Covered Services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for handling all interactions with its Providers, including contracting with Participating Providers.

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When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

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

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

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

**Special Cases: Value-Based Programs**

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

**Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

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

**Nonparticipating Providers Outside Florida**

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

## Blue Cross Blue Shield Global® Core

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

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**Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

**Outpatient Services**

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

**Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

## DEFINITIONS

The following definitions are added:

**Care Coordination** means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

**Care Coordinator Fee** means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

**Provider Incentive** means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

**Value-Based Program** means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

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This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Brian D. Pieninck
Chief Executive Officer

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# BlueOptions 2027 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's first Anniversary Date occurring on or after **January 01, 2027**.

## WHAT IS COVERED?

The **Surgical Procedures** category is amended as follows:

The **Exclusion** is amended by deleting the paragraph before the list in its entirety and replacing it with the following:

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

## WHAT IS NOT COVERED?

The **Cosmetic Services** exclusion is deleted in its entirety and replaced with the following:

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

The **Drugs** exclusion is amended by adding the following in numerical order:

12. Obesity-Labeled Products: Benefits are not available for any Drug or biological product that was initially approved by the FDA and introduced to market for the treatment of obesity or weight management, including but not limited to Wegovy, Zepbound, Saxenda, or similar agents. The exclusion applies regardless of diagnosis, prescriber intent, or any subsequent FDA approvals for additional indications. Additionally, this exclusion includes all formulations, strengths, and dosage regimens of such products, and applies without regard to later changes in labeling.

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The **Sexual Reassignment, or Modification Services** exclusion is deleted in its entirety.

## DEFINITIONS

The **Allowed Amount** definition is amended as follows:

**Item number 2** is deleted in its entirety and replaced with the following:

2. In the case of an In-Network Provider, referred to as a participating 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 PROGRAM section for more details.

**Item number 5** is deleted in its entirety and replaced with the following:

5. In the case of an Out-of-Network Provider in Florida that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by BCBSF that may be based on several factors including (but not necessarily limited to): (i) payment for such Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that we determine are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by us, with our provider network strategies (e.g., does not result in payment that encourages Providers participating in a BCBSF network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider, referred to as a Nonparticipating Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the Allowed Amount for the specific Covered Services provided to you may be based upon the amount provided to BCBSF by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay Nonparticipating Providers in its geographic area for such Services or the payment we would make if we were paying an Out-of-Network provider in Florida when the Host Blue's corresponding payment may be more than our payment to an Out-of-Network provider in Florida. See the BLUECARD PROGRAM section for more details.

The paragraphs after item number 6 are deleted in their entirety and replaced with the following:

If a particular Covered Service is not available from any NetworkBlue Provider, 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.

For purposes of this definition, a Nonparticipating Provider is a healthcare provider that does not have a contractual agreement with the applicable Host Blue plan in the geographic area where services are

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received, regardless of whether such provider may be described as “in-network” or “out-of-network” elsewhere in this Benefit Booklet.

You may obtain an estimate of the Allowed Amount for particular Services by calling the customer service phone number on your ID Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Booklet apply. You should refer to the WHAT IS COVERED? section of this Booklet and your Schedule of Benefits to determine what is covered and how much we will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between our Allowed Amount and the amount billed for Covered Services by any such Out-of-Network Provider.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Brian D. Pieninck
Chief Executive Officer

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# BlueScript 2027 Pharmacy Program Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's first Anniversary Date occurring on or after **January 01, 2027**.

## LIMITATIONS AND EXCLUSIONS

The following new **Exclusion** is added in numerical order.

25. Obesity-Labeled Products: Benefits are not available for any Drug or biological product that was initially approved by the FDA and introduced to market for the treatment of obesity or weight management, including but not limited to Wegovy, Zepbound, Saxenda, or similar agents. The exclusion applies regardless of diagnosis, prescriber intent, or any subsequent FDA approvals for additional indications. Additionally, this exclusion includes all formulations, strengths, and dosage regimens of such products, and applies without regard to later changes in labeling.

## COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Specialty Pharmacy: Split Fill Option** subsection is deleted in its entirety.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Booklet, other than as specifically stated in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Brian D. Pieninck
Chief Executive Officer

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