BlueChoice

Schedule of Benefits Plan 201

Covered Persons should carefully review this Schedule of Benefits. If the Covered Person did not receive, or cannot find, the Certificate of Coverage, of which this Schedule of Benefits is a part, contact BCBSF to obtain a copy of the Certificate of Coverage issued to the Small Employer.

It is the Covered Person's sole responsibility to select and verify a health care Provider's participation status at the time a Health Care Service is rendered. To verify a Provider's specialty or participation status, refer to the most recent provider directory at www.floridablue.com, or call the customer service phone number on the Covered Person's ID Card.

FINANCIAL FEATURES	PPO PROVIDERS (INN)	NON-PPO PROVIDERS (OON)
Calendar Year Deductible (CYD) Per Individual	$300	Combined with INN
Per Family	$900	Combined with INN
Emergency Room Per Visit Deductible (PVD)	$0	$0
Per Admission Deductible (PAD)	$0	$300
Coinsurance (The percentage of the Allowance or Allowed Amount the **Covered Person pays** for Covered Services)	20%	30%
Coinsurance Responsibility Limit Per Individual	$1,500	Combined with INN
Per Family	$4,500	Combined with INN

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NOTE: Coinsurance Responsibility Limits do not include the CYD, PAD, PVD, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowance or Allowed Amount. The Hospital Per Admission Deductible and the Emergency Room Per Visit Deductible are in addition to the Calendar Year Deductible.

OFFICE SERVICES	PPO PROVIDERS (INN)	NON-PPO PROVIDERS (OON)
Office Visits rendered by		
Primary Care Providers	20% after CYD	30% after CYD
Other health care professionals licensed to perform such Services	20% after CYD	30% after CYD
Allergy Injections		
Primary Care Providers	20% after CYD	30% after CYD
Other health care professionals licensed to perform such Services	20% after CYD	30% after CYD
Durable Medical Equipment, Orthotics and Prosthetics	20% after CYD	30% after CYD

VIRTUAL HEALTH	PPO PROVIDERS (INN)
Virtual Visits	
General Medicine and Urgent Care rendered by a designated Virtual Care Provider	$0
Specialized Care rendered by a designated Virtual Care Provider	20% after CYD
Behavioral Health rendered by a designated Virtual Care Provider	$0

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

OUTPATIENT DIAGNOSTIC SERVICES	PPO PROVIDERS (INN)	NON-PPO PROVIDERS (OON)
Independent Clinical Lab	20% after CYD	30% after CYD
Independent Diagnostic Testing Facility	20% after CYD	30% after CYD
Outpatient Hospital Facility	20% after CYD	30% after CYD

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EMERGENCY AND URGENT CARE SERVICES	PPO PROVIDERS (INN)	NON-PPO PROVIDERS (OON)
Ambulance Services	20% after CYD	20% after INN CYD
Emergency Room Visits Facility	20% after CYD and PVD	20% after INN CYD and PVD
Physician and other health care professional Services	20% after CYD	20% after INN CYD
Urgent Care Center	20% after CYD	20% after CYD

FACILITY SERVICES	PPO PROVIDERS (INN)	NON-PPO PROVIDERS (OON)
Ambulatory Surgical Center Facility	20% after CYD	30% after CYD
Physician and other health care professional Services	20% after CYD	30% after CYD
Inpatient Facility (per admission)	20% after CYD and PAD	*30% after CYD and PAD
Physician and other health care professional Services	20% after CYD	30% after CYD
Outpatient Facility	20% after CYD	30% after CYD
Physician and other health care professional Services	20% after CYD	30% after CYD

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Important:

PPO Providers in certain categories may not be available in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room Physicians. BCBSF will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the PPO benefit level. Claims paid in accordance with this note will be applied to the PPO CYD and Coinsurance Responsibility Limits.

*If a Covered Person is admitted to a Hospital that is not a PPO Provider, as an inpatient at the time of the emergency room visit to the same facility, the inpatient cost share that applies to PPO Providers will apply to that admission.

BENEFIT MAXIMUMS

Calendar Year Benefit Maximums per Covered Person

Mental Health Services:

Inpatient days/visits or combination of inpatient and Partial Hospitalization days 30

Outpatient visits 20

Home Health Care visits 10

Skilled Nursing Facility days 60

Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulation visits 15

NOTE: Refer to the Certificate of Coverage for Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations reimbursement guidelines.

BENEFIT MAXIMUM CARRYOVER

If immediately before the Effective Date of the Small Employer, a Covered Person was covered under a prior group policy issued by BCBSF to the Small Employer, amounts applied to a Covered Person's Calendar Year benefit maximums under the prior BCBSF policy, will be applied toward the Covered Person's Calendar Year benefit maximums under this policy.

PHARMACY DRUG PROGRAM

The Small Employer may have purchased optional pharmacy coverage from BCBSF. If so, please refer to the Pharmacy Program Endorsement issued to the Small Employer.

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BlueChoice

CERTIFICATE OF COVERAGE

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This Certificate Contains Deductible Provisions

For Customer Service Assistance: 1-800-FLA-BLUE

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Small Group

19298 0400SR

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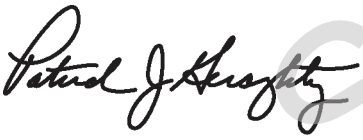
Home Office
4800 Deerwood Campus Parkway
Jacksonville, Fl 32246

Thank you for selecting Blue Cross and Blue Shield of Florida's (BCBSF) **BlueChoice**.

BlueChoice gives you access to two of BCBSF's provider networks - BCBSF's statewide network of preferred providers and BCBSF's network of traditional providers. With **BlueChoice**, you have the freedom to select any provider you wish to see. However, you may be able to lower your out-of-pocket expenses by receiving care from participating PPO Providers. To find out about a health care provider's participation status, you can review the PPO Provider Directory then in effect, call the provider's office, access our web-site at www.bcbsfl.com and/or call the Customer Service phone number on the front cover of this booklet or on your Identification Card. You should also carefully review the Schedule of Benefits which is a part of this Certificate of Coverage for a detailed list of your financial responsibilities. This is important because with **BlueChoice** your financial responsibilities, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **may vary** depending upon the Providers you choose to see.

If you did not receive, or cannot find, the Schedule of Benefits, which is a part of your Certificate of Coverage, it is important that you call the number on the front cover of this booklet or on your Identification Card and we will mail you another one.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.



Patrick J. Geraghty
Chief Executive Officer

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INTRODUCTION TO THE CERTIFICATE OF COVERAGE

This Certificate of Coverage (Certificate), which includes the Schedule of Benefits, sets forth the Covered Person's rights and obligations and those of BCBSF. It is important that each Covered Person read the Certificate carefully and become familiar with its terms, including its coverage, benefits, exclusions and limitations.

Set out below are highlights from the Certificate and information on where to look for relevant information.

The **Schedule of Benefits** includes information about the limitations and maximums of coverage and explains any financial obligations.

The **Covered Person's Financial Obligations Section** sets forth requirements and responsibilities that apply to Covered Persons under this Certificate. Refer to the Schedule of Benefits for additional information concerning these requirements and financial responsibilities.

The **Health Care Provider Alternatives Section** sets forth BCBSF's payment rules for Covered Services depending on the health care Provider selected by a Covered Person to provide Health Care Services.

The **Covered Services Section** describes the Health Care Services which may be covered, and highlights specific exclusions and limitations that apply to particular types of Health Care Services.

The **General Exclusions Section** lists other exclusions and limitations in addition to those specifically listed in the Covered Services Section.

The **Eligibility Section** describes who is eligible for coverage and how and when this coverage begins.

The **Glossary of Terms Section** will define many of the words and phrases used throughout the Certificate. 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 this section or where used in the Certificate.

Other sections contained in this Certificate explain when benefits may change; how and when coverage stops; how to obtain coverage if coverage ends; how BCBSF will coordinate benefits with other policies or plans; BCBSF's subrogation rights; and BCBSF's right of reimbursement. These sections also explain how to file a claim when services are received from a Provider who does not participate in BCBSF's PPO or traditional networks.

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COVERED PERSON'S FINANCIAL OBLIGATIONS

This section sets out a Covered Person's financial obligations under this Certificate. Important information concerning these financial obligations is set forth in the Schedule of Benefits. If a Covered Person did not receive, or cannot find, the Schedule of Benefits, which is a part of this Certificate, it is important that the Covered Person call the customer service number on the front cover of this booklet or on the Identification Card and BCBSF will mail another one.

Calendar Year Deductible Requirement

1. Individual Calendar Year Deductible Requirement

   This requirement, when applicable, must be satisfied by each Covered Person each Calendar Year, as determined by BCBSF, before any payment will be made by BCBSF for any claim. Only those charges indicated on claims received by BCBSF for Covered Services will be credited by BCBSF toward the Individual Calendar Year Deductible requirement and only up to the applicable Allowed Amount.

2. Family Calendar Year Deductible Requirement Limit

   Once the Covered Employee's family has reached such limit, no Covered Person in that family will have any additional Calendar Year Deductible responsibility for the remainder of that Calendar Year. The maximum amount that any Covered Person in the family can contribute toward the Family Calendar Year Deductible requirement is the amount applied toward the Individual Calendar Year Deductible amount.

3. Prior Coverage Credit for Deductible

   BCBSF shall, under this Certificate, give a Covered Person credit for the satisfaction or partial satisfaction of any deductible met by such Covered Person under a prior group, blanket or franchise insurance policy maintained by the Small Employer, which is replaced by this Small Employer Master Policy. This provision only applies if the prior group, blanket or franchise insurance policy was in effect immediately preceding the Effective Date of the Small Employer. In administering this provision, the following rules will apply:

   a. For the initial Calendar Year of coverage under this Certificate only, charges credited by the Small Employer's prior insurer, towards a Covered Person's Deductible requirement, during the 90 day period immediately preceding the Effective Date of the Small Employer Master Policy, shall be credited to that Covered Person's Calendar Year Deductible requirement under this Certificate, but only to the extent those charges were for Health Care Services that would have been Covered Services under this Certificate if the Covered Person had, at that time, been covered by BCBSF.

   b. Prior coverage credit under this Certificate only applies at the initial enrollment of the entire Small Employer. The Small Employer and/or each Covered Person is responsible for providing BCBSF with any information necessary for BCBSF to apply this prior coverage credit.

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Hospital Per Admission Deductible

The Hospital Per Admission Deductible must be satisfied by each Covered Person, for each Hospital admission, before any payment will be made by BCBSF for any claim for inpatient Health Care Services. The Hospital Per Admission Deductible applies regardless of the reason for the admission, is in addition to the Calendar Year Deductible requirement, and applies to all Hospital admissions in or outside the State of Florida.

Emergency Room Per Visit Deductible

The Emergency Room Per Visit Deductible is set forth in the Schedule of Benefits. The Emergency Room Per Visit Deductible applies regardless of the reason for the visit, is in addition to the Calendar Year Deductible, and applies to emergency room services in or outside the State of Florida. The Emergency Room Per Visit Deductible must be satisfied by each Covered Person for each visit. If the Covered Person is admitted to the Hospital at the time of the emergency room visit, the Emergency Room Per Visit Deductible will be waived.

Coinsurance Responsibility

After the Covered Person has satisfied the applicable Deductible responsibility, BCBSF will pay claims for Covered Services at the Coinsurance percentage of the applicable Allowed Amount as set forth in the Schedule of Benefits. The unpaid percentage of the Allowed Amount is the Covered Person's Coinsurance responsibility.

1. Coinsurance Responsibility Limit/Maximum Out-of-Pocket Coinsurance Amount

    a. Individual Coinsurance Responsibility Limit

    Once a Covered Person has reached the Individual Coinsurance responsibility limit amount as set forth in the Schedule of Benefits, the Covered Person will have no additional Coinsurance responsibility for the remainder of the Calendar Year and BCBSF will pay for Covered Services at 100 percent of the Allowed Amount.

    b. Family Coinsurance Responsibility Limit

    Once the Covered Employee's family has reached the family Coinsurance responsibility limit amount as set forth in the Schedule of Benefits, no Covered Person in the Covered Employee's family will have any additional Coinsurance responsibility for the remainder of that Calendar Year and BCBSF will pay for Covered Services at 100 percent of the Allowed Amount. The maximum amount any Covered Person can contribute toward the Family Coinsurance responsibility limit is the amount applied toward the Individual Coinsurance responsibility limit amount.

    NOTE: Coinsurance responsibility limits do not include the Calendar Year Deductible, Hospital Per Admission Deductible, Emergency Room Per Visit Deductible, any Copayment (if applicable), any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount. If the Small Employer has purchased prescription drug coverage and benefits, the applicable Copayment does not apply to the Calendar Year Deductible and Coinsurance.

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2. Prior Coverage Credit for Out-of-Pocket Coinsurance Limitation

   BCBSF shall, under this Certificate, give a Covered Person credit for the satisfaction or partial satisfaction of any out-of-pocket coinsurance limitation met by such Covered Person under a prior group, blanket, or franchise insurance 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 coverage purchased by the Small Employer was in effect immediately preceding the Effective Date of the Small Employer. In administering this provision, the following rules will apply:

   a. For the initial Calendar Year of coverage under this Certificate only, charges credited by the Small Employer's prior insurer, towards a Covered Person's out-of-pocket coinsurance limitation, during the 90 day period immediately preceding the Effective Date of the Small Employer Master Policy, shall be credited to that Covered Person's Calendar Year Maximum Out of Pocket Coinsurance requirement, under this Certificate, but only to the extent those charges were for Health Care Services that would have been Covered Services under this Certificate.

   b. Prior coverage credit under this Certificate only applies at the initial enrollment of the entire Small Employer. The Small Employer and/or each Covered Person is responsible for providing BCBSF with any information necessary for BCBSF to apply this prior coverage credit.

Benefit Maximum Carryover

If immediately before the Effective Date of the Small Employer, a Covered Person was covered under a prior group policy issued by BCBSF to the Small Employer, amounts applied to a Covered Person's Calendar Year benefit maximums and lifetime maximums under the prior BCBSF policy, will be applied toward the Covered Person's Calendar Year benefit maximums and lifetime maximums under this Certificate.

Additional Financial Responsibilities

In addition to the financial obligations set forth above, Covered Persons are also responsible for:

1. any applicable Copayments;
2. expenses incurred for non-Covered Services;
3. charges in excess of any maximum benefit limitation set forth in the Schedule of Benefits (e.g., the lifetime maximum and Calendar Year maximums);
4. charges in excess of the applicable Allowed Amount; and
5. any benefit reduction (e.g., benefit penalties resulting from a Covered Person's failure to comply with any Individual Benefit Utilization Management/Utilization Review Program requirements).

Additionally, the Covered Employee is responsible for any Premium contribution amount required by the Small Employer.

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Additional Information

1. If the Small Employer purchased the “PPO Family Physician” plan, Physician Health Care Services (except for Durable Medical Equipment, Prosthetics, and Orthotics) rendered in the PPO Physician’s office are only subject to the Copayment amount set forth on the Schedule of Benefits, when the PPO Physician practices in the areas of the following: Family Practice, General Practice, Internal Medicine, or Pediatrics. If the Small Employer did not purchase the “PPO Family Physician” plan, this paragraph does not apply.
2. If the Small Employer purchased the “PPO Physician Copayment” plan, Physician Health Care Services (except for Durable Medical Equipment, Prosthetics, and Orthotics) rendered in the PPO Physician’s office are only subject to the Copayment amount set forth on the Schedule of Benefits. If the Small Employer did not purchase the “PPO Physician Copayment” plan, this paragraph does not apply.

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HEALTH CARE PROVIDER ALTERNATIVES AND REIMBURSEMENT RULES

Introduction

BlueChoice gives Covered Persons access to BCBSF's statewide network of PPO Providers and also access to BCBSF's statewide Traditional Insurance Program Providers.

Covered Persons are free to obtain services from any health care Provider of their choice, including PPO Providers, Traditional Insurance Providers, or health care Providers who do not participate in any of BCBSF's Provider contracting programs. BCBSF's reimbursement rules for Covered Services varies, as explained below, depending on the health care Provider selected by a Covered Person to provide Health Care Services. To find out about a health care Provider's participation status, a Covered Person can review the PPO Provider Directory then in effect, call the Provider's office, access our web site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this booklet or on the Covered Person's Identification Card.

It is the Covered Person's sole responsibility to select a Provider when obtaining Health Care Services and to verify such Provider's participation status, if any, at the time the Health Care Services are rendered.

Reimbursement Rules for BCBSF PPC Providers

A "BCBSF PPC℠ Provider" is a PPO Provider in the State of Florida, or in certain counties outside of Florida, that is also a "Preferred Patient Care℠" or "PPC℠" Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC program). To find out about a health care Provider's participation status, a Covered Person can review the PPO Provider Directory then in effect, call the Provider's office, access our web site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this booklet or on the Covered Person's Identification Card. BCBSF PPC Providers have agreed to file claims for the services they render. They have also agreed not to bill or otherwise collect from a Covered Person any amounts in excess of BCBSF's PPO Schedule Amount, except as otherwise permitted under the terms of their Provider contracts and this Certificate. **BCBSF's payment for Covered Services rendered by a BCBSF PPC Provider, if any, will always be made directly to the BCBSF PPC Provider.** For a list of the type of Providers that are currently eligible to participate as BCBSF PPC Providers, see the Eligible Providers subsection of this section.

When a Covered Person receives Health Care Services from a BCBSF PPC Provider, BCBSF's payment of expenses for those services which are Covered Services (as defined in this Certificate) will be at the Coinsurance percentage set forth in the Schedule of Benefits based on BCBSF's Allowed Amount for such services. The Covered Person's financial responsibility includes:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
2. the payment of expenses which are not covered, limited, or excluded;
3. the payment of any expenses in excess of any benefit maximum limitations; and

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4. the payment of any applicable benefit reductions or penalties.

Note: For additional reimbursement rules for certain out-of-state PPO Providers, see the BlueCard Program Section of this Certificate.

Rules for Providers Who Do Not Participate in BCBSF's PPC Network

1. Traditional Insurance Providers

   Traditional Insurance Providers are those health care Providers who are not BCBSF PPC Providers, but who have entered into a contract, then in effect, to participate in BCBSF's traditional programs (these programs are also known as Payment for Physician Services "PPS" and Payment for Hospital Services "PHS"), as applicable, in Florida or in certain counties outside of Florida, when such programs exist. These Providers have agreed to accept BCBSF's Allowance as payment in full for Covered Services. Traditional Insurance Providers have agreed to file claims for the services they render. They have also agreed not to bill or otherwise collect from a Covered Person any amounts in excess of BCBSF's Allowance, except as otherwise permitted under the terms of this Certificate and their Provider contract. **BCBSF's payment for Covered Services rendered by a Traditional Insurance Provider, if any, will always be made directly to the Provider**. For a list of the type of Providers that are currently eligible to participate as Traditional Insurance Providers, see the Eligible Providers subsection of this section.

   The Covered Person's financial responsibility for services rendered by Traditional Insurance Providers includes, but is not limited to:

   1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
   2. the payment of expenses which are not covered, limited, or excluded;
   3. the payment of any expenses in excess of any benefit maximum limitations; and
   4. the payment of any applicable benefit reductions or penalties.

2. Reimbursement Rules for Providers Who Are Eligible To Participate As BCBSF Traditional Insurance Providers But Who Have Not Entered Into A Traditional Insurance Provider Contract

   Certain Providers who are eligible to participate as Traditional Insurance Providers, but who have not entered into a Traditional Insurance Provider contract with BCBSF, may not accept BCBSF's Allowance as payment in full for Covered Services. Covered Persons receiving Health Care Services from such Providers are responsible for filing claims in connection with those services and payment for those services. **BCBSF's payment, if any, will always be made directly to the Covered Person and not the Provider.** The Covered Person's financial responsibility includes:

   1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
   2. the payment of expenses which are not covered, limited, or excluded;
   3. the payment of any expenses in excess of any benefit maximum limitations;
   4. the payment of any applicable benefit reductions or penalties; and
   5. the payment of the difference between BCBSF's Allowance and the Provider's charges.

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3. Reimbursement Rules for Providers Not Eligible to Participate In Any Of BCBSF's Provider Programs

   Certain categories of health care Providers are not eligible to participate as BCBSF PPC Providers or as Traditional Insurance Providers. To determine which categories of health care Providers are not eligible to participate as BCBSF PPC Providers or as Traditional Insurance Providers, a Covered Person can review the PPO Provider Directory then in effect, call the Provider's office, access our web site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this booklet or on the Covered Person's Identification Card. The Covered Person is responsible for filing claims for Health Care Services rendered by these Providers. **BCBSF's payment for Covered Services rendered by these Providers, if any, will be made to the Covered Person, unless the Covered Person has properly assigned the benefits to the Provider.** BCBSF's payment, if any, for Covered Services rendered by these Providers will be at the Coinsurance percentage as set forth in the Schedule of Benefits. The Covered Person's financial responsibility includes:

   1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
   2. the payment of expenses which are not covered, limited, or excluded;
   3. the payment of any expenses in excess of any benefit maximum limitations;
   4. the payment of any applicable benefit reductions or penalties; and
   5. the payment of the difference between BCBSF's Allowance and the Provider's charges.

Assignment of Benefits to Providers

BCBSF is not required to honor any assignment to a Provider who does not participate in any of BCBSF's Provider contracting programs including, without limitation, any of the following: an assignment of the benefits due the Covered Person under this Certificate; an assignment of the right to receive payments due under this Certificate; or an assignment of a claim for damage resulting from a breach, or an alleged breach, of the Small Employer Master Policy.

Note: For additional reimbursement rules for certain out-of-state PPO Providers, see the BlueCard Program Section of this Certificate.

Eligible Providers

The following categories of Providers are eligible to participate as BCBSF PPC Providers and/or Traditional Networks:

1. Acute Care General Hospitals/Osteopathic Hospitals
2. Ambulatory Surgical Centers
3. Dialysis Centers
4. Doctors of Chiropractic (D.C.)
5. Doctors of Dental Medicine (D.M.D.)
6. Doctors of Dental Science (D.D.S.)
7. Doctors of Dental Surgery (D.D.S.)

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8. Doctors of Medicine (M.D.)
9. Doctors of Optometry (O.D.)
10. Doctors of Osteopathy (D.O.)
11. Doctors of Podiatric Medicine (D.P.M.)
12. Durable Medical Equipment Providers
13. Home Health Agencies
14. Independent Clinical Laboratories
15. Mental Health Professionals
16. Physical Therapist Providers
17. Prosthetists/Orthotists
18. Psychiatric Facilities
19. Psychologists
20. Substance Abuse Facilities

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BLUECARD® PROGRAM

Providers Outside the State of Florida

When amounts are paid or payable by BCBSF under this Certificate to a Provider outside the State of Florida who is not in BCBSF's network, reimbursement to the out-of-state Provider may be determined based on the Provider arrangements, if any, the Blue Cross and/or Blue Shield plan has with the Provider in the area where services are provided. Also, the Covered Person's financial responsibilities (e.g., coinsurance requirement limits) may be determined using the same Provider arrangements. In those instances the Blue Cross and/or Blue Shield plan in that area is called a "Host Plan." BCBSF will coordinate with the appropriate Host Plan when reimbursement and financial responsibilities are to be so handled. This is done by use of a special national program of the Blue Cross and Blue Shield Association called the BlueCard® Program. Participation in this program allows BCBSF to make available coverage for out-of-area services using favorable Allowed Amounts that would generally not be available had BCBSF paid the Provider directly.

Covered Persons have access to a Host Plan's BlueCard® PPO Provider network where available. Payment for Covered Services rendered by an applicable Host Plan's PPO Providers will be at the Coinsurance percentage which is highest under this Certificate, using the applicable Allowed Amount under the BlueCard® Program. Certain categories of Providers may not be eligible to participate in a specific Host Plan's PPO network. Further, only certain Providers will participate in any specific Host Plan PPO network. Under the BlueCard® Program, however, certain additional Providers may also participate. Payment for Covered Services rendered by such non-PPO Providers will be at the Coinsurance percentage which is lowest under this Certificate, using the applicable Allowed Amount under the BlueCard® Program, as set forth on the Schedule of Benefits.

A Covered Person's financial responsibilities may vary depending upon the Provider chosen under the BlueCard® Program. For information on the BlueCard® participation status of Providers, call the BlueCard® access number on the Covered Person's Identification Card when listed or call the customer service number on the Covered Person's Identification Card for further assistance.

Under the BlueCard® Program, Host Plans may charge BCBSF a fee (called an access fee) for making their negotiated payment rates available on claims incurred. The access fee may be up to 10 percent (but not to exceed $2,000 for any claim) of the discount the Host Plan has obtained from its Providers. The access fee may be charged only if the Host Plan's arrangement with the Provider prohibits billing Covered Persons for amounts in excess of the negotiated payment rate. However, Providers may bill for Deductibles, Coinsurance and/or Copayments if applicable.

When BCBSF is charged an access fee, BCBSF will pass the charge along to the Small Employer as a claims expense in those instances where the Small Employer has responsibility for claims expenses under its agreement with BCBSF. If BCBSF receives an access fee credit in such situations, BCBSF will give the Small Employer a claims expense credit. Access fees are considered a claims expense in such situations because they represent claim dollars BCBSF was unable to, or in the case of a credit was able to, avoid. Further, while additional administrative charges will be paid by BCBSF for each claim processed under the BlueCard® Program, such charges will not be passed along as a claims expense.

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Instances may occur in which BCBSF does not pay a claim (or pays only a small amount) because the amounts eligible for payment were applied to the Deductible, Coinsurance or Copayment if applicable. In such instances the Host Plan's arrangement with its Provider may allow the negotiated payment rate to apply when the amount is fully or mostly a Covered Person's obligation. If so, BCBSF will pay the Host Plan's access fee and pass it along to the Small Employer as a claims expense even though BCBSF paid little or none of the claim.

The Allowed Amount paid by BCBSF to the Host Plan under the BlueCard® Program for Health Care Services will be arrived at using one of the following three options. The first option uses the actual price paid on the claim. In limited circumstances this price may be greater than charges (e.g. sometimes payment under a "DRG" Diagnostic Related Grouping payment system will be greater than charges). The second option uses an estimated price. This price reflects an adjusted aggregate payment expected to result from past or future settlements or other non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers. The third option uses a discount from billed charges. This price is obtained by applying an average savings factor representing the Host plan's expected savings for all of its Providers or for a specified group of Providers. Estimated and average pricing used under options two and three may be prospectively adjusted. This helps correct for either over or under estimation of past prices.

The calculation of Coinsurance and other Covered Person liability for Covered Services will be at the lower of the Provider's billed charges or the Allowed Amount BCBSF pays the Host Plan under the BlueCard® Program. Also note that statutes in a small number of states require local Blue Cross and/or Blue Shield plans to use a basis for calculating Covered Person's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When a Covered Person receives Covered Services in these states, liability for these services will be calculated using these states' statutory methods.

Under the BlueCard® Program, the Covered Person's financial responsibility includes:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
2. the payment of expenses which are not covered, limited, or excluded;
3. the payment of any expenses in excess of any benefit maximum limitations; and
4. the payment of any applicable benefit reductions or penalties.

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PRE-EXISTING CONDITIONS EXCLUSION PERIOD

A Pre-existing Condition, for a Small Employer who has two or more employees or for a Small Employer who has fewer than two employees which have been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date, is any 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 the earlier of:

1. the first day the Covered Person's Waiting Period, typically the date full-time employment begins, for individuals enrolling during their Initial Enrollment Period; or
2. the Effective Date of the Covered Person's coverage for individuals enrolling during a Special or Annual Enrollment Period.

A Pre-existing Condition does not include:

1. pregnancy;
2. genetic information in the absence of a diagnosis of the Condition;
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; or
5. conditions arising from domestic violence.

A Pre-existing Condition, for a Small Employer who has fewer than two employees and which have not been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date, is any Condition that during the 24-month period immediately preceding the Covered Person's 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 the pregnant Covered Person's coverage regardless of whether the pregnant Covered Person knew she was pregnant prior to the Effective Date.

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.

Creditable Coverage is any of the following health care coverage under which an individual may have been previously covered:

1. a group health plan;
2. health insurance coverage;
3. Part A and Part B of Title XVIII of the Social Security Act (Medicare);

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4. Title XIX of the Social Security Act (Medicaid, other than coverage consisting solely of benefits under Section 1928 of the program for distribution of pediatric vaccines);
5. Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents);
6. a medical care program of the Indian Health Services or of a tribal organization;
7. a State health benefits risk pool (FCHA);
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan; and
10. a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504 [E]).

Pre-existing Condition Exclusion Period for a Small Employer who has two or more employees or for a Small Employer who has fewer than two employees which have been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date:

There is no coverage for Health Care Services to treat a Pre-existing Condition or Conditions arising from a Pre-existing Condition until the Covered Person has been continuously Covered for a 12-month period if the Small Employer has more than one employee. This Pre-existing Condition exclusionary period begins on the first day of the Waiting Period for initial enrollees or the Covered Person's Effective Date of coverage for special and annual enrollees. This limitation also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

Note: For a Small Employer who has fewer than two employees, if there is any prior Creditable Coverage applicable at the time of enrollment, the 24 month Pre-existing Condition Exclusion Period will be reduced to 12 months with credit given for any amount of Creditable Coverage toward the Pre-existing Condition exclusion period.

There is no coverage for Health Care Services to treat a Pre-existing Condition or Conditions arising from a Pre-existing Condition until the Covered Person has been continuously covered for a 24-month period. This 24 month Pre-existing Condition exclusionary period begins on the Covered Person's Effective Date. This limitation also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

Note: For a Small Employer who has fewer than two employees, if there is any prior Creditable Coverage applicable at the time of enrollment, the 24 month Pre-existing Condition Exclusion Period will be reduced to 12 months with credit given for any amount of Creditable Coverage toward the 12 month Pre-existing Condition exclusion period.

General Pre-existing Condition Exclusion Period Limitations

All employees and dependents enrolled subsequent to the Effective Date will be subject to the Pre-existing Conditions exclusionary period, except newborn or Adopted dependents who are properly enrolled. However, credit will be given for the time an eligible Covered Person or dependent was covered under previous Creditable Coverage if there was previous Creditable Coverage with no more than 63 consecutive day break in coverage prior to the earlier of the Covered Person's:

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1. first day of the Waiting Period (i.e., first day of employment) for individuals applying for coverage during his or her Initial Enrollment Period; or
2. the Effective Date of coverage for individuals applying for coverage during a Special or Annual Enrollment Period.

If there was a break in coverage of 63 consecutive days or more, no credit will be given for prior Creditable Coverage.

Credit will be given for the time an Eligible Employer or dependent was covered under previous Creditable Coverage if there was previous Creditable Coverage with no more than a 63 consecutive day break in coverage prior to the earlier of the Covered Person's:

1. date of hire for initial enrollees; or
2. effective date of coverage for special or annual enrollees.

Prior health insurance and/or group health plans are required to provide a certification of Creditable Coverage to the Covered Person upon termination of their coverage.

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INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT / UTILIZATION REVIEW PROGRAMS

Introduction

BCBSF has established various Benefit Utilization Management/Utilization Review Programs ("UM/UR Programs"), including Admission Certification, Concurrent Review, Discharge Planning and Case Management. These programs help BCBSF facilitate the management and review of coverage and benefits provided under BCBSF's policies and, under certain limited circumstances, present opportunities, as explained below, to agree upon alternative benefits or payment alternatives for cost-effective Health Care Services.

IMPORTANT INFORMATION RELATING TO BCBSF'S UM/UR PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely the responsibility of the Covered Person and the Covered Person's treating Physicians and health care Providers together with the Covered Person. Covered Persons and their Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. BCBSF is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Certificate. In fulfilling this responsibility, BCBSF shall not be deemed to participate in or override the medical decisions of any Covered Person's health care Provider.

Admission Certification Program

The Admission Certification Program helps BCBSF determine, for coverage and payment purposes only, whether an admission is Medically Necessary as defined by BCBSF. In administering the Admission Certification Program, BCBSF may review specific medical facts or information and assess, among other things, the appropriateness, health care setting and/or the level of care of a Hospital admission. The coverage and/or benefit determinations made by BCBSF, and any reviews or assessments of specific medical facts or information which it conducts, are solely for purposes of making such coverage or payment decisions under this Certificate and not for the purpose of recommending or providing medical care. As explained below, the Admission Certification Program requirements vary depending on whether or not the Hospital utilized is a BCBSF PPC℠ Provider. A BCBSF PPC℠ Provider is a PPO Provider in the State of Florida, or in certain counties outside of Florida, that is also a "Preferred Patient Care℠" or "PPC℠" Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC℠ program). To find out about a health care Provider's participation status, the Covered Person can review the PPO Provider Directory then in effect, call the Provider's office, access our web site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this booklet or on the Covered Person's Identification Card.

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1. Admission Certification Requirements For Inpatient Admissions To Hospitals that are BCBSF PPC Providers

   Under the Admission Certification Program, ALL inpatient admissions (i.e., elective, planned, urgent or emergency) must be certified by BCBSF in order for the Covered Person to receive full benefits for an inpatient admission to a Hospital that is a BCBSF PPC[sm] Provider.

   The Admission Certification Program requirements for admissions to such Hospitals are the Hospital's sole responsibility. Covered Persons are not responsible for satisfying such requirement, or for any potential benefit reductions for failure to obtain certification, when the Covered Person is admitted to any such Hospital.

   Once BCBSF has the necessary medical information, BCBSF will review the information and make a certification decision, for coverage and payment purposes, based upon the Admission Certification Program's established criteria then in effect.

   For admissions to such Hospitals which are not certified under this program, payment to the Hospital will be reduced by the amount specified in that Hospital's PPC[sm] contract with BCBSF.

2. Covered Persons' Admission Certification Requirements For Admissions To Florida Hospitals That Are Not BCBSF PPC Providers

   The Admission Certification Program also requires Covered Persons to obtain from BCBSF certification for ANY admission (e.g., elective, planned, urgent, or emergency) to a Hospital in the State of Florida that is not a BCBSF PPC[sm] Provider. If the Covered Person fails to obtain certification from BCBSF for the admission, the Allowance for such admission will be reduced by 25 percent as a penalty. This penalty is the Covered Person's responsibility and is in addition to all applicable obligations and limitations under this Certificate (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

   a. Obtaining Certification from BCBSF

      1) Planned Admissions

         For all planned admissions (i.e., an inpatient Hospital admission which is not an emergency or urgent as determined by BCBSF) to a Hospital in the State of Florida that is not then a PPC Provider, the Covered Person must obtain a "Request For Admission Certification" form, or other applicable form, from BCBSF (**Note:** the Covered Person may want to ask his/her Provider to assist) and deliver such form to the Covered Person's Physician requesting the admission. The Physician must complete the form and submit it to BCBSF in advance of the planned admission so that BCBSF receives the form at least two working days prior to the planned admission.

      2) Unplanned Admissions

         For all unplanned admissions (i.e., an inpatient Hospital admission that is an emergency or is urgent or cannot be scheduled in advance) to a Hospital in the State of Florida that is not then a BCBSF PPC[sm] Provider, the Covered Person must ensure that the Physician or the Hospital contacts BCBSF by telephone within 24 hours of the admission or the first business day following a weekend or holiday admission. In the event the Covered Person's Condition

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makes it impossible for the Covered Person to ensure that BCBSF is so notified within the applicable time frame, the Covered Person must ensure that BCBSF is so notified as soon as possible.

3) BCBSF's Certification Decision

Once BCBSF has received the necessary information, in conformity with paragraphs above, BCBSF will review the information and make a certification decision, for coverage and payment purposes only, based upon the Admission Certification program's criteria then in effect. BCBSF will notify the Covered Person, the Physician and the Hospital of the certification decision as soon as possible.

In the event the admission is not certified under this program, BCBSF will, as noted above, reduce the Allowance for such admission by 25 percent as a penalty. The Covered Person may obtain Covered Services on an outpatient basis without a reduction in the applicable Allowance.

Concurrent Review Program

The Concurrent Review Program is completely voluntary for BCBSF and Covered Persons. Under this UM/UR program, BCBSF may (but shall not be required to) review Hospital stays and other health care treatment programs during the course of such stay or treatment program. Any such review is conducted solely to determine whether BCBSF should continue coverage and/or payment for a particular admission. Using established criteria then in effect, concurrent review of the Hospital stay may occur at regular intervals. In those instances where BCBSF administers the program, BCBSF will provide the Covered Person's Physician with notification when BCBSF's criteria under this program for coverage and payment for continued inpatient care are no longer met. In administering the Concurrent Review Program, BCBSF may review specific medical facts or information and assess, among other things, the appropriateness, health care setting and/or the level of care, of a Hospital admission or other health care treatment programs. Such coverage and/or payment determinations made by BCBSF, and any reviews or assessments of specific medical facts or information which it conducts, are solely for purposes of making such coverage or payment decisions under this Certificate and not for the purpose of recommending or providing medical care.

Discharge Planning

The Discharge Planning Program is completely voluntary for BCBSF and Covered Persons. Under this UM/UR program, BCBSF may (but shall not be required to) assist the Covered Person and the Covered Person’s Physician identify health care resources which may be available in the Covered Person's community following hospitalization. BCBSF will, upon request, answer questions the Covered Person's Physician has regarding the Covered Person's coverage or benefits under this Certificate following discharge from the Hospital.

Case Management Program

This program may be made available by BCBSF, in its sole discretion, for those Covered Persons who have a catastrophic or chronic Condition. Under this voluntary program, BCBSF may elect to (but is not required to) offer alternative benefits or payment for cost-effective Health Care Services. These

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alternative benefits or payments may be made available by BCBSF on a case-by-case basis to Covered Persons who meet BCBSF's criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which the Covered Person, or a representative of the Covered Person acceptable to BCBSF, and the Covered Person's Physician agree to in writing. In addition, the Small Employer may be required to specifically agree to such treatment plan.

BCBSF's offering to provide or providing of any alternative benefits or payments in no way obligates BCBSF to continue to provide such alternative benefit payments, or to provide alternative benefits or payments to the Covered Person or any other Covered Person at any time. Nothing contained in this section shall be deemed a waiver of BCBSF's right to enforce this Certificate in strict accordance with its terms. The terms of this Certificate will continue to apply, except as specifically modified in writing by BCBSF when alternative benefits or payments under this program are made available.

Appeal Process

The Covered Person, a treating Physician or a Hospital may request that BCBSF review a UM/UR Program coverage/or payment decision, provided such request is received by BCBSF in writing within 90 days of the date of the decision. The review request must include all information deemed relevant or necessary by BCBSF. BCBSF will review the decision in light of such information and notify the Covered Person or the Covered Person's representative, the Hospital and/or the Physician of the review decision.

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MEDICAL NECESSITY

In order for Health Care Services to be covered under this Certificate, such services must be: 1) not otherwise limited or excluded under this Certificate; 2) rendered while coverage is in force; 3) within the service categories set forth in the Covered Services Section; and 4) Medically Necessary, as defined by BCBSF.

It is important to remember that any review of Medical Necessity by BCBSF is solely for the purposes of determining coverage or benefits under this Certificate and not for the purpose of recommending or providing medical care. In this respect, BCBSF may review specific medical facts or information pertaining to a Covered Person. Any such review, however, is strictly for the purpose of determining, among other things, whether a Health Care Service provided or proposed meets BCBSF's 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 the responsibility of the Covered Person and the Covered Person's treating Physicians and health care Providers. Covered Persons and their Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. BCBSF is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Certificate. In making coverage decisions, BCBSF shall not be deemed to participate in or override the medical decisions of a Covered Person or a Covered Person's health care Providers.

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

1. continued hospitalization 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 the treatment plan;
3. hospitalization because supervision in the home, or care in the home is inconvenient; or hospitalization 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 and/or his/her family members or the 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 BCBSF) or a Covered Service. Please refer to the Glossary of Terms for the definitions of "Medically Necessary" or "Medical Necessity".

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COVERED SERVICES

Introduction

The following subsections describe the Health Care Services which may be Covered Services under this Certificate. All benefits for Covered Services are subject to the Covered Person's applicable financial responsibilities, benefit maximums (e.g., Calendar Year Deductible and Lifetime Maximum), the applicable Allowed Amount, limitations, exclusions, and all other provisions contained in this Certificate (including the Schedule of Benefits) in accordance with BCBSF's Medical Necessity criteria and guidelines then in effect.

Expenses for the Health Care Services listed below will be covered under this Certificate only if the services are:

1. within the services categories set forth in this Covered Services Section;
2. rendered by an appropriate licensed health care Provider who is recognized for payment by BCBSF;
3. Medically Necessary, as defined in this Certificate and determined by BCBSF;
4. rendered while a Covered Person's coverage is in force; and
5. not specifically or generally limited (e.g., Pre-existing Condition exclusionary period) or excluded under this Certificate.

Note: More than one limitation or exclusion may apply to a specific Health Care Service or a particular situation.

Under most circumstances, BCBSF will determine whether Health Care Services are Covered Services under this Certificate when processing a Covered Person's claim after the Covered Person has obtained such services and a claim has been received by BCBSF for such services. In some circumstances, BCBSF may, but is not required to, determine whether Health Care Services are Covered Services under this Certificate before the Covered Person is provided the service. For example, BCBSF may determine whether a proposed Bone Marrow Transplant is a Covered Service under this Certificate before such transplant has been provided. In determining whether Health Care Services are Covered Services under this Certificate, 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 Certificate, and, therefore, neither the Covered Person, nor the Small Employer, nor any health care Provider or other person should rely on any such written or verbal representation.

BCBSF's Benefit Guidelines

In providing benefits for Covered Services, BCBSF may apply the benefit guidelines set forth below as well as any other applicable reimbursement rules specific to particular categories of Health Care Services:

1. BCBSF's reimbursement for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable by BCBSF for any such services and/or supplies.

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2. BCBSF's reimbursement is based on the Allowed Amount for the actual service rendered (i.e., not based on the Allowed Amount for a service which is more complex than the service 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. BCBSF's reimbursement for a service includes all components of the service when such 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.

Covered Services Categories

The Health Care Services listed below may be Covered Services under this Certificate. For ease of reference, limitations and exclusions which apply to specific services have been included in this section. Any specific limitations and/or exclusions included in this section are in addition to any other limitations and/or exclusions listed in this Certificate including those listed in the General Exclusion Section.

Accident Care

Health Care Services to treat an injury resulting from an Accident not related to a Covered Person's job or employment.

Exclusion

Health Care Services to treat an injury resulting from an Accident related to a Covered Person's job or employment are excluded except for 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.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum. 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 to transport a Covered Person from:

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

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

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

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Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center including:

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

Anesthesia Administration Services

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

Exclusion

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

Breast Reconstructive Surgery

Breast Reconstructive Surgery and implanted prostheses incident to Mastectomy. In order to be covered, such surgery must be provided in a manner chosen by the Covered Person's Physician, consistent with prevailing medical standards, and in consultation with the Covered Person.

Child Cleft Lip and Cleft Palate Treatment

Treatment and services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition services for treatment of a child under the age of 18 who has cleft lip or cleft palate. In order for such services to be covered, the Covered Person's Physician must specifically prescribe such services and such services must be consequent to treatment of the cleft lip or cleft palate.

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Child Health Supervision Services

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

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

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

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

Concurrent Physician Care

Physician medical services provided: (a) the additional Physician actively participates in the Covered Person's treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the same specialty with different sub-specialties.

Consultations

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

Contraceptive Injections

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

Reimbursement Guidelines for Medication and Administration by Injection for Contraception

Physician office services, rendered on the same day, in connection with the administration by injection of the contraceptive medication, are not reimbursed separately unless the Small Employer has purchased the adult wellness benefit.

Dental

Dental Care limited to the following:

1. Care and treatment initiated within 62 days of an Accidental Dental Injury provided such services were for the treatment of damage to sound natural teeth.
2. Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Covered Person in a Hospital or Ambulatory Surgical Center if:

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a. the Covered Person is under 8 years of age when it is determined by a dentist and the Covered Person's Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Covered Person has a developmental disability in which patient management in the dental office has proven to be ineffective; or

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

Diabetes Outpatient Self-Management

Diabetes outpatient self-management training and educational services and nutrition counseling, (including all medically appropriate and necessary equipment and supplies), to treat diabetes, if the Covered Person's treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are 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.

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

Dialysis Services

Including equipment, training, and medical supplies, when provided at any location, by a Dialysis Center or a Provider licensed to perform Dialysis.

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed for a Covered Person by a Physician, limited to the most cost effective Durable Equipment, which meets the Covered Person's needs as determined by BCBSF.

Reimbursement Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be Covered Services only if the Covered Person owns the equipment or is purchasing the equipment. BCBSF's Allowed Amount for Durable Medical

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Equipment will be the lowest of the following: (1) the purchase price; (2) the lease/purchase price; or (3) the rental rate. BCBSF's total Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of Durable Medical Equipment due to growth of a child or due to a change in the Covered Person's Condition is a Covered Service.

Exclusion

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes such as 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, humidifiers, water purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails, heat appliances and dehumidifiers.

Enteral Formulas

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

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

Benefits for low protein food products are limited as set forth in the Schedule of Benefits.

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 or disease to a Covered Person's eyes.

Exclusion

Health Care Services to diagnose or treat vision problems, including but not limited to: any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK), which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercises or visual training; eye glasses and contact lenses and their fitting.

Home Health Care

The following Home Health Care Services only when: 1) provided directly by (or indirectly through) a Home Health Agency licensed pursuant to Part IV Chapter 400 of the *Florida Statutes* or another state's applicable laws; 2) the Covered Person's Physician submits a written treatment plan to BCBSF; 3) the treatment plan is acceptable to BCBSF for coverage and payment purposes; and 4) the Covered Person is confined to home and is unable to carry out the basic activities of daily living.

1. part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse;

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2. home health aide services;
3. medical social services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen);
6. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist.

Benefits for Covered Services for Home Health Care are limited as set forth in the Schedule of Benefits.

Exclusion

1. any Home Health Care service which is not directly provided by (or indirectly provided) through a Home Health Agency;
2. homemaker services;
3. domestic maid services;
4. sitter services;
5. companion services;
6. 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;
7. Custodial Care; and
8. food, housing, and home delivered meals.

Hospice Services

Health Care Services provided to a Covered Person in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by the Covered Person's Physician and the Covered Person is not expected to live more than one year. BCBSF shall have the right to request that a Covered Person's Physician certify in writing the life expectancy of a Covered Person.

Benefits for Covered Services for Hospice are limited as set forth in the Schedule of Benefits.

Hospital Services

Hospital services including:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;

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7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, Cardiac therapies; and
14. transplants as set forth in the Transplant Section.

Exclusion

Expenses for the following Hospital Health Care Services are excluded when such services could have been provided without admitting the Covered Person to the Hospital: 1) room and board provided during the Covered Person's admission; 2) Physician visits provided while the Covered Person was an inpatient; and 3) Occupational Therapy, Speech Therapy, Physical Therapy, Cardiac Therapy are not covered.

In addition, expenses for the following are also excluded:

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

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening, are Covered Services.

Benefits for Mammograms are not subject to the Calendar Year Deductible, Coinsurance, or Copayment (if applicable).

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 the Covered Person's attending Physician and the Covered Person. Outpatient post-surgical follow-up care for Mastectomy services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Covered Person. The treating Physician, after consultation with the Covered Person, may choose the appropriate setting.

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Maternity Services

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

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

Mental Health Services

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

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

Benefits for care and treatment of a Mental and Nervous Disorder are limited as set forth in the Schedule of Benefits.

Exclusion

1. services rendered in connection with a Condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;
2. services extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;
3. services for marriage and juvenile counseling;
4. services for court ordered care or testing, or required as a condition of parole or probation;
5. services for testing of aptitude, ability, intelligence or interest;
6. services for testing and evaluation for the purpose of maintaining employment; or
7. services for cognitive remediation.

Newborn Care

A newborn child of a Covered Person shall be covered from the moment of birth provided that the newborn child is properly enrolled. Covered Services shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

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Newborn Assessment

An assessment of the newborn child provided the services were rendered at a Hospital, at the attending Physician's office, at 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 in keeping with prevailing medical standards. These services are not subject to the Calendar Year Deductible.

Ambulance services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn child's Condition, as determined by BCBSF and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child.

Orthotic Devices

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets when prescribed by a Physician.

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

Reimbursement for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six month period unless determined by BCBSF to be Medically Necessary.

Exclusion

Expenses for the following are excluded:

Arch Supports, orthopedic 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.

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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.

Prosthetic Devices

The following Prosthetic Devices are covered when prescribed by a Physician:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery;

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2. appliances needed to effectively use artificial limbs or corrective braces;
3. penile prosthesis and surgery to insert penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, epispadias, and exstrophy.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by the Covered Person when due to irreparable damage, wear, or a change in the Covered Person's Condition, or when necessitated due to growth of a child.

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.

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when: 1) the Covered Person is an inpatient in a Skilled Nursing Facility; and 2) the Covered Person's Physician submits a treatment plan that is acceptable to BCBSF for coverage and payment purposes:

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

Benefits for Covered Services at a Skilled Nursing Facility are limited as set forth in the Schedule of Benefits.

Exclusion

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members or the Provider. Expenses for any inpatient days beyond the Per Covered Person Per Calendar Year maximum number of days set forth on the Schedule of Benefits are also excluded.

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Substance Dependency Care and Treatment

Substance Dependency Care and Treatment including:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided to a Covered Person by a Physician or Psychologist in a program accredited by the Joint Commission of the Accreditation of Healthcare Organizations or approved by the State of Florida for the Detoxification or Substance Dependency Care and Treatment.
2. Physician and Psychologist outpatient visits for the care and treatment of substance dependency as set forth in the Schedule of Benefits.

Benefits for Substance Dependency Care and Treatment are limited as set forth in the Schedule of Benefits.

Exclusion

Expenses for Substance Dependency Care and Treatment in excess of the maximum amount set forth on the Schedule of Benefits for treatment of alcoholism or drug addiction, including prolonged treatment in a specialized inpatient or residential facility.

Surgical Assistant Services

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary. The Allowed Amount for such is limited to 20 percent of the surgical procedure's Allowed Amount.

Surgical Procedures

Surgical procedures performed by a Physician including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excisions 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;
5. surgical procedures performed on a Covered Person for the treatment of Morbid Obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and the associated care provided the Covered Person has not previously undergone the same or similar procedure in their lifetime;
6. services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.

BCBSF's Reimbursement Guidelines for Surgical Procedures

1. Reimbursement for multiple surgical procedures, performed on the same or different areas of the body, during the same operative session will be limited to 50 percent of the Allowed Amount for the

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primary procedure. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service;

2. Reimbursement 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 the opinion of BCBSF, is not clearly identified and/or do 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 reimbursement for the removal of the normal appendix in the example); and
3. Reimbursement for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

Exclusion

Surgical procedures for the treatment of Morbid Obesity including intestinal bypass, stomach stapling, balloon dilation and associated care for the surgical treatment of Morbid Obesity, if the Covered Person has previously undergone the same or similar procedures in their lifetime. Surgical procedures performed to revise, or correct defects related to, a prior intestinal bypass, stomach stapling or balloon dilation are also excluded.

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

1. Outpatient therapies listed below when ordered by a Physician or other health care professional licensed to perform such services:
    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.
    c. **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.

        Reimbursement Guidelines for Physical Therapy

        Physical Therapy services are limited to 4 modalities per day not to exceed the benefit maximum set forth on the Schedule of Benefits.

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

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Reimbursement Guidelines for Massage Therapy

Massage Therapy services are limited to 4 modalities per day not to exceed the benefit maximum set forth on the Schedule of Benefits.

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

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

Reimbursement for spinal manipulations

Spinal manipulations are limited to 26 spinal manipulations per Calendar Year, or the combined outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum set forth in the Schedule of Benefits, whichever occurs first.

The Schedule of Benefits sets forth the maximum amount that BCBSF will pay for any combination of the outpatient therapies and spinal manipulation services listed above. The outpatient Cardiac, Occupational, Physical, Massage and Speech Therapy and Spinal Manipulation benefits specified above are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility subsections herein.

Transplant Services

Limited to the procedures listed below, if coverage has been predetermined by BCBSF and if performed at a facility acceptable to BCBSF, subject to the conditions and limitations described below:

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

1. Bone Marrow Transplant, as defined herein, which is 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 Health Care Financing Administration. BCBSF will cover the cost of donating bone marrow by a donor to a Covered Person to the same extent such cost would be covered for a Covered Person and subject to the same limitations and exclusions as would be applicable to a Covered Person. Coverage for the reasonable costs 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;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or

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9. lung-whole single or whole bilateral transplant.

In order to ensure that a proposed transplant is covered, the Covered Person should notify or the Covered Person's Physician should notify BCBSF in advance of the Covered Person's initial evaluation for the procedure. Corneal and kidney transplants only, do not require prior benefit determination.

BCBSF will make a prior benefit determination concerning the proposed transplant, however, BCBSF must be given the opportunity to evaluate the clinical results of the Covered Person's initial evaluation for the transplant as well as any applicable protocols. If BCBSF is not given an opportunity to make the prior benefit determination, the transplant may be subject to a reduction in payment in accordance with the rules set forth in the Individual Utilization Management/Utilization Review Section. Once coverage for the transplant is predetermined, BCBSF will advise the Covered Person or the Covered Person's Physician of the coverage decision.

For covered transplants, and all related complications, BCBSF will cover:

1. Hospital and Physician expenses provided that such services will be paid in accordance with the same terms and conditions for care and treatment of any other covered Condition.
2. 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.

Covered Persons may call the customer service phone number indicated on the front cover of this booklet or on the Covered Person's Identification Card in order to determine which Bone Marrow Transplants are covered under this Certificate.

Exclusion

The following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Certificate (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 BCBSF;
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 to the Covered Person;
6. 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 Health Care Financing Administration as evidenced in the most recently published *Medicare Coverage Issues Manual;*
7. any service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant. The reasonable cost of searching for a donor is covered and will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;

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8. any transportation costs for the Covered Person or the Covered Person's family to and from the approved facility;
9. any direct, non-medical costs for the Covered Person to and from the approved facility;
10. any temporary lodging; and
11. any artificial heart devices (if used as a bridge to transplant).

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GENERAL EXCLUSIONS

Introduction

The following subsections describe Health Care Services for which expenses are excluded. These exclusions are in addition to any exclusions specified in the Covered Services Section.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to a Covered Person's Effective Date or after the date a Covered Person's coverage terminates, unless coverage is extended in accordance with the Extension of Benefits Section;
2. any Health Care Services not specifically listed in the Covered Services Section or in any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
3. any Health Care Services provided by a Physician or other health care Provider related to the Covered Person by blood or marriage;
4. any Health Care Service which is not Medically Necessary as defined in this Certificate and determined by BCBSF. The ordering of a service by a health care Provider does not in itself make such service Medically Necessary or a Covered Service;
5. Experimental or Investigational services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection, and except for any drug prescribed for the treatment of cancer that has been approved by the Federal Food and Drug Administration (FDA) for at least one indication, provided the drug is recognized for treatment of the Covered Person's cancer in a Standard Reference Compendium or recommended for treatment of the Covered Person's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;
6. any Health Care Services to treat a work related Condition to the extent the Covered Person is covered or required to be covered by Workers' Compensation law. Any service or supply to diagnose or treat any Condition resulting from or in connection with a Covered Person's job or employment will not be covered, 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;
7. any Health Care Services rendered at no charge;
8. any Health Care Service to diagnose or treat any Condition which initially occurred while a Covered Person was (or which, directly or indirectly, resulted from, or is in connection with, a Covered Person being) under the influence of alcoholic beverages, any chemical substance set forth in Section 877.111 of the *Florida Statutes,* or any substance controlled under Chapter 893 of the *Florida Statutes* (or, with respect to such statutory provisions, any successor statutory provisions). Notwithstanding, this exclusion shall not apply to the use of any prescription medication by the

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Covered Person if such medication is taken on the specific advice of a Physician in a manner consistent with such advice;

9. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a. war or an act of war, whether declared or not;
    b. the Covered Person's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot, or rebellion;
    c. the Covered Person's engaging in a illegal occupation;
    d. services received at military or government facilities including service in the armed forces, reserves and/or National Guard;
    e. the Covered Person being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice; or
    f. an intentionally self-inflicted Condition, suicide or attempted suicide, whether the Covered Person is sane or insane.
10. court ordered care or treatment, unless otherwise covered;
11. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

Additional General Exclusions

Expenses for the following Health Care Services are also excluded. These exclusions are in addition to any exclusions specified above and in the Covered Services Section.

Abortion, by choice; not Medically Necessary.

Adult Wellness, preventive care or routine screening services, except as specified on the Schedule of Benefits.

Arch Supports, orthopedic 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 BCBSF.

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;

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

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

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception except when indicated as covered, under the adult wellness benefit, on the Schedule of Benefits (when purchased by the Small Employer), or otherwise covered in the Covered Services Section.

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

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

Custodial Care, and any service of a custodial nature, including without limitation: Health Care Services primarily to assist the Covered Person in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; and respite care.

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 Accidental Dental Care, Child Cleft Lip and Cleft Palate Treatment Services.

Drugs

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Covered Person's cancer in a Standard Reference Compendium or recommended for treatment of the Covered Person's 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, a Covered Person from a pharmacy, except as otherwise covered when the Covered Person is inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital.

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3. Any non-Prescription medicine, remedy, vaccine, biological product (except insulin), pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, over the counter drugs, products, or health foods.

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

Genetic Screening, including the evaluation of genes of a Covered Person to determine if they are carriers of an abnormal gene that puts them at risk for a disease.

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

Oral Surgery for the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided under the Covered Services Section.

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

Personal Comfort, Hygiene or Convenience Items and services deemed to be not Medically Necessary and not directly related to the treatment of the Covered Person including, but not limited to; beauty and barber services; clothing including support hose; radio and television; guest meals and accommodations; telephone charges; take-home supplies; travel expenses; other than Medically Necessary Ambulance services; motel/hotel accommodations; air conditioners; humidifiers; or Physical fitness equipment; and massages except as covered in the Covered Services Section of this Certificate.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided to a Covered Person on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations categories of the Covered Services Section.

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

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

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

Sports-Related devices and services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, 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.

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

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

Weight Control Services including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise programs; equipment; whether or not it is part of a treatment plan for a Condition.

Wigs and/or cranial prosthesis.

SAMPLE

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in the Group Plan, and who meets and continues to meet BCBSF's eligibility requirements described in this Certificate, shall be entitled to apply to become a Covered Person of BCBSF. Such eligibility requirements shall be binding upon the Small Employer and the Covered Person and no change in such requirements shall be permitted unless BCBSF has been notified of and has agreed in writing to any such change in advance. BCBSF may require acceptable documentation that an individual meets and continues to meet the eligibility requirements (e.g., court order naming the Covered Employee as the legal guardian or "Adoption" documentation).

Eligibility Requirements for Covered Employees

To be an Eligible Employee, a person must be a bona fide employee of the Small Employer and must meet each of the following requirements:

1. the employee must have completed any applicable Waiting Period set forth on the Small Employer Application; and
2. the employee must have completed any applicable eligibility requirements(s) set forth on the Small Employer Application.

The Covered Employee eligibility classification may be modified, and may be expanded to include:

1. retired employees;
2. employees of affiliated or subsidiary companies of the Small Employer, provided such companies and the Small Employer are under common control; and
3. other individuals as determined by BCBSF 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 BCBSF and the Small Employer prior to such expansion, and may be subject to different Rates.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under the Small Employer Master Policy:

1. the Covered Employee's present spouse;
2. the Covered Employee's natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year, in which the child reaches age 25, and who is:
    a. dependent upon the Covered Employee for financial support; and
    b. living in the household of the Covered Employee or a full-time or part-time student.

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3. the newborn child of a Covered Person other than the Covered Employee or the newborn child of a Covered Person other than the Covered Employee's spouse. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn.

4. Handicapped Children

A handicapped dependent child is eligible to continue coverage, beyond the limiting age of 25, as a Covered Dependent if such child is otherwise eligible for coverage under the Small Employer Master Policy, incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of such child's handicap existed prior to such child's 25th birthday. This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

Note: It is the Covered Employee's sole responsibility 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.

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ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Any individual (even if such individual is an Eligible Employee or Eligible Dependent) who is not properly enrolled hereunder shall not be covered under the Small Employer Master Policy and BCBSF shall have no obligation whatsoever with respect to such individual.

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

General Rules for Enrollment

1. All factual representations on the enrollment forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) BCBSF may have, in disqualification for, termination of, or rescission of coverage.
2. BCBSF shall not be required to provide coverage and/or benefits to any individual who would not have been entitled to enrollment with BCBSF, had accurate and complete information been provided on a timely basis on the enrollment forms. In such cases, BCBSF may require such individual, or an individual legally responsible for that individual, to reimburse BCBSF for any payments made by BCBSF on behalf of such individual.
3. If the Small Employer requires an individual to make a periodic financial contribution in order to be a Covered Person, such individual shall have agreed in writing to make, and actually shall make, all required contributions.

Enrollment Forms/Electing Coverage

To apply for coverage, the Eligible Employee must:

1. complete and submit, through his or her Small Employer, an Individual Application For Group Insurance/Membership form to BCBSF;
2. provide any additional information needed to determine eligibility, if requested by BCBSF;
3. agree to pay his or her portion of the required Premium; and
4. complete and submit, through his or her Small Employer, a Member Status Change Request to add Eligible Dependents or delete Covered Dependents.

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Small Employer's program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.
2. Employee/Spouse Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's present lawful spouse only.
3. Employee/Child(ren) Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's eligible child(ren) only.

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

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

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

1. **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.
2. **Annual Open Enrollment Period** is an annual 30-day period occurring no less than 30 days prior to the Anniversary Date, 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.
3. **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 sub-section.

Employee Enrollment

1. An individual who is an Eligible Employee on the Small Employer's Effective Date must enroll during the Initial Enrollment Period. The Eligible Employee shall become a Covered Employee 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 an Eligible Dependent(s) shall 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.

1. **Newborn Child** – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit a Member Status Change Request form to BCBSF through the Small Employer prior to or during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

   BCBSF must be notified, in writing, within 30 days after the birth. If timely notice is given, no additional Premium will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, BCBSF will charge the applicable Premium from the date of birth. The applicable Premium for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child if the Covered Employee provides notice to the Small Employer, and BCBSF receives the Member Status Change Request form, within

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the 60-day period of the birth of the child and any applicable Premium is paid back to the date of birth. In the event BCBSF is not notified before or within 60 days of the birth of the newborn child, the Covered Employee must make application during an Annual Open Enrollment Period.

Note: Coverage for a newborn child of an Covered Person other than the Covered Employee or the Covered Employee's spouse will automatically terminate 18 months after the birth of the newborn child.

2. **Adopted Newborn Child** – To enroll an Adopted newborn child, the Covered Employee must submit a Member Status Change Request form through the Small Employer to BCBSF prior to or during the 30-day period immediately following the date of birth and pay the additional Premium, if any. 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. If timely notice is given, no additional Premium will be charged for coverage of the Adopted newborn child for the duration of the notice period. If timely notice is not received, BCBSF will charge the applicable Premium from the date of birth of the Adopted newborn. Any Pre-existing Condition exclusionary period will not apply. BCBSF may require the Covered Employee to provide any information and/or documents which BCBSF deems necessary in order to administer this provision.

   In the event BCBSF is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Employee provides notice to the Small Employer, and BCBSF receives the Member Status Change Request form within 60 days of the birth and any applicable Premium is paid back to the date of birth. In the event BCBSF is not notified before or within 60 days of the date of birth, the Covered Employee must make application during an Annual Open 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 the responsibility of the Covered Employee to notify BCBSF within ten calendar days if the Adopted newborn child is not Placed in the residence of the Covered Employee.

3. **Adopted/Foster Children** – To enroll an Adopted or Foster Child, the Covered Employee must submit a Member Status Change Request form through the Small Employer to BCBSF prior to or 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 Person in compliance with Florida law. If timely notice is given, no additional Premium will be charged for coverage of the Adopted child for the duration of the notice period. Any Pre-existing Condition exclusionary period will not apply to an Adopted child but will apply to a Foster child. BCBSF may require the Covered Person to provide any information and/or documents deemed necessary, by BCBSF, in order to properly administer this section.

   In the event BCBSF is 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 BCBSF receives the Member Status Change Request form within 60 days of the Placement, and any applicable Premium is paid back to the date of Placement. In the event BCBSF is not notified

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before or within 60 days of the date of Placement, the Covered Employee must make application during an Annual Open Enrollment Period.

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. Proof of final Adoption must be submitted to BCBSF. It is the responsibility of the Covered Employee to notify BCBSF if the Adoption does not take place. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the first billing date following receipt of the written notice.

If the Covered Employee's status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is the responsibility of the Covered Employee to notify BCBSF that the Foster Child is no longer in the Covered Employee's care. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the first billing date following receipt of the written notice.

4. **Marital Status** – A Covered Employee may apply for coverage of an Eligible Dependent(s) due to marriage. To apply for coverage, the Covered Employee must complete the Member Status Change Request form through the Small Employer and forward it to BCBSF. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent(s) who is enrolled as a result of marriage is the date of the marriage.
5. **Court Order** – A Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Covered Employee's plan. To apply for coverage, the Covered Employee must complete the Member Status Change Request form through the Small Employer and forward it to BCBSF. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Universal Individual Application For Group Insurance/Membership form during the Annual Open Enrollment Period.

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

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

Special Enrollment Period

An Eligible Employee who declined coverage in writing at the time of his/her Initial Enrollment Period may apply for coverage due to loss of eligibility for coverage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the applicable

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Enrollment Form and forward it to the Small Employer. The Eligible Employee must make application for enrollment within 30 days of the special circumstance.

Loss of Eligibility for Coverage – An Eligible Employee and/or Eligible Dependent(s) may request enrollment outside of the Initial Enrollment Period and Annual Open Enrollment Period if the individual:

1. was covered under another group health benefit plan as an employee or dependent, or was covered under other health insurance coverage or, was covered under COBRA continuation of coverage or Florida continuation of coverage at the time he or she was initially eligible to enroll for coverage under this Small Employer Master Policy;
2. when offered coverage at the time of initial eligibility, stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment;
3. demonstrates that he or she has lost coverage under a group health benefit plan or health insurance coverage within the past 30 days as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage; and
4. requests enrollment within 30 days after the termination of coverage under another employer health benefit plan.

An individual who loses coverage as a result of termination for failure to pay his or her portion of 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) does not have the right to make application for coverage during the Special Enrollment Period.

Special Circumstances – An Eligible Employee may apply for coverage due to the following special circumstances: birth of a child, Placement for adoption, or marriage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the Universal Individual Application For Group Insurance/Membership form and forward through the Small Employer to BCBSF. The Eligible Employee must make application for enrollment within 30 days of the special circumstance. The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) who are enrolled as a result of birth, Adoption, Placement for Adoption, or marriage is the date of the event. Any Pre-existing Condition exclusionary period will not apply to a newborn child or Adopted child.

Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period. (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Employee.)

Other Provisions Regarding Enrollment and Effective Date Of Coverage

1. Rehired Employees

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

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(e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

2. Premium Payments

In those instances where an individual is to be added to coverage (e.g., a new Eligible Employee or a new Eligible Dependent, including a newborn or Adopted child), that individual's coverage shall be effective, as set forth in this section, provided BCBSF receives the applicable additional Premium payment within 30 days of the date BCBSF notified the Small Employer of such amount. In no event shall an individual be covered under this Small Employer Master Policy if BCBSF does not receive the applicable Premium payment within such time period.

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TERMINATION OF INDIVIDUAL 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 the 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 specified by BCBSF that the Covered Dependent's coverage is terminated by BCBSF for cause; or
5. on the date specified by the Small Employer that the Covered Dependent's coverage terminates.

In the event the Covered Employee wishes to delete a Covered Dependent from coverage, a Member Status Change Request form should be forwarded to BCBSF through the Small Employer.

In the event the Covered Employee wishes to terminate a spouse's coverage, (e.g., in the case of divorce), the Covered Employee must submit a Member Status Change Request 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.

Termination of an Individual's Coverage for Cause

If, in BCBSF's opinion, any of the following events occur, BCBSF 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 the Universal Individual Application for Group Insurance/Membership, Member Status Change Request form, or other forms completed for BCBSF, by or on behalf of the Covered Person;
3. misuse of the Identification Card;

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4. failure to fully cooperate with BCBSF in the administration of coverage under this Certificate.

Note: Relative to a misstatement in the Universal Individual Application for Group Membership or Member Status Change Request form, after two years from the Covered Person's Effective Date, only fraudulent misstatements on the application may be used by BCBSF to void coverage or deny any claim for loss incurred or disability starting after the two year period.

Notice of Termination to Covered Persons

It is the Small Employer's responsibility to immediately notify Covered Persons of termination of the Small Employer Master Policy for any reason.

Responsibilities of BCBSF Upon Termination of a Covered Person's Coverage

Upon termination of a Covered Person's coverage for any reason, BCBSF shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Certificate.

Certification of Creditable Coverage

In the event coverage terminates for any reason, BCBSF will issue a written Certification of Creditable Coverage to the Covered Person.

The Certification of Creditable Coverage will indicate the period of time the Covered Person was enrolled with BCBSF. Creditable Coverage may reduce the length of any Pre-existing condition exclusion period by the length of time the Covered Person had prior Creditable Coverage.

Covered Persons may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

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

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CONTINUING COVERAGE

Continuing Coverage under COBRA

Federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, also known as Section 4980B of the Internal Revenue Code of 1986, may apply to the Small Employer if the Small Employer employ 20 or more employees. If COBRA applies to the Small Employer, a Covered Person may be entitled to continue coverage for a limited period of time, if the Covered Person meets the applicable requirements, makes a timely election, and pays the proper Premiums.

A Covered Person must contact the Small Employer to determine if he or she is 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 employees and dependents of their rights under COBRA. If the Small Employer or the Covered Person fails to meet its obligations under COBRA and this Small Employer Master Policy, BCBSF shall not be liable for any claims incurred by the Covered Person after his/her termination of coverage.

Solely for informational purposes, a summary of the COBRA rights of a Covered Person and the general conditions for a Covered Person's 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.

Covered Persons may elect, if COBRA applies to the Small Employer and the Covered Person is eligible for such coverage, to continue their group health insurance if they qualify under one of the following circumstances:

1. If coverage would otherwise be lost due to the death of a covered active or retired employee of the Small Employer, the surviving spouse and dependent children may qualify to elect to continue their group health coverage for a period of time not to exceed 36 months from the date of death.
2. A spouse who would otherwise lose coverage due to a divorce or legal separation from a covered active or retired employee of the Small Employer, and dependent children who would otherwise lose coverage due to the divorce or legal separation, may qualify to elect to continue their group health coverage for a period of time not to exceed 36 months from the date of divorce or legal separation.
3. A spouse or dependent child of a covered active or retired employee who would otherwise lose coverage due to the employee's (or retired employee's) entitlement to Medicare, may qualify to elect to continue their group health coverage for a period not to exceed 36 months from the date the employee or covered retiree first becomes entitled to Medicare.
4. Children of a covered active or retired employee, who would otherwise lose coverage due to a failure to meet the group health plan's eligibility requirements (e.g., exceeding the limiting age), may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the child ceased to meet such eligibility requirements.

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5. a. Covered employees, their covered spouse and dependent children may qualify to elect to continue their group health coverage if coverage would otherwise be lost due to termination of employment with the Small Employer (other than for reasons of gross misconduct), or due to a reduction in hours of employment with the Small Employer. This continuation of coverage may continue for a period not to exceed 18 months from the date of termination or reduction in hours.

   b. If the Covered Person is totally disabled (as defined by the Social Security Administration) at the time of the employee's termination, reduction in hours, or within the first 60 days of COBRA continuation of coverage, an extension of coverage of up to 11 additional months may be available (29 months total), if all notification and eligibility requirements have been met. This extension of coverage will not be provided if the Covered Person fails to provide the Small Employer with a copy of the "Determination of Disability" letter from the Social Security Administration within 60 days of the date of the determination of disability. The "Determination of Disability" letter must be provided to the Small Employer prior to the end of the 18-month COBRA continuation period. If the extension of coverage for the 11 additional months is granted, the extension applies to all non-disabled covered family members.

6. If a Covered Person is receiving continuation of coverage under paragraph 5, such coverage may continue for a period longer than the time stipulated in that paragraph if an event that would otherwise have entitled the Covered Person to COBRA continuation of coverage (e.g., divorce, legal separation or death) later occurs. But in no case will the Covered Person receive coverage beyond 36 months from the event that originally made him or her eligible for coverage.

7. If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to the Small Employer, continuation rights shall be provided to the Covered Person to the extent required under COBRA.

In order for the group health coverage to continue pursuant to COBRA, the following conditions must be met:

1. a. If coverage would be lost due to a reduction in hours or termination of employment (for reasons other than gross misconduct), the Small Employer must notify the employee and dependents of their continuation of coverage rights under COBRA within 14 days of the termination of employment or reduction in hours causing loss of coverage.

   b. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a covered dependent child to meet eligibility requirements, the employee or dependent must notify the Small Employer, in writing, within 60 days of any of these events. The Small Employer must notify the dependents of their continuation of coverage rights within 14 days of receipt of such notice from the employee or dependent.

2. The qualified Covered Person must elect to continue the group health insurance within 60 days of the later of the date that the coverage terminates or the date the notification of continuation of coverage rights is sent by the Small Employer.

3. The qualified Covered Person who elects continuation of coverage must not become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect the continuant's coverage.

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4. The qualified Covered Person who elects continuation of coverage, must not become after electing, entitled to Medicare.

5. A totally disabled Covered Person who is eligible to extend and who elects to extend his or her continuation of coverage may not continue such coverage more than 30 days after a determination by the Social Security Administration that the Covered Person is no longer disabled. The Covered Person must inform the Small Employer of the Social Security determination within 30 days of such determination.

   For purposes of this section, a totally disabled Covered Person is a Covered Person who is determined to be disabled under the Social Security Acts (Title II, OASDI or Title XVII, SSI).

6. The qualified Covered Person electing continuation of coverage, must meet all Premium payment requirements, and all other eligibility requirements set forth in COBRA, and, to the extent not inconsistent with COBRA, in the Small Employer Master Policy.

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

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

The Covered Person does not need to show insurability to receive COBRA continuation of coverage. However, the Covered Person must pay the applicable Premiums charged by the Small Employer and the Small Employer Master Policy.

In the case of a qualified Covered Person whose maximum period of continuation of coverage expires, the Small Employer must, during the 180-day period prior to such expiration date, provide the qualified Covered Person the option of enrolling in an individual conversion policy made available to the Covered Persons of the Small Employer by BCBSF.

NOTE: This section shall not be interpreted to grant to any Covered Person 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 Health Insurance Coverage Continuation Act (FHICCA) Provisions (For employers with one to 19 employees)

Effective January 1, 1997, *Florida Statute* 627.6692, known as the Florida Health Insurance Coverage Continuation Act, requires that a Small Employer with fewer than 20 employees who does not qualify for the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), offer to Covered Employees and their Covered Dependents the opportunity for a temporary extension of health coverage (called “continuation of coverage”) in certain instances where coverage would otherwise end. The Covered Person has certain rights and obligations under the continuation of coverage provision of the law.

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Initial Notice of Rights to Continuation of Coverage

Each Covered Person and the Covered Person's dependents should review this provision and refer to it in the event that any action is required on the part of the Covered Person or the Covered Person's dependents.

Types of Qualifying Events

If an employee's employer has fewer than 20 employees and the employee is covered by this Small Employer Master Policy, the Covered Employee has the right to choose this continuation of coverage of this Small Employer Master Policy if:

1. the Covered Employee loses group health coverage because of a reduction in the Covered Employee's hours of employment; or
2. the termination of the Covered Employee's employment (for reasons other than gross misconduct on the part of the Covered Employee).

The covered 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 five 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. parents' divorce or legal separation;
4. the Covered Employee becomes entitled to Medicare; or
5. the dependent ceases to be a "dependent child" under the terms of the Small Employer Master Policy.

Covered Persons also have a right to elect continuation of coverage if the Covered Person is covered under the plan as a retiree, or spouse or child of a retiree, and loses coverage within one year before or after the commencement of proceeding under Title 11 (bankruptcy), United States Code, by the employer from whose employment the Covered Employee retired.

Under the law, the Covered Employee or a family member has the responsibility to inform BCBSF's Florida Health Insurance Coverage Continuation Act administrator, Coverage Continuation Service Inc. (CCSI) of a divorce, legal separation, or a child losing dependent status under the Small Employer Master Policy. **This notification must be made within 30 days of the date of the qualifying event which would cause a loss of coverage.**

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The notice must be in writing and include:

1. the name of the qualified beneficiary;
2. the date of the qualifying event;
3. one of the types of qualifying events as listed above;
4. the name of the employer;
5. the Group Plan number;
6. the name and address of all qualified beneficiaries; and
7. the contract number, identification number, or social security number of all qualified beneficiaries.

When CCSI receives the timely written notice as described above, CCSI will send to the Covered Person by Certified Mail a **Premium Notice and Election Form** that describes the Continuation Coverage options available. Under the law, Covered Persons have 30 days from the date of receipt of the **Premium Notice and Election Form** to elect Continuation Coverage. To elect Continuation Coverage, complete and return the Premium Notice and Election Form with applicable Premium payment to CCSI. Continuation Coverage begins on the day after coverage would otherwise be terminated, only if the Premium Notice and Election Form and full Premium payment are sent and received by CCSI within the allotted time period and all other eligibility requirements are satisfied.

If the Covered Person does not elect coverage and pay the Premium, the Covered Person's group health insurance coverage will terminate in accordance with the provisions outlined in the Covered Person's Small Employer Master Policy, Certificate, or other applicable plan documents.

If the Covered Person chooses continuation of coverage, the coverage will be identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that Covered Persons be afforded the opportunity to maintain continuation of coverage for 18 months. However, the law also provides that a Covered Person's continuation of coverage may be terminated for any of the following reasons:

1. the employer/former employer no longer provides group health coverage to any of its employees;
2. the Premium for Covered Person's continuation of coverage is not paid by the grace period expiration date, which is 30 days;
3. the Covered Person first becomes, after electing continuation of coverage, 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;
4. the Covered Person is approved, after electing continuation of coverage, 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 CCSI 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. The carrier can charge up to 150 percent of the group rate during the 11-month extension. The disabled individual must notify the carrier within 30 days of any final determination that he or she is no longer disabled.

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Covered Persons do not have to show insurability to choose continuation of coverage. However, a Covered Person 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, Covered Persons must be allowed to enroll in an individual conversion health plan as provided for in the Conversion Privilege Section.

Any questions regarding this should be directed to the person or office shown below. Also if the Covered Person has changed marital status, or has changed addresses, please notify in writing, the person or office shown below:

Coverage Continuation Service Inc. (CCSI)
P. O. Box 9071
Clearwater, Florida 34618-9071
1 (888) 342-5888

If any covered child is at a different address, please notify CCSI in writing, so that a separate notice may be sent to the separate household.

SAMPLE

CONVERSION PRIVILEGE

Eligibility Criteria for Conversion

A Covered Person is entitled to apply for a BCBSF individual policy (herein after referred to as a "converted policy") if:

1. the Covered Person was continuously covered for at least three months under the Small Employer Master Policy and/or under another group policy, in effect, immediately prior to the Small Employer Master Policy providing similar benefits; and
2. the Covered Person's coverage has been terminated for any reason, including discontinuance of this Small Employer Master Policy in its entirety and termination of continued coverage under COBRA or FHICCA.

BCBSF will mail to a Covered Person, within 14 days after the Covered Person gives proper notice to BCBSF that he/she is considering applying for a converted policy or the Covered Person requests such information, a converted policy application and premium notice, including an outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

BCBSF must receive a completed converted policy application and the applicable Premium payment within the 63-day period beginning on the date the coverage under the Small Employer Master Policy terminated. If coverage has been terminated due to the non-payment of Premium by the Small Employer, BCBSF 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 BCBSF does not receive the converted policy application and the initial Premium payment within such 63-day period, the Covered Person's converted policy application will be denied and the Covered Person will not be entitled to a converted policy.

Additionally, a Covered Person is not entitled to a converted policy if:

1. the Covered Person is eligible for or covered under the Medicare program;
2. the Covered Person's coverage terminated because the Covered Employee failed to make any Premium contribution payment on a timely basis;
3. the Small Employer Master Policy was replaced 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 Certificate; or
4. a. the Covered Person is covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Certificate; or

   b. the Covered Person is 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 Certificate; or

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c. benefits similar to the benefits provided under this Certificate are provided for or are available to the Covered Person pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and

d. the benefits provided under the sources referred to in paragraph 4a. or the benefits provided or available under the source referred to in paragraph 4b. and c. above, together with the benefits provided by BCBSF's converted policy would result in over insurance in accordance with BCBSF's over insurance standards, as determined by BCBSF.

BCBSF has no obligation to notify any Covered Person of this conversion privilege when the Covered Person's coverage terminates or at any other time. It is the sole responsibility of the Covered Person to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial Premium payment to BCBSF on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day the individual's coverage hereunder terminated.

Note: BCBSF's converted policies are not a continuation of coverage under COBRA or FHICCA, or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Certificate. A Covered Person applying for a BCBSF converted policy has two options: 1) a converted policy providing major medical coverage meeting the requirements of 627.6675(10) *Florida Statutes;* and 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) *Florida Statutes.* In any event, BCBSF shall not be required to issue a converted policy unless required to do so by Florida law.

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EXTENSION OF BENEFITS

Extension of Benefits

In the event the Small Employer Master Policy is terminated, BCBSF will not provide coverage for any Health Care Service rendered on or after the termination date. The extension of benefits provisions set forth below only apply when the Small Employer Master Policy is terminated. The extension of benefits provided hereunder do not apply when an individual Covered Person's coverage terminates as long as 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 the Covered Person's responsibility to provide acceptable documentation to BCBSF that the Covered Person is entitled to an extension of benefits.

1. In the event a Covered Person is Totally Disabled on the termination date of the Small Employer Master Policy as a result of a specific Accident or illness incurred while the Covered Person was covered under this Certificate, as determined by BCBSF, BCBSF will provide a limited extension of benefits for the disabled Covered Person 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, 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 Small Employer Master Policy.

   For purposes of this section, a person is "Totally Disabled" only if, in the opinion of BCBSF, the Covered Person is unable to work at any gainful job for which the Covered Person is suited by education, training, or experience, and the Covered Person requires regular care and attendance by a Physician. For those Covered Persons who do not work (e.g., a student, child, or non-working spouse) such Covered Person is Totally Disabled only if, in the opinion of BCBSF, such Covered Person is unable to perform those normal day-to-day activities which they would otherwise perform and such Covered Person requires regular care and attendance by a Physician.

2. In the event a Covered Person is receiving covered dental treatment as of the termination date of the Small Employer Master Policy, BCBSF will provide a limited extension of benefits for 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 the Covered Person was 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 Covered Person's coverage terminated under the Small Employer Master Policy, and the termination did not occur as a result of the Covered Employee's voluntary termination of coverage.

      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

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beginning on the termination date of the Small Employer Master Policy or on the date the Covered Person becomes covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or services for similar dental procedures. This extension of benefits is not predicated upon the Covered Person being Totally Disabled.

3. In the event a Covered Person is pregnant as of the termination date of the Small Employer Master Policy, BCBSF will provide a limited extension of the maternity expense benefits provided by this Certificate, provided the pregnancy commenced while the pregnant Covered Person was covered under the Small Employer Master Policy, as determined by BCBSF. 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. This extension of benefits is not predicated upon the Covered Person being Totally Disabled.

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THE EFFECT OF MEDICARE COVERAGE / MEDICARE SECONDARY PAYER PROVISIONS

When a Covered Person becomes covered under Medicare and continues to be eligible and covered under the Small Employer Master Policy, BCBSF's coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, BCBSF's coverage hereunder shall be secondary to any Medicare benefits. To the extent BCBSF is the primary payer, claims for Covered Services should be filed with BCBSF first.

Under Medicare, the Small Employer MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such Covered Person. Also, the Small Employer MAY NOT induce such Covered Person to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

A Covered Person who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease ("ESRD") must notify the Small Employer.

Individuals With End Stage Renal Disease

For a Covered Person who is entitled to Medicare coverage because of ESRD, BCBSF will provide group health coverage on a primary basis for 30 months beginning with the earlier of:

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

If Medicare was primary prior to the individual becoming 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. For individuals eligible for Medicare due to ESRD, BCBSF will provide group health coverage, as set forth herein, 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. BCBSF shall 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 set forth in this section.
3. If BCBSF should elect to make primary payments covering services rendered to an employee or dependent described in this section in a period prior to receipt of the information required by the

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terms of this section, BCBSF may require the Small Employer to reimburse BCBSF for such payments. Alternatively, BCBSF may require the Small Employer to pay the rate differential that resulted from the Small Employer's failure to provide BCBSF with the required information in a timely manner.

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DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS / PROGRAMS

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided by BCBSF. COB determines the manner in which expenses will be paid when a Covered Person is 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. Contracts 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 insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage;
4. Medicare, as described in The Effect of Medicare Coverage/Medicare Secondary Payer Provisions Section.

The amount of payment by BCBSF, if any, is based on whether or not BCBSF is the primary payer. When BCBSF is primary, BCBSF will pay for Covered Services without regard to the Covered Person's coverage under other plans. When BCBSF is other than primary, BCBSF's payment for Covered Services may be reduced so that total benefits under all such plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event a Covered Person receives Covered Services from a PPO Provider or a Traditional Insurance Provider, "total reasonable expenses" shall mean the amount BCBSF is obligated to pay to the Provider pursuant to the applicable agreement BCBSF has with such Provider. In the event that the primary payer's payment exceeds BCBSF 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 BCBSF covers the Covered Person as a Covered Dependent and the other plan covers the Covered Person as other than a dependent, BCBSF will be secondary.
2. When BCBSF covers 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;
    b. if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than BCBSF, BCBSF will be secondary.
3. When BCBSF covers 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;

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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 BCBSF covers the Covered Person as a dependent child and the other plan covers the Covered Person 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.

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

   BCBSF 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 an individual is 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;

   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.

Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in *Florida Statutes* 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

Facility of Payment

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

Non-Duplication of Government Programs

The benefits under this Certificate shall not duplicate any benefits to which the Covered Person is entitled to or eligible to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) 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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SUBROGATION

Subrogation

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

A Covered Person shall do nothing to prejudice BCBSF's right of subrogation hereunder and no waiver, release of liability, or other documents executed by the Covered Person, without notice to and written consent of BCBSF, shall be binding upon BCBSF.

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RIGHT OF REIMBURSEMENT

Right of Reimbursement

If any payment under this Certificate is made to or on behalf of a Covered Person on account of any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, BCBSF shall have a right to be reimbursed by the Covered Person (out of any settlement or judgment proceeds recovered which include payment for medical expenses) one dollar ($1.00) for each dollar paid under the terms of this Certificate minus its pro rata share for any costs and attorney fees incurred by the Covered Person in pursuing and recovering such proceeds.

BCBSF's right of reimbursement shall be in addition to any subrogation right or claim available to BCBSF, and the Covered Person shall execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by BCBSF to exercise its right of reimbursement hereunder. A Covered Person shall do nothing to prejudice BCBSF's right of reimbursement hereunder and no waiver, release of liability, or other documents executed by the Covered Person, without notice to and written consent of BCBSF, shall be binding upon BCBSF.

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CLAIMS PROCESSING

How to File a Claim for Benefits/Time Requirement

PPO Providers and Traditional Insurance Providers have agreed to file with BCBSF claims for Health Care Services they rendered to Covered Persons. In the event a Provider who renders services to a Covered Person does not file a claim for such services, it is the Covered Person's responsibility to file the claim with BCBSF.

A claim must be received by BCBSF within 90 days of the date the service or supply was rendered, or if it is not reasonably possible to file the claim within such 90 day period, the Covered Person shall ensure that the claim is filed as soon as possible. In any event, no claim for Health Care Services will be considered for payment if, BCBSF does not receive the claim at the address indicated on the Covered Person's Identification Card within one year of the date the Health Care Service was rendered unless the Covered Person was legally incapacitated.

To file a claim, the Covered Person must obtain an itemized statement from the health care Provider and attach it to a completed BCBSF claim form. The Covered Person may obtain a BCBSF claim form by contacting the local BCBSF office. The itemized statement must contain the following information:

1. the date the service or supply was provided;
2. a description of the service or supply;
3. the amount actually charged by the Provider;
4. the diagnosis;
5. the Provider's name and address;
6. the patient's name; and
7. the Covered Employee's name.

The itemized statement and claim form must be sent to BCBSF at the address indicated on the Covered Person's Identification Card.

Note: Please reference the pharmacy program Endorsement for information on the processing of prescription drug claims. Further, special claims processing rules may apply when amounts are payable by BCBSF outside the State of Florida, under the BlueCard Program®. (See the BlueCard Program® Section of this Certificate).

The Processing of the Claim

Once BCBSF has received the completed claim, BCBSF will promptly process it. BCBSF will process all claims for which it has all of the necessary information, as determined by BCBSF, within 45 days of receipt of the completed claim for benefits (proof of claim). In the event BCBSF contests or denies the claim or a portion of the claim, or needs additional information, BCBSF will so notify the Covered Person (or the Covered Person's assignee, if any assignment of benefits is required to be honored by BCBSF), within 45 days of receipt of the initial claim. The notice will identify the contested or denied portion of the

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claim and the reason(s) for contesting or denying the claim or a portion of the claim. It is the Covered Person's responsibility to ensure that BCBSF receives all information that BCBSF determines is necessary to complete processing of the claim. If BCBSF does not receive necessary information, a claim or a portion of a claim may be denied. BCBSF will then complete the processing of the claim within 60 days of receipt of the additional information requested by BCBSF. In any event, all claims will be paid or denied 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 processing decision is deposited in the mail by BCBSF. Any claims payment not made by BCBSF within the applicable time frame is subject to the payment of simple interest at the rate of 10 percent per annum.

BCBSF will investigate any claim of improper billing by a Provider, upon written notification by a Covered Person. If BCBSF determines that the Covered Person was improperly billed, any payment amount will be adjusted, and if applicable, a refund will be requested. If payment to the Provider is reduced due solely to the notification from the Covered Person, BCBSF will pay the Covered Person 20 percent of the amount of the reduction, up to a total of $500.

The Review of Claims which are Denied

In the event BCBSF denies a claim, the Covered Person may request BCBSF to review the decision to deny the claim. The Covered Person must request such review within 60 days of receipt of the notice of the claim denial. The Covered Person should submit to BCBSF any additional information the Covered Person wants BCBSF to consider during the review. BCBSF will promptly notify the Covered Person of its review decision. The Covered Person may designate, in writing, an individual to represent the Covered Person during the review process.

Each Covered Person, or a Provider acting on behalf of a Covered Person, 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 review. The appeal may be by telephone and BCBSF's Physician will respond to the Covered Person within a reasonable time, not to exceed 15 business days.

Additional Claims Processing Provision

1. Release of Information/Cooperation

   In order to process claims, BCBSF may need information, including medical information, from the health care Provider who rendered the Health Care Service. Covered Persons shall cooperate with BCBSF in its effort to obtain such information by, among other ways, signing any release of information form as requested by BCBSF. Failure by a Covered Person to fully cooperate with BCBSF may result in a denial of the pending claim and BCBSF shall have no liability for such claim.

2. Physical Examination

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

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3. Legal Actions

No legal action arising out of or in connection with coverage under the Small Employer Master Policy may be brought against BCBSF within the 60-day period following BCBSF's receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits

BCBSF relies 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 BCBSF may have, in denial of the claim or cancellation or rescission of the Covered Person's coverage.

5. Explanation of Benefits Form

All claims decisions, including denial and claims review decisions, will be communicated to the Covered Person in writing in an explanation of benefits form:

This form may indicate:

a. the reason(s) the claim was denied;

b. a reference to the applicable provision upon which the denial is based;

c. a description of additional material or information necessary to make the claim payable and why such material or information is necessary; and

d. an explanation of the steps to be taken if a Covered Person wants a claim denial decision reviewed.

6. Circumstances Beyond the Control of BCBSF

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of BCBSF, results in facilities, personnel or financial resources of BCBSF being unable to process claims for Covered Services, BCBSF shall have no liability or obligation for any delay in the payment of claims for such Covered Services, except that BCBSF shall 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 the control of BCBSF if BCBSF cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

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RELATIONSHIPS BETWEEN THE PARTIES

BCBSF and Health Care Providers

Neither BCBSF nor any of its officers, directors or employees provide Health Care Services to Covered Persons. Rather, BCBSF and such individuals are engaged in making coverage and/or benefit decisions under this Certificate. By accepting BCBSF coverage and/or benefits, Covered Persons agree that making such coverage and/or benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering Health Care Services are not the employees or agents of BCBSF. **In this regard, BCBSF hereby expressly disclaims any agency relationship, actual or implied, with any health care Provider.** BCBSF does not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care Provider. Any decisions made by BCBSF 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 Covered Person is the agent or representative of BCBSF, and neither shall be liable for any acts or omissions of BCBSF, its agents, servants, or employees. Additionally, neither the Small Employer, any Covered Person, nor BCBSF shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which BCBSF has made or hereafter makes arrangements for the provision of Covered Services. BCBSF is not the agent, servant, or representative of the Small Employer or any Covered Person, and shall not be liable for any acts or omissions of the Small Employer, its agents, servants, employees, any Covered Person, or any person or organization with which the Small Employer has entered into any agreement or arrangement. By acceptance of coverage and/or benefits hereunder, each Covered Person agrees to the foregoing.

Medical Decisions - Responsibility of a Covered Person's 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 the Covered Person, the Covered Person's family and the Covered Person's treating Physician in accordance with the patient/physician relationship. It is possible that the Covered Person or the Covered Person's 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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GENERAL PROVISIONS

Access to Information

BCBSF shall have the right to receive, from any health care Provider rendering services to a Covered Person, information that is reasonably necessary, as determined by BCBSF, in order to administer the coverage and/or benefits it provides, subject to all applicable confidentiality requirements set forth below. By accepting coverage, each Covered Person authorizes every health care Provider who renders Health Care Services to a Covered Person, to disclose to BCBSF or to entities affiliated with BCBSF, upon request, all facts, records, and reports pertaining to such Covered Person's care, treatment, and physical or mental Condition, and to permit BCBSF to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and/or benefits, BCBSF 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 Covered Person or applicant for enrollment which BCBSF deems to be necessary.

Right to Recovery

Whenever BCBSF has made payments in excess of the maximum provided for under this Certificate, BCBSF shall have the right to recover any such payments, to the extent of such excess, from any Covered Person, person, plan, or other organization that received such payments.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for BCBSF to administer coverage and/or benefits, specific medical information concerning Covered Persons received by Providers shall be kept confidential by BCBSF 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/or benefits, specifically including BCBSF's quality assurance and UM/UR Programs. Additionally, BCBSF may disclose such information to entities affiliated with BCBSF or other persons or entities utilized by BCBSF to assist in providing coverage, benefits or services under this Certificate. 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.

BCBSF's arrangements with Providers may require that BCBSF release certain claims and medical information about Covered Persons even if the Covered Person has not sought treatment by or through that Provider. By accepting coverage, each Covered Person hereby authorizes BCBSF to release to Providers claims information, including related medical information, pertaining to the Covered Person in order for any such Provider to evaluate the Covered Person’s financial responsibility under this Certificate.

SAMPLE

Identification Cards

The Identification Cards issued to Covered Persons in no way create, or serve to verify, eligibility to receive coverage and/or benefits hereunder. Identification cards are the property of BCBSF and must be destroyed or returned to BCBSF immediately following termination of the Covered Employee's coverage.

Modification of Provider Networks and the Participation Status

Provider networks, in participation status of individual Providers, available under this Certificate are subject to change at any time without prior notice to, or approval of, the Small Employer or any Covered Person. Additionally, BCBSF 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 any Covered Person. It is the Covered Person's responsibility to determine whether a health care Provider is participating in any Provider network at the time the Health Care Service is rendered. Under this Certificate, a Covered Person's financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of Covered Persons

Each Covered Person shall cooperate with BCBSF, and shall execute and submit to BCBSF such consents, releases, assignments, and other documents as may be requested by BCBSF in order to administer, and exercise its rights hereunder. Failure to do so shall constitute grounds for termination for cause by BCBSF. (See the Termination of an Individual's Coverage for Cause subsection in the Termination of Individual Coverage Section.)

Non-Waiver of Defaults

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

Notices

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

If to BCBSF:

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

If to a Covered Person:

To the latest address provided by the Covered Person or to the Covered Employee's latest address on the Universal Individual Application for Group Insurance/Membership or change of address form actually delivered to BCBSF.

The Covered Employee shall notify BCBSF immediately of any address change.

SAMPLE

If to Small Employer:

To the address indicated on the Small Employer Application.

Obligations of BCBSF Upon Termination

Upon termination of an individual's coverage for any reason, BCBSF shall have no further liability or responsibility under the Small Employer Master Policy with respect to such individual, except as specifically set forth herein.

SAMPLE

GLOSSARY OF TERMS

For purposes of this Certificate and any Endorsements, the following terms shall have the meanings set forth below. Additional definitions pertaining to Providers may be found in the Health Care Provider Alternatives and Reimbursement Rules Section of this Certificate.

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 Statutes* or the similar applicable laws of another state.

Allowance means the maximum amount BCBSF will base payment on for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was not a PPO Provider. This Allowance is determined and established solely by BCBSF and is based upon many factors. Such factors may (but not necessarily will) include: pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); relative value scales; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area established by BCBSF; and/or the cost of providing the Covered Service. The Allowance may be modified by BCBSF at any time without the consent or notice to the Small Employer or any Covered Person.

Allowed Amount means the maximum amount BCBSF will base payment on for Covered Services. The Allowed Amount is the PPO Schedule Amount when the Provider who rendered the Covered Service(s) was a BCBSF PPC℠ Provider, and the Allowance when the Provider who rendered the Covered Service(s) was not a PPO Provider. Further, under the BlueCard® Program, the Allowed Amount means the maximum amount upon which BCBSF will base payment to the applicable Host Plan for Covered Services provided in the applicable Host Plan's geographic area. Each Allowed Amount is determined and established by BCBSF and is subject to change at any time without notice to or consent of the Small Employer or any Covered Person.

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. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.

SAMPLE

Anniversary Date means the date, one year after the Effective Date, stated on the Small Employer Application and subsequent annual anniversaries of that date.

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.

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 Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield. Subject to any applicable BlueCard® Program rules and protocols, Covered Persons may have access to the Provider discounts of other participating Blue Cross and/or Blue Shield plans.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

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

Calendar Year begins January 1st and ends December 31st in any given Calendar Year.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Certified Nurse Midwife means a person who is 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.

Coinsurance means the sharing of health care expenses for Covered Services between BCBSF and the Covered Person. After the Covered Person's Deductible requirement is met, BCBSF will pay a percentage of the Allowed Amount for Covered Services, as set forth in the Schedule of Benefits.

SAMPLE

Condition means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Covered Person.

Copayment (if applicable) means the dollar amount established solely by BCBSF which is required to be paid to a health care Provider by a Covered Person at the time certain Covered Services are rendered by that Provider. While this amount may vary depending on, among other things, the contracting status of the health care Provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Schedule of Benefits for the service. Except as otherwise established solely by BCBSF, if more than one Covered Service is rendered by a health care Provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Benefits for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.

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 Dependent(s) subsection of the Eligibility for Coverage Section.)

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

Covered Person means any Covered Employee or Covered Dependent.

Covered Services means those Medically Necessary Health Care Services described in the Covered Services Section. The term Health Care Services include, as applicable, any treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of, Providers.

Creditable Coverage means health care coverage which is continuous to a date within 63 days of the Covered Person's Enrollment Date. Such health care coverage may include any of the following:

1. a group health 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; or
10. a health benefit plan of the Peace Corps.

SAMPLE

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which a Covered Person must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Certificate, before BCBSF's payment for Covered Services begins.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, Covered Person is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the Covered Person 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 Health Care Financing Administration, and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management services.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) not for comfort or convenience; (4) generally is not useful to an individual in the absence of a Condition; and (5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law (or a similar applicable law of another state) to provide home medical equipment, oxygen therapy services, or dialysis supplies in the patient's home under a Physician's prescription.

Effective Date with respect to the Small Employer and to Covered Persons properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the Small Employer Application and cover page of the BlueChoice Small Employer Master Policy; and with respect to Covered Person's who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section of the Certificate of Coverage.

Eligible Dependent means a Covered Employee's (1) legal spouse or (2) 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 is:

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1. dependent upon the Covered Employee for financial support;
2. under the limiting age set forth in the Eligibility Requirements for Dependent(s) subsection of this Certificate; and
3. living in the household of the Covered Employee or a full-time or part-time student.

A newborn child of a Covered Person other than the Covered Employee or the newborn child of a Covered Person other than the Covered Employee's spouse is an Eligible Dependent hereunder. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Eligible Employee means an employee who meets all of the eligibility requirements set forth in the Eligibility Requirements for Covered Employees subsection of the Eligibility for Coverage Section, 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, BCBSF.

Endorsement means any amendment to the Small Employer Master Policy or the Certificate.

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 which are used to maintain accurate enrollment files under the Small Employer Master Policy. Such forms include: the Universal Individual Application for Group Insurance/Membership form and the Member Status Change Request form and any forms required by BCBSF for enrollment purposes.

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 BCBSF:

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 the Covered Person;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s),

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toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by BCBSF):

1. records maintained by Physicians or Hospitals rendering care or treatment to the Covered Person 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 Covered Services Section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

Foster Child means a person under the age of 18 who is placed in the Covered Employee's residence and care by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state's applicable laws.

Gamete Intrafallopian Transfer (GIFT*)* means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.

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Health Care Services include treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, Providers.

Home Health Agency means a properly licensed agency or organization which provides health services in the home pursuant to Chapter 400 of the *Florida Statutes*, or a similar applicable law of another state.

Home Health Care means Physician directed professional, technical and related medical and personal care services provided in the Covered Person's home or residence on a visiting or part-time basis by a Home Health Agency.

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 facility for diagnosis, care and treatment of Mental Health Services or Substance Dependency Care and Treatment; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities or 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 Card means the card(s) issued by BCBSF to Covered Employees. The card is the property of BCBSF, 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 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.

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.

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

Massage or Massage Therapy means the manipulation of superficial tissues of the human body by using the hand, foot, arm, or elbow.

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

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

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

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

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.

Member Status Change Request form means the form(s) provided by or acceptable to BCBSF, which a Covered Employee must complete and submit through the Small Employer and received by BCBSF, when adding or deleting a Covered Dependent.

Mental Health Professional means a person properly licensed to treat 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 Health Services means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

SAMPLE

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

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.

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.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Partial Hospitalization means treatment in which the patient receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

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

Physician means any individual who is properly licensed by the State of Florida, or other similar states' applicable laws, 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.

Placement or To Place means the process of a person giving a child up for Adoption and the prospective parent receiving and Adopting the child, or the process where a Foster Child will reside with and be cared for by the Covered Person and includes all actions by any person or agency participating in the process, or as otherwise defined by *Florida Statutes*.

PPO means, or refers to, the network of PPO Providers available to Covered Persons under this Certificate.

PPO Provider means, or refers to, any health care Provider who or which, at the time Health Care Services were rendered to a Covered Person, was under contract with BCBSF to participate in BCBSF's network of preferred Providers, such Providers also known as "Preferred Patient Care℠" or "PPC℠" Providers or BCBSF PPC℠ Providers. The term PPO Provider also refers, when applicable, to health care Providers in certain counties who or which, at the time Health Care Services were rendered to a Covered Person, were under contract to participate as PPC℠ Providers. A Covered Person, when receiving Covered Services from any PPC℠ Provider, is also considered a policyholder, as that term is defined and used in the applicable PPC Provider agreement between such Provider and BCBSF. For purposes of this Certificate, the term PPO 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

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rendered to a Covered Person, participated as Host Plan PPO Providers under the Blue Cross and Blue Shield Association's BlueCard® Program.

PPO Schedule Amount means the amount BCBSF will base payment on for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was a BCBSF PPC Provider. This amount is determined and established by BCBSF and is a pre-established maximum schedule amount which may vary by geographical area.

The amount of charges credited to the Deductible requirement will not exceed the Allowed Amount.

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

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 under a Physician's prescription.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

Provider means any facility, person or entity recognized for payment by BCBSF and defined in the Certificate.

Psychiatric Facility means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Certificate, a Psychiatric Facility is not a Hospital, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the *Florida Statutes*, or a similar applicable law of another state.

Rate means the amount BCBSF charges the 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.

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

Skilled Nursing Facility means an institution or part thereof which is licensed as a Skilled Nursing Facility by the State of Florida, or a similar applicable law of another state, 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; and which provides Covered Services that are skilled nursing services, as determined by BCBSF, to Covered Persons under a contract then in effect.

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Small Employer means the person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association (which meets the definition of a "small employer," as that term is defined by Section 627.6699(3)(v), *Florida Statutes*) through which coverage and/or benefits are issued by BCBSF and through which Covered Employees and Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

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 evidence of, and is, the entire agreement between the Group and BCBSF whereby coverage and/or benefits will be provided to Covered Persons. The Small Employer Master Policy includes the Certificate of Coverage (including the Schedule of Benefits), the Small Employer Application, the Universal Individual Application for Group Insurance/Membership, the Member Status Change Request form, and any Endorsements to the Certificate or the Small Employer Master Policy.

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

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

Standard Reference Compendium means: (1) The United States Pharmacopoeia Drug Information; (2) The American Medical Association Drug Evaluation; or (3) The American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency Care and Treatment. For purposes of this Certificate, a Substance Abuse Facility is not a Hospital.

Substance Dependency Care and Treatment 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 Insurance Providers are those health care Providers who are not PPO Providers, but who or which have entered into a contract then in effect to participate in BCBSF's traditional provider programs (these programs are also known as Payment for Physician Services "PPS" or Payment for Hospital Services "PHS"), as applicable, in Florida or in certain counties outside of Florida, when such programs exist.

Universal Individual Application for Group Insurance/Membership means the BCBSF form that individual(s) must submit to the Small Employer when applying for coverage during the 30 day period immediately following the date that individual(s) first became eligible for coverage under the Small Employer Master Policy, or as part of the initial enrollment of the Small Employer.

Waiting Period means the period of time specified on the Small Employer Application, if any, which must follow the date an individual is initially employed by the Small Employer before such individual may become a Covered Person.

SAMPLE

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.

SAMPLE

MediScript® Pharmacy Program Endorsement

This Endorsement is to be attached to, and made a part of, the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage issued to the Covered Employee. The Certificate of Coverage is hereby amended by adding the following MediScript® Pharmacy Program provisions.

Introduction

Under this BCBSF MediScript® Pharmacy Program Endorsement, BCBSF reimburses Covered Persons for a portion of the expenses they incur in purchasing Covered Prescription Drugs and/or Covered Syringes and Needles purchased at any Pharmacy. In order to obtain benefits under this Endorsement, Covered Persons must first pay for Covered Prescription Drugs and/or Covered Syringes and Needles and submit a claim form to BCBSF for processing and payment. Covered Persons may be able to reduce their out-of-pocket expenses by purchasing Covered Prescription Drugs and/or Covered Syringes and Needles from Participating Pharmacies. Participating Pharmacies are Pharmacies participating in BCBSF's statewide network of contracting Pharmacies in Florida and, for Covered Persons traveling or residing outside Florida, National Network Pharmacies. National Network Pharmacies are Pharmacies outside of Florida participating in a national network of Pharmacies available to BCBSF Covered Persons through BCBSF's Pharmacy Benefit Manager.

The coverage to be provided under this MediScript® Pharmacy Program Endorsement is subject to the definitions in the Glossary of Terms of the Certificate of Coverage amended by this Endorsement. Coverage is also subject to the Calendar Year Deductible(s) and Coinsurance percentage(s) payable by BCBSF to ***Providers Not Participating in PPO*** as set forth in the Certificate of Coverage's Schedule of Benefits.* Additionally, the coverage to be provided by BCBSF under this MediScript® Pharmacy Program Endorsement is subject to any limitations and specific and/or general exclusions set forth herein. Coverage is also subject to all exclusions and limitations contained in the Certificate of Coverage which this Endorsement amends.

SAMPLE

* **Note:** The percentage referred to means the Coinsurance percentage payable by BCBSF. Please refer to the Certificate of Coverage's Schedule of Benefits for the specific percentage amount. The unpaid percentage of the Participating Pharmacy Allowance is the Covered Person's Coinsurance responsibility and will apply towards the Covered Person's ***Individual Coinsurance Limit*** as specified in the ***Coinsurance Responsibility Per Calendar Year*** subsection of the Certificate of Coverage's Schedule of Benefits.

To the extent of any conflict between any specific provisions in this MediScript® Pharmacy Program Endorsement and the provisions of the Certificate of Coverage which it amends, the provisions of this Endorsement shall control.

Unless otherwise specified, in order to be covered under this Endorsement, Prescription Drugs must be:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;
2. dispensed by a Pharmacist;

3. be Medically Necessary as defined by BCBSF; and

4. not otherwise limited or excluded herein.

For further details concerning the Calendar Year Deductible(s) and the Coinsurance percentage(s) applicable to Covered Prescription Drugs and Covered Syringes and Needles, please refer to the Schedule of Benefits which is a part of the Certificate of Coverage which is amended by this Endorsement.

Pharmacy Alternatives and Reimbursement Rules

Covered Persons may fill their Prescriptions for Covered Prescription Drugs and/or Covered Syringes and Needles at any Pharmacy of their choice. Under this MediScript® Pharmacy Program Endorsement, the amount of BCBSF's reimbursement for, and the reimbursement rules applicable to, Covered Prescription Drugs and/or Covered Syringes and Needles will vary depending on the Pharmacy selected.

For reimbursement purposes, there are two types of Pharmacies: (1) "Participating Pharmacies" and (2) "Non-Participating Pharmacies." Participating Pharmacies are Pharmacies participating in BCBSF's MediScript® Pharmacy Program or the national Pharmacy network belonging to BCBSF's Pharmacy Benefit Manager at the time Covered Prescription Drugs and/or Covered Syringes and Needles are purchased by a Covered Person. These Pharmacies have agreed not to charge or collect more than the Participating Pharmacy Allowance per Prescription for Covered Prescription Drugs and/or Covered Syringes and Needles.

There are two types of Participating Pharmacies: (1) Pharmacies in Florida that have signed a MediScript® Participating Pharmacy Provider Agreement with BCBSF and (2) National Network Pharmacies. National Network Pharmacies are Pharmacies outside of Florida participating in the national network of Pharmacies available to BCBSF Covered Persons through BCBSF's Pharmacy Benefit Manager.

A Non-Participating Pharmacy is a Pharmacy which has not agreed to participate in BCBSF's MediScript® Participating Pharmacy Program and which is not a National Network Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, the Covered Person may refer to the Pharmacy Program Provider Directory then in effect and/or call the customer service telephone number included in the Certificate of Coverage or on the Covered Person's Identification Card.

NOTE: In order to be eligible to be charged the Participating Pharmacy Allowance under this Endorsement, a Covered Person must, prior to the filling of a Prescription, present his or her BCBSF Identification Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that the Covered Person is, in fact, covered by BCBSF.

Reimbursement Rules for Participating Pharmacies Located in Florida

BCBSF's reimbursement for Covered Prescription Drugs and/or Covered Syringes and Needles purchased at Participating Pharmacies located in Florida will be based upon the "Participating Pharmacy Allowance." The Participating Pharmacy Allowance for Participating Pharmacies in Florida is established by BCBSF. Such Participating Pharmacies have agreed to charge the Covered Person no more than the

SAMPLE

Participating Pharmacy Allowance and, therefore, the Covered Person's financial obligation will include the following:

1. the payment of any applicable Calendar Year Deductible(s) and/or Coinsurance requirements;
2. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non-covered, limited, or excluded syringes and needles and Drugs;
3. the payment of expenses in excess of any maximum benefit limitation; and
4. the payment of any applicable benefit reductions or penalties.

Participating Pharmacies in Florida have agreed to provide the Covered Person with all of the information necessary to file a claim with BCBSF. BCBSF's reimbursement will be:

1. made directly to the Covered Person;
2. subject to the Calendar Year Deductible; and
3. based on the Participating Pharmacy Allowance, at the Coinsurance percentage applicable to ***Providers Not Participating in PPO***, as set forth in the Certificate of Coverage's Schedule of Benefits.

Reimbursement Rules for Participating Pharmacies Located Outside of Florida Which Are National Network Pharmacies

BCBSF provides, for Covered Persons traveling or residing outside Florida, benefits for Covered Prescription Drugs and/or Covered Syringes and Needles purchased at a National Network Pharmacy. A National Network Pharmacy has agreed to charge Covered Persons for Covered Prescription Drugs and/or Covered Syringes and Needles BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance. Therefore, a Covered Person's financial obligation will include the following:

1. the payment of any applicable Calendar Year Deductibles(s) and/or Coinsurance requirement;
2. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non- covered, limited, or excluded syringes and needles and Drugs;
3. the payment of expenses in excess of any maximum benefit limitation; and
4. the payment of any applicable benefit reductions or penalties.

National Network Pharmacies have agreed to provide the Covered Person with all of the information necessary to file a claim with BCBSF. BCBSF's reimbursement will be:

1. made directly to the Covered Person;
2. subject to the Calendar Year Deductible; and
3. based on BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance, at the Coinsurance percentage applicable to ***Providers Not Participating in PPO***, as set forth in the Certificate of Coverage's Schedule of Benefits.

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Reimbursement Rules for Non-Participating Pharmacies

"Non-Participating Pharmacies" are Pharmacies which have not agreed to participate in BCBSF's MediScript® Participating Pharmacy Program and which are not National Network Pharmacies. BCBSF's reimbursement for Covered Prescription Drugs and/or for Covered Syringes and Needles is based upon BCBSF's Participating Pharmacy Allowance. Non-Participating Pharmacies have NOT agreed to accept BCBSF's or BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance; therefore, the Covered Person's financial responsibility will include the following:

1. the payment of any difference between BCBSF's "Participating Pharmacy Allowance" and the Non-Participating Pharmacy's charge;
2. the payment of any applicable Calendar Year Deductible(s) and/or Coinsurance requirements;
3. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non-covered, limited, or excluded syringes and needles and Drugs;
4. the payment of expenses in excess of any maximum benefit limitation; and
5. the payment of any applicable benefit reductions or penalties.

BCBSF's reimbursement will be:

1. made directly to the Covered Person;
2. subject to the Calendar Year Deductible; and
3. will be based on the "Participating Pharmacy Allowance" and payable at the Coinsurance percentage applicable to ***Providers Not Participating in PPO***, as set forth in the Certificate of Coverage's Schedule of Benefits.

Covered Prescription Drugs and/or Covered Syringes and Needles

All Prescription Drugs and/or Covered Syringes and Needles are covered under this Endorsement unless otherwise limited or excluded herein or by the Certificate of Coverage, or limited or excluded by any Endorsements to this Endorsement. In order to be covered under this Endorsement, Prescription Drugs and/or Covered Syringes and Needles must be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license, dispensed by a Pharmacist, and be Medically Necessary.

The only medical supplies and/or equipment which are covered under this Endorsement are Prescription diaphragms, and syringes and needles prescribed in conjunction with Insulin or Imitrex. Syringes and needles which are included in Anaphylactic kits are also covered. Other medical supplies and/or equipment are not covered under this Endorsement.

BCBSF's Coverage and Benefit Guidelines for Prescription Drugs

In providing benefits for Covered Prescription Drugs and/or Covered Syringes and Needles, BCBSF may apply the benefit guidelines set forth below, as well as any other applicable reimbursement rules specific to particular Covered Services listed in the Certificate of Coverage:

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Contraceptive Coverage

All Prescription diaphragms and oral contraceptive Prescription Drugs will be covered subject to the limitations and exclusions listed in this Endorsement.

Exclusion

Contraceptive injectable Prescription Drugs, and implants (e.g., IUD, etc.) inserted for purposes of contraception, are excluded from coverage under this Endorsement.

Diabetic Coverage

All Prescription Drugs used in the treatment of diabetes will be 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 dispensing Insulin will be covered only when prescribed in conjunction with Insulin.

Exclusion

All diabetic supplies and equipment, except for syringes and needles prescribed in conjunction with Insulin, are excluded from coverage under this Endorsement.

Note: Other diabetic supplies and equipment (e.g., blood glucose testing strips, lancets, glucometers, etc.) may be covered under other provisions of the Certificate of Coverage which this Endorsement amends although specifically excluded under this Endorsement.

Mineral Supplements, Fluoride Drugs or Vitamins

Prescription prenatal vitamins, oral single-product fluoride (non-vitamin supplementation), Prescription sustained release niacin, Prescription folic acid, Prescription oral hematinic agents, dihydrotachysterol and calcitriol are covered only when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license.

Exclusion

Non-prescription mineral supplements and non-prescription vitamins are excluded from coverage under this Endorsement.

Self-Injectable Drugs

The only self administered injectable Prescription Drugs covered under this Endorsement are Insulin, Imitrex and Prescription Drugs contained in Anaphylactic kits (i.e. Epi-Pen, Epi-Pen Jr., Ana-Kit). Syringes and needles prescribed in conjunction with Insulin or Imitrex or contained in Anaphylactic kits are covered.

Exclusion

All self-administered injectable Prescription Drugs, except for Drugs included in Anaphylactic kits, Insulin and Imitrex, are excluded. Syringes and needles which are not prescribed in conjunction with Insulin or Imitrex or contained in Anaphylactic kits are excluded.

SAMPLE

Limitations

Coverage and benefits for Covered Prescription Drugs and/or Covered Syringes and Needles under this Endorsement are subject to the following limitations in addition to all other provisions and exclusions of the Certificate of Coverage:

1. a maximum quantity of a One-Month Supply per Covered Prescription Drug and/or Covered Syringes and Needles;
2. refills must be filled within six months or one year from the original Prescription date, depending on federal law designations.

Exclusions

Expenses for the following are excluded under this MediScript® Pharmacy Program Endorsement:

1. Prescription Drugs which are covered and payable under a specific Covered Services subsection of the Certificate of Coverage which this Endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a facility or provider);
2. Except for Insulin, Imitrex, and Prescription Drugs contained in Anaphylactic kits, any Prescription Drugs obtained from a Pharmacy which are dispensed for administration by intravenous infusion or injection regardless of the setting in which such Prescription Drugs are to be administered or type of provider administering such Prescription Drugs;
3. Any Drug 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 those items listed in BCBSF's Coverage and Benefit Guidelines for Prescription Drugs set forth in this Endorsement (e.g. Insulin);
4. Contraceptive injectable Prescription Drugs, and implants (e.g., IUD, etc.) inserted for purposes of contraception;
5. All injectable Prescription Drugs, other than Prescription Drugs contained in Anaphylactic kits, Insulin, and Imitrex;
6. Syringes and needles which are not prescribed in conjunction with Insulin or Imitrex or contained in Anaphylactic kits;
7. All supplies and equipment other than Prescription diaphragms, and syringes and needles prescribed in conjunction with Insulin or Imitrex or syringes or needles contained in Anaphylactic kits;
8. Prescription Drugs, Prescription diaphragms, and syringes and needles (which would otherwise be covered) dispensed prior to the Effective Date of coverage for this MediScript® Pharmacy Program Endorsement;
9. Prescription Drugs, Prescription diaphragms, and syringes and needles (which would otherwise be covered) dispensed after the termination date of coverage for this MediScript® Pharmacy Program Endorsement;

SAMPLE

10. Any charge for therapeutic devices or appliances (e.g., support garments and other non-medical substances) regardless of their intended use, medical or other supplies (except for Covered Syringes and Needles, and Prescription diaphragms) and equipment;
11. Prescription Drugs and syringes and needles in excess of the limitations specified in this MediScript® Pharmacy Program Endorsement;
12. Prescription Drugs and syringes and needles which are furnished to the Covered Person without cost;
13. Prescription Drugs and syringes and needles which are Experimental or Investigational;
14. Mineral supplements, fluoride or vitamins except for those items listed in BCBSF's Coverage and Benefit Guidelines for Prescription Drugs;
15. Any appetite suppressant and/or other Prescription Drug indicated or used for purposes of weight reduction or control;
16. Injectable Drugs other than Insulin, Imitrex and Anaphylactic kits;
17. Immunization agents, biological sera, blood and blood plasma;
18. Any Prescription Drug indicated or used for the treatment of infertility;
19. Prescription Drugs used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova. (Retin-A is excluded after age 26);
20. Prescription Drugs prescribed by a Pharmacist;
21. Drugs used for smoking cessation (e.g., Zyban, Nicorette);
22. Drugs listed in the Homeopathic Pharmacopoeia;
23. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of 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 excluded;
24. Prescription Drugs which have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce;
25. Prescription Drugs and syringes and needles which are not Medically Necessary;
26. Prescription Drugs indicated or used for sexual dysfunction (e.g., Viagra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine);
27. Any Prescription 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 Prescription Drug. This exclusion does not apply if:
    a. the dosages, frequency of use, or duration of administration of a Prescription Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

SAMPLE

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

c. BCBSF, in its sole discretion, waives this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs;

28. Any Prescription Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Prescription 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 American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research unless BCBSF, in its sole discretion, decides to waive this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs.

Submitting a Claim for Reimbursement and BCBSF's Claims Processing

In order to obtain benefits under this Endorsement, Covered Persons must first pay for Covered Prescription Drugs and/or Covered Syringes and Needles and submit a properly completed claim form (with any required documentation). BCBSF must receive the Covered Person's claim form. All claim forms must contain the following information:

1. the Covered Employee's name;
2. the Covered Employee's Contract or Identification number;
3. name of the person for whom the Prescription Drug was dispensed;
4. date of birth of the person for whom the Prescription Drug was dispensed;
5. gender of the person for whom the Prescription Drug was dispensed; and
6. relationship to the Covered Employee (e.g., spouse, child, etc.).

Claim forms for Covered Prescription Drugs and/or Covered Syringes and Needles must be accompanied by an itemized statement from the Pharmacy. The itemized statement for a Prescription Drug must include:

1. the name of the person for whom the Prescription Drug was dispensed;
2. the date the Prescription was purchased; the Prescription number; whether the Prescription is new or a refill;
3. the metric quantity of the Prescription;
4. the National Drug Code for the Prescription (label number; product number; package);
5. the name of the prescribing Physician;
6. the Pharmacy name, address, and BCBSF identification number; and

SAMPLE

7. the charge for each Covered Prescription Drug purchased.

Pharmacy claims, including the itemized statement, must be sent to the following address:

Blue Cross and Blue Shield of Florida
PAID Prescriptions, LLC
MediScript® Prescription Program
P.O. Box 738
Lee's Summit, MO 64063-0738

Note: Participating Pharmacies have agreed to provide Covered Persons with all of the information necessary for claims filing purposes.

Additional Definitions

Certain important terms applicable to this MediScript® Pharmacy Program Endorsement are set forth below. For additional applicable definitions, please refer to the Glossary of Terms in the Certificate of Coverage which this Endorsement amends.

Covered Prescription Drug(s)

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

Covered Syringes and Needles

Syringes and needles prescribed and purchased either in conjunction with Insulin or included in Anaphylactic kits and syringes and needles prescribed and purchased in conjunction with an injectable formulation of Imitrex.

Drug

Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound.

FDA

United States Food and Drug Administration.

National Drug Code (NDC)

The universal code which 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

A Pharmacy located outside of Florida which is part of the national network of Pharmacies established by BCBSF's contracting Pharmacy Benefit Manager.

Non-Participating Pharmacy

A Pharmacy which is not a Participating Pharmacy.

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One-Month Supply

A maximum quantity per Prescription up to a 31-day supply as defined by the Drug manufacturer's dosing recommendations.

Participating Pharmacy

As to Pharmacies located in Florida, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with BCBSF to participate in the MediScript® Pharmacy Program. As to Pharmacies located outside of Florida, Pharmacies which are National Network Pharmacies are Participating Pharmacies. National Network Pharmacies are Pharmacies outside of Florida participating in a national network of Pharmacies available to BCBSF Covered Persons through BCBSF's Pharmacy Benefit Manager.

Participating Pharmacy Allowance

The maximum amount allowed to be charged by a Participating Pharmacy per Prescription for Covered Prescription Drugs and/or Covered Syringes and Needles under this Endorsement.

Pharmacist

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 which regulates the profession of Pharmacy.

Pharmacy

An establishment licensed as a Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state, where Prescription Drugs are dispensed by a Pharmacist.

Pharmacy Benefit Manager

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 BCBSF to make such a network and/or programs available to Covered Persons.

Prescription

An order for medications or medicinal supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or supplies.

Prescription Drug

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."

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Prescription Drug Prior Coverage Authorization List

Prescription Drugs Requiring Prior Authorization

In accordance with the terms of the BlueScript® Pharmacy Program Endorsement or BlueCare Rx Pharmacy Program Endorsement, coverage authorization for certain Prescription Drugs is required. If the Physician prescribes any of the Prescription Drugs on the following list, the person covered by the BlueScript® Pharmacy Program Endorsement or BlueCare Rx Pharmacy Program Endorsement will need to call the Customer Service Number on the identification card to obtain prior coverage authorization.

1. Procrit, Epogen (erythropoietin)
2. Genotropin, Humatrope, Norditropin, Nutropin, Saizen (somatropin)
3. Protropin (somatrem)
4. Serostim (somatropin)
5. Leukine (GM-CSF)
6. Neupogen (G-CSF)
7. Neumega (interleukin-11)
8. Avonex
9. Betaseron
10. Copaxone
11. Rebif

This Prescription Drug Prior Coverage Authorization List supersedes any prior list issued before 10/15/2002 and replaces any previously received list.

SAMPLE

Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage (“Certificate”) which includes any Endorsements issued therewith. The Certificate is hereby amended as follows:

The Health Care Provider Alternatives and Reimbursement Rules Section of the Certificate is hereby amended by deleting the Eligible Providers subsection and replacing it with the following:

Eligible Providers

The following categories of Providers are eligible to participate in BCBSF’s PPC and/or Traditional Networks.

1. Acute Care General Hospitals/Osteopathic Hospitals
2. Ambulatory Surgical Centers
3. Dialysis Centers
4. Doctors of Chiropractic (D.C.)
5. Doctors of Dental Medicine (D.M.D.)
6. Doctors of Dental Science (D.D.S.)
7. Doctors of Dental Surgery (D.D.S.)
8. Doctors of Medicine (M.D.)
9. Doctors of Optometry (O.D.)
10. Doctors of Osteopathy (D.O.)
11. Doctors of Podiatric Medicine (D.P.M.)
12. Durable Medical Equipment Providers
13. Home Health Agencies
14. Independent Clinical Laboratories
15. Mental Health Providers
16. Outpatient Rehabilitation Facility
17. Physical Therapy Providers
18. Prosthetists/Orthotists
19. Psychiatric Facilities
20. Psychologists
21. Skilled Nursing Facilities
22. Substance Abuse Facilities

SAMPLE

The **Glossary of Terms** Section of the Certificate is hereby amended by adding the definition of Outpatient Rehabilitation Facility, deleting the definition of Skilled Nursing Facility and replacing it with the definition below:

Outpatient Rehabilitation Facility

An entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet BCBSF's criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, *Florida Administrative Code* or the similar law or laws of another state.

Skilled Nursing Facility

An institution or part thereof which meets BCBSF's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the State of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by BCBSF.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate, 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 Certificate, 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

BlueChoice Endorsement Treatment for Self-Inflicted Injury/Under the Influence Coverage

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

The **General Exclusions** Section is hereby amended as follows:

Deletion of exclusion #8 in its entirety.

8. any Health Care Service to diagnose or treat any Condition which initially occurred while a Covered Person was (or which, directly or indirectly, resulted from, or is in connection with, a Covered Person being) under the influence of alcoholic beverages, any chemical substance set forth in Section 877.111 of the *Florida Statutes,* or any substance controlled under Chapter 893 of the *Florida Statutes* (or, with respect to such statutory provisions, any successor statutory provisions). Notwithstanding, this exclusion shall not apply to the use of any prescription medication by the Covered Person if such medication is taken on the specific advice of a Physician in a manner consistent with such advice;

Deletion of the following subsets “e” and “f” of exclusion #9, in their entirety.

9. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or in connection with;

    e. the Covered Person being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice; or

    f. an intentionally self-inflicted Condition, suicide or attempted suicide, whether the Covered Person is sane or insane.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage (“Certificate”) which includes any Endorsements issued therewith. The Certificate is hereby amended as follows:

The Health Care Provider Alternatives and Reimbursement Rules Section of the Certificate is hereby amended by deleting in its entirety the Eligible Providers subsection and replacing it with the following:

Eligible Providers The following categories of Providers are eligible to participate in BCBSF’s PPC and/or Traditional Networks.

1. Acute Care General Hospitals/Osteopathic Hospitals
2. Ambulatory Surgical Centers
3. Dialysis Centers
4. Doctors of Chiropractic (D.C.)
5. Doctors of Dental Medicine (D.M.D.)
6. Doctors of Dental Science (D.D.S.)
7. Doctors of Dental Surgery (D.D.S.)
8. Doctors of Medicine (M.D.)
9. Doctors of Optometry (O.D.)
10. Doctors of Osteopathy (D.O.)
11. Doctors of Podiatric Medicine (D.P.M.)
12. Durable Medical Equipment Providers
13. Home Health Agencies
14. Independent Clinical Laboratories
15. Independent Diagnostic Testing Facilities
16. Mental Health Providers
17. Outpatient Rehabilitation Facilities
18. Physical Therapy Providers
19. Prosthetists/Orthotists
20. Psychiatric Facilities
21. Psychologists
22. Skilled Nursing Facilities
23. Substance Abuse Facilities

SAMPLE

The **Glossary of Terms Section** of the Certificate is hereby amended by adding the definition of Independent Diagnostic Testing Facility below:

Independent Diagnostic Testing Facility

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 a licensed, certified non-physician personnel under appropriate physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida law or laws of the State in which it operates. Further, such an entity must meet BCBSF's criteria for eligibility as an Independent Diagnostic Testing Facility.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

MediScript® Self-Administered Injectable Prescription Drugs Pharmacy Endorsement

This MediScript® Self-Administered Injectable Prescription Drugs Pharmacy Endorsement amends any Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") MediScript® Pharmacy Program Endorsement, including but not limited to, any such Endorsement amending a group policy.

Delete the Self Injectable Drug subsection and replacing it with the following:

Self-Administered Injectable Prescription Drugs

The only self-administered injectable Prescription Drugs covered under this Endorsement are: Insulin; Imitrex; Avonex; Betaseron; Copaxone; Rebif; and Prescription Drugs contained in Anaphylactic kits (i.e. Epi-Pen, Epi-Pen Jr., Ana-Kit). Syringes and needles prescribed in conjunction with: Insulin; Imitrex; Avonex; Betaseron; Copaxone; Rebif; and Prescription Drugs contained in Anaphylactic kits are covered.

Exclusion

All self-administered injectable Prescription Drugs, except for: Drugs included in Anaphylactic kits; Insulin; Imitrex; Avonex; Betaseron; Copaxone; and Rebif are excluded. Syringes and needles which are not prescribed in conjunction with: Insulin; Imitrex; Avonex; Betaseron; Copaxone; Rebif; and Prescription Drugs contained in Anaphylactic kits are excluded.

The Exclusions Section is amended by **deleting** exclusions 2, 5, 6, 7 and 16 in their entirety from the Exclusions Section and replacing them with the following:

2. Any Prescription Drugs obtained from a Pharmacy which are dispensed for administration by intravenous infusion or injection regardless of the setting in which such Prescription Drugs are to be administered or type of provider administering such Prescription Drugs; except any Prescription Drug covered under the Self-Administered Injectable Prescription Drugs subsection;
5. All injectable Prescription Drugs, other than Prescription Drugs covered under the Self-Administered Injectable Prescription Drugs subsection;
6. Syringes and needles which are not prescribed in conjunction with Prescription Drugs covered under the Self-Administered Injectable Prescription Drugs subsection;
7. All supplies and equipment other than Prescription diaphragms, and syringes and needles prescribed in conjunction with Prescription Drugs covered under the Self-Administered Injectable Prescription Drugs subsection; and
16. Injectable Drugs other than Prescription Drugs covered under the Self-Administered Injectable Prescription Drugs subsection.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement: Claims Processing

This Endorsement is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended by deleting the prior Claims Processing section in its entirety and replacing it with the following:

Claims Processing

Introduction

This section is intended to:

- help the Covered Person understand what the Covered Person or the Covered Person's treating Providers must do, under the terms of the Certificate of Coverage, in order to obtain payment for expenses for Covered Services they have rendered or will render to the Covered Person; and
- provide the Covered Person with a general description of the applicable procedures BCBSF will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying the Covered Person when BCBSF denies benefits.

If the Covered Person's Group Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Covered Person's 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, BCBSF is not legally responsible for notifying the Covered Person of any rights the Covered Person may have under ERISA. The Covered Person can contact the plan administrator or an attorney of the Covered Person's choice to determine if the Covered Person has rights under ERISA. BCBSF will follow the claim determination procedures and notice requirements set forth in this section even if the Covered Person's Group Plan is not subject to ERISA.

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

Types of Claims

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

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Definitions

The following terms, as used in this section, are defined as follows:

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

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 the Covered Person with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Covered Person's Condition, would subject the Covered Person to severe pain that cannot be adequately managed without the proposed services being rendered.

Concurrent Care Decision means a decision by BCBSF 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 BCBSF 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 Case Management Program as described in the Individual Benefit Utilization Management/Utilization Review Programs section of the Certificate of Coverage.

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

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

Pre-Service Claim means any request or application for coverage or benefits for a service that has not yet been provided to the Covered Person and with respect to which the terms of the Certificate of Coverage condition payment for the service (in whole or in part) on approval by BCBSF of coverage or benefits for the service before the Covered Person receives 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 BCBSF regarding coverage, benefits, or payment for a service that has not actually been rendered to the Covered Person if the terms of the Certificate of Coverage do not require (or condition payment upon) approval by BCBSF of coverage or benefits for the service before it is received.

Post-Service Claims

How to File a Post-Service Claim

This section defines and describes the three types of claims that may be submitted to BCBSF. Experience shows that the most common type of claim BCBSF will receive from the Covered Person or the Covered Person's treating Providers will likely be Post-Service Claims.

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PPO Providers have agreed to file Post-Service Claims for services rendered to a Covered Person. In the event a Provider who renders services to the Covered Person does not file a Post-Service Claim for such services, it is the Covered Person's responsibility to file it with BCBSF.

BCBSF 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 BCBSF does not receive it at the address indicated on the Covered Person's ID Card within one year of the date the service was rendered unless the Covered Person was legally incapacitated.

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

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

The itemized statement and claim form must be received by BCBSF at the address indicated on the Covered Person's ID 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. Further, special claims processing rules may apply for Health Care Services received outside the State of Florida under the BlueCard® Program (See the BlueCard® Program section of the Certificate of Coverage).

The Processing of Post-Service Claims

BCBSF will use its best efforts to pay, contest, or deny all Post-Service Claims for which BCBSF has all of the necessary information, as determined by BCBSF. 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 the Certificate of Coverage, BCBSF will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, BCBSF will use its best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. The Covered Person may receive notice of payment for paper claims within 30 days of receipt. If BCBSF is unable to determine whether the claim or a portion of the claim is payable because more or additional information is needed, BCBSF may contest the claim within the timeframes set forth below.

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- Contested Post-Service Claims

  In the event BCBSF contests an electronically submitted Post-Service Claim, or a portion of such a claim, BCBSF will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event BCBSF contests a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, BCBSF will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that BCBSF reasonably expects to notify the Covered Person of the decision. The notice may also indicate whether additional information is needed in order to complete processing of the claim. If BCBSF requests additional information, BCBSF must receive it within 45 days of the request for the information. **If BCBSF does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in the possession of BCBSF at the time and may be denied.** Upon receipt of the requested information, BCBSF will use its 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 BCBSF denies a Post-Service Claim submitted electronically, BCBSF will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event BCBSF denies a paper Post-Service Claim, BCSBF will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Covered Person's responsibility to ensure that BCBSF receives all information determined by BCBSF as necessary to adjudicate a Post-Service Claim. **If BCBSF does 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, BCBSF will use its 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 BCBSF or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by BCBSF within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

BCBSF will investigate any allegation of improper billing by a Provider upon receipt of written notification from the Covered Person. If BCBSF determines that the Covered Person was 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 the Covered Person, BCBSF will pay the Covered Person 20 percent of the amount of the reduction, up to a total of $500.

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Pre-Service Claims

How to File A Pre-Service Claim

The Certificate of Coverage may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by BCBSF of a Pre-Service Claim as that term is defined herein. In order to determine whether BCBSF must receive a Pre-Service Claim for a particular Covered Service, please refer to the Covered Services section and other applicable sections of the Certificate of Coverage. The Covered Person may also call the customer service number on the Covered Person's ID card for assistance.

BCBSF is 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 the Covered Person unless the terms of the Certificate of Coverage require (or condition payment upon) approval by BCBSF for the service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

BCBSF will use its 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. BCBSF may extend this 15-day determination period one time for up to an additional 15 days. If such an extension is necessary, BCBSF will use its best efforts to provide notice of the extension and reasons for it. BCBSF will use its best efforts to provide notification of the decision on the Covered Person's Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by BCBSF.

If additional information is necessary to make a determination, BCBSF will use its 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 the Covered Person or the Covered Person's Provider may need to provide; and 3) inform the Covered Person of the date that BCBSF reasonably expects to notify the Covered Person of the decision. If BCBSF requests additional information, BCBSF must receive it within 45 days of the request for the information. BCBSF will use its best efforts to provide notification of the decision on the Covered Person's Pre-Service Claim within 15 days of receipt of the requested information.

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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:

- BCBSF has approved in writing coverage or benefits for an ongoing course of services to be provided over a period of time or a number of services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of services; and
- the reduction or termination of coverage or benefits by BCBSF was not due to an amendment of the Certificate of Coverage or termination of the Covered Person's coverage as provided by the Certificate of Coverage.

BCBSF will use its best efforts to notify the Covered Person of such reduction or termination in advance so that the Covered Person will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall BCBSF be required to provide more than a reasonable period of time within which the Covered Person may develop their appeal before BCBSF actually terminates or reduces coverage for the services.

Requests for Extension of Services

The Covered Person's 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, BCBSF will use its best efforts to notify the Covered Person of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such services. BCBSF will use its best efforts to notify the Covered Person within 24 hours if: 1) additional information is needed; or 2) the Covered Person or the Covered Person's representative failed to follow proper procedures in the request for an extension. If BCBSF requests additional information, the Covered Person will have 48 hours to provide the requested information. BCBSF may notify the Covered Person orally or in writing, unless the Covered Person or the Covered Person's 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

BCBSF will use its 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 the Covered Person free of charge upon request):

- the specific reason or reasons for the Adverse Benefit Determination;

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- a reference to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Person how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If the Covered Person's claim is a Claim Involving Urgent Care, BCBSF may notify the Covered Person orally within the proper timeframes, provided BCBSF follows-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

The Covered Person, or a representative designated by the Covered Person in writing, has the right to appeal an Adverse Benefit Determination. BCBSF will review the Covered Person's appeal through the review process described below. The Covered Person's appeal must be submitted in writing to BCBSF within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require the Covered Person to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

- BCBSF must receive the Covered Person's appeal of an Adverse Benefit Determination in person or in writing;
- The Covered Person may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, the Covered Person 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 the Certificate of Coverage to the Covered Person's medical circumstances;
- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;
- BCBSF may consult with appropriate Physicians, as necessary;
- Any independent medical consultant who reviews a Covered Person's Adverse Benefit Determination on behalf of BCBSF will be identified upon request; and
- If the Covered Person's claim is a Claim Involving Urgent Care, the Covered Person may request an expedited appeal orally or in writing in which case all necessary information on review may be

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transmitted between the Covered Person and BCBSF by telephone, facsimile or other available expeditious method.

Timing of Appeal Review on Adverse Benefit Determinations by BCBSF

BCBSF will use its best efforts to review a Covered Person's appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims within 30 days of the receipt of the Covered Person's appeal; or
- Post-Service Claims within 60 days of the receipt of the Covered Person's appeal; or
- Claims Involving Urgent Care (and requests to extend concurrent care services made within 24 hours prior to the termination of the services) within 72 hours of receipt of the Covered Person's request. If additional information is necessary BCBSF will notify the Covered Person within 24 hours and BCBSF must receive the requested additional information within 48 hours of the request. After BCBSF receives the additional information, BCBSF 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.

The Covered Person, or a Provider acting on behalf of the Covered Person, 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 the Covered Person, within a reasonable time, not to exceed 15 business days.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

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

2. Physical Examination:

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

3. Legal Actions:

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

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

   BCBSF relies 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 BCBSF may have, in denial of the claim or cancellation or rescission of the Covered Person's coverage.

5. Explanation of Benefits Form:

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

   a. the specific reason or reasons for the Adverse Benefit Determination;

   b. reference to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

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

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

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

6. Circumstances Beyond the Control of BCBSF

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of BCBSF, results in facilities, personnel or financial resources of BCBSF being unable to process claims for Covered Services, BCBSF will have no liability or obligation for any delay in the payment of claims for Covered Services, except that BCBSF 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 the control of BCBSF if BCBSF 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, the Covered Employee or the Covered Employee's 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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This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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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Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage (“Certificate”) which includes any Endorsements issued therewith. The Certificate is hereby amended as follows:

Eligible Providers

The Health Care Provider Alternatives and Reimbursement Rules Section of the Certificate is hereby amended by deleting in its entirety the Eligible Providers subsection and replacing it with the following:

The following categories of Providers are eligible to participate in BCBSF’s PPC and/or Traditional Networks. This list may be expanded, as determined by BCBSF, to include additional Providers who are eligible to participate as PPO Providers and/or Traditional Insurance Providers and who are properly licensed pursuant to Florida Statutes, or similar applicable law of another state. To determine if additional Providers are eligible to participate in BCBSF’s PPC and/or Traditional Networks, please access BCBSF’s Provider Directory online at www.bcbsfl.com or call the customer service number indicated on your identification card.

1. Acute Care General Hospitals/Osteopathic Hospitals
2. Ambulatory Surgical Centers
3. Dialysis Centers
4. Doctors of Chiropractic (D.C.)
5. Doctors of Dental Medicine (D.M.D.)
6. Doctors of Dental Science (D.D.S.)
7. Doctors of Dental Surgery (D.D.S.)
8. Doctors of Medicine (M.D.)
9. Doctors of Optometry (O.D.)
10. Doctors of Osteopathy (D.O.)
11. Doctors of Podiatric Medicine (D.P.M.)
12. Durable Medical Equipment Providers
13. Home Health Agencies
14. Independent Clinical Laboratories
15. Independent Diagnostic Testing Facilities
16. Mental Health Providers
17. Outpatient Rehabilitation Facilities
18. Physical Therapy Providers
19. Prosthetists/Orthotists

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20. Psychiatric Facilities
21. Psychologists
22. Skilled Nursing Facilities
23. Substance Abuse Facilities

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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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BlueChoice Certificate of Coverage Endorsement

This Endorsement is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. This Endorsement replaces any prior Endorsements to the Certificate of Coverage that reference surgical procedures performed for morbid obesity, including 60664 0801 SR. The Certificate of Coverage is amended as described below.

1. The Covered Services section is amended by **deleting** the following Covered Service and exclusion from the Surgical Procedures subsection:

   Surgical procedures performed on a Covered Person for the treatment of Morbid Obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and the associated care provided the Covered Person has not previously undergone the same or similar procedure in their lifetime;

   Exclusion

   Surgical procedures for the treatment of Morbid Obesity including: intestinal bypass; stomach stapling; balloon dilation and associated care for the surgical treatment of Morbid Obesity, if the Covered Person has previously undergone the same or similar procedures in their lifetime. Surgical procedures performed to revise, or correct defects related to, a prior intestinal bypass, stomach stapling or balloon dilation are also excluded.

2. The General Exclusions Section is amended by **deleting** the Weight Control Services exclusion in its entirety and replacing it 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. 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 a Covered Person's ability to assimilate food.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

62958 1003 SR

Small Group

SAMPLE

BlueChoice 2005 Certificate of Coverage Changes Endorsement One

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended as described below.

The **Covered Services** Section is amended as follows:

The **Mental Health Services** subsection is **deleted** in its entirety and **replaced** with the following:

Mental Health Services

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

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

Benefits for care and treatment of a Mental and Nervous Disorder are limited as set forth in the Schedule of Benefits.

Exclusion

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

SAMPLE

The **Surgical Procedures** subsection is amended by **deleting** item number one under BCBSF's Reimbursement Guidelines for Surgical Procedures, and **replacing** it with the following:

1. Reimbursement for multiple surgical procedures, performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance or Copayment (if any) indicated in the Covered Person's Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service;

The **Transplant Services** subsection is amended by **deleting** item number three in its entirety and **replacing** it with the following:

3. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);

The **Transplant Services** subsection is amended by **deleting** item number 11 of the exclusion in its entirety and **replacing** it with the following:

11. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

The **Additional General Exclusions** subsection of the General Exclusions section is amended by **deleting** the Arch Supports exclusion in its entirety and **replacing** it with the following:

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.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement: AHCA Performance Data

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended as described below.

The **General Provisions** section is amended by adding the Internet web site address for the performance outcome and financial data published by the Florida Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute. The web site address is www.floridahealthstat.com and may be accessed through the link provided on the Blue Cross and Blue Shield of Florida's corporate web site at www.bcbsfl.com.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement: Special Enrollment Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended as described below.

The **Enrollment and Effective Date of Coverage** section is amended as follows:

Item number three under the Loss of Eligibility for Coverage heading within the **Special Enrollment** subsection is deleted in its entirety and replaced with the following:

3. demonstrates that he or she has lost coverage under a group health benefit plan or health insurance coverage within the past 30 days as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, reaching or exceeding the maximum lifetime of all benefits under other health coverage, or the coverage was terminated as a result of the termination of employer contributions toward such coverage; and

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement: Special Enrollment Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended as described below.

The **Glossary of Terms** section is amended as follows:

The definition for **Creditable Coverage** is amended by adding numbers 11, 12 and 13 below:

11. State Children's Health Insurance Program (S-CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement: Continuation of Coverage Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended as described below.

This Endorsement changes the Florida Health Insurance Coverage Continuation Act (FHICCA) qualifying event notification period from 30 to 63 days.

The **Types of Qualifying Events** subsection of the **Continuing Coverage** section is amended by deleting the following paragraph in its entirety:

Under the law, the Covered Employee or a family member has the responsibility to inform BCBSF's Florida Health Insurance Coverage Continuation Act administrator, Coverage Continuation Service Inc. (CCSI) of a divorce, legal separation, or a child losing dependent status under the Small Employer Master Policy. **This notification must be made within 30 days of the date of the qualifying event which would cause a loss of coverage.**

The above deleted paragraph under the **Types of Qualifying Events** subsection of the **Continuing Coverage** section is replaced by the following paragraph:

Under the law, the Covered Employee or a family member has the responsibility to inform BCBSF's Florida Health Insurance Coverage Continuation Act administrator, Coverage Continuation Service Inc. (CCSI) of a divorce, legal separation, or a child losing dependent status under the Small Employer Master Policy. **This notification must be made within 63 days of the date of the qualifying event which would cause a loss of coverage.**

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement: Dependent Enrollment Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage and any Endorsements attached thereto. The Certificate of Coverage is amended as described below.

The Certificate of Coverage is amended by deleting the *Dependent Enrollment* subsection of the Enrollment and Effective Date of Coverage section in its entirety and replacing it with the following:

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Employee.

1. **Newborn Child** – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit a Member Status Change Request form to BCBSF through the Small Employer. The Effective Date of coverage for a newborn child shall be the date of birth. BCBSF must be notified, in writing, and the following guidelines will be applied when enrolling a newborn child:

    a. If BCBSF receives 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 BCBSF receives 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 BCBSF receives written notice more than 60 days after the date of birth and Annual Open Enrollment has not occurred since the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

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

    Note: The guidelines above only apply to newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment Period, BCBSF must receive the Member Status Change Request form. If the Member Status Change Request 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 Member Status Change Request form is received 31–60 days after the birth of the child, the applicable Premium must be paid back to the Effective Date of coverage of the Covered Employee. In the event BCBSF is 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 Person other than the Covered Employee or the Covered Employee's spouse will automatically terminate 18 months after the birth of the newborn child.

SAMPLE

2. **Adopted Newborn Child** – To enroll an Adopted newborn child, the Covered Employee must submit a Member Status Change Request form through the Small Employer to BCBSF. 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. BCBSF may require the Covered Employee to provide any information and/or documents which BCBSF deems necessary in order to administer this provision. BCBSF must be notified, in writing, and the following Guidelines will be applied when enrolling an Adopted newborn child:

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

   Note: The guidelines above only apply to Adopted newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment Period, BCBSF must receive the Member Status Change Request form. If the Member Status Change Request 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 Member Status Change Request form is received 31-60 days after the birth of the child, the applicable Premium must be paid back to the Effective Date of coverage of the Covered Employee. In the event BCBSF is 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 the responsibility of the Covered Employee to notify BCBSF within ten calendar days if the Adopted newborn child is not Placed in the residence of the Covered Employee.

3. **Adopted/Foster Children** – To enroll an Adopted child or Foster Child, the Covered Employee must submit a Member Status Change Request form through the Small Employer to BCBSF prior to or during the 30-day period immediately following the date of Placement and pay the additional Premium, if any. The Effective Date for an Adopted child or Foster Child (other than an Adopted newborn child) shall be the date such Adopted child or Foster Child is Placed in the residence of the Covered Person in compliance with Florida law. If timely notice is given, no additional Premium will be charged for coverage of the Adopted child for the duration of the notice period. Any Pre-existing Condition exclusionary period will not apply to an Adopted child but will apply to a Foster Child.

SAMPLE

BCBSF may require the Covered Person to provide any information and/or documents deemed necessary, by BCBSF, in order to properly administer this section.

In the event BCBSF is 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 BCBSF receives the Member Status Change Request form within 60 days of the Placement, and any applicable Premium is paid back to the date of Placement. In the event BCBSF is not notified before or within 60 days of the date of Placement, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period.

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. Proof of final Adoption must be submitted to BCBSF. It is the responsibility of the Covered Employee to notify BCBSF if the Adoption does not take place. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the first billing date following receipt of the written notice.

If the Covered Employee's status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is the responsibility of the Covered Employee to notify BCBSF in writing that the Foster Child is no longer in the Covered Employee's care. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the date provided by the Group or on the first billing date following receipt of the written notice.

4. **Marital Status** – A Covered Employee may apply for coverage of an Eligible Dependent(s) due to marriage. To apply for coverage, the Covered Employee must complete the Member Status Change Request form through the Small Employer and forward it to BCBSF. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent(s) who is enrolled as a result of marriage is the date of the marriage.
5. **Court Order** – A Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Covered Employee’s plan. To apply for coverage, the Covered Employee must complete the Member Status Change Request form through the Small Employer and forward it to BCBSF. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Mediscript® Claims Address Amendment

This MediScript® Claims Address Amendment amends the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") MediScript Pharmacy Program Endorsement to the Certificate of Coverage issued to the Certificateholder. The MediScript Pharmacy Program Endorsement is hereby amended as follows.

The section entitled Submitting a Claim for Reimbursement and BCBSF's Claims Processing, is amended by removing the following statement:

Pharmacy Claims, including the itemized statement, must be sent to the following address:

Blue Cross and Blue Shield of Florida
PAID Prescriptions, LLC.
MediScript Prescription Program
P.O Box 738
Lee's Summit, MO 64063-0738

The above statement shall be replaced with the following:

Pharmacy Claims, including the itemized statement, must be sent to the address listed on the claim form.

This Amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

Endorsement Pre-Existing Conditions Exclusion Period

This Endorsement is to be attached to, and made a part of, the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage including any Endorsements attached thereto. The provisions of this Endorsement shall become effective and apply to any paper or electronic Post-Service Claim for benefits received and processed by BCBSF on or after December 1, 2007.

The **Pre-existing Conditions Exclusion Period** section is amended by deleting the list of items where a Pre-existing Condition does not apply in its entirety and replacing it with the following:

A Pre-existing Condition does not include:

1. pregnancy;
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; or
5. any Post-Service Claim for a Drug that would otherwise be covered and payable under any retail pharmacy Endorsement and/or amendment issued with and part of this Certificate of Coverage.

For purposes of this Endorsement, the term Drug shall have the same definition as that set forth in any retail pharmacy endorsement, including any amendments, issued with and part of this Certificate of Coverage.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

23019-0807 BCA

Small Group

SAMPLE

BlueChoice 2008 Mandate Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Certificate of Coverage including any Endorsements attached thereto.

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

This Endorsement is effective October 1, 2008.

The "**ELIGIBILITY FOR COVERAGE"** section is amended as follows:

The **Eligibility Requirements for Dependent(s)** subsection is deleted in its entirety and replaced with the following:

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under the Small Employer Master Policy:

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

SAMPLE

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

3. 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 the Covered Employee's sole responsibility 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.

The **"ENROLLMENT AND EFFECTIVE DATE OF COVERAGE"** section is amended as follows:

The **Dependent Enrollment** subsection is amended by deleting the note at the end of the Newborn Child subparagraph 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 end of the Calendar Year in which the Dependent child 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.

The **"TERMINATION OF INDIVIDUAL COVERAGE"** section is amended as follows:

The **Termination of a Covered Dependent's Coverage** subsection is amended by adding the following under subparagraph four:

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.

SAMPLE

The **"GLOSSARY OF TERMS"** section is amended as follows:

The following definitions are deleted in their entirety and replaced as follows:

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).

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection of the "Eligibility for Coverage" section in this Certificate of Coverage and is eligible to enroll as a Covered Dependent.

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.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 2008 Omnibus Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueChoice Certificate of Coverage including any Endorsements attached thereto. The Certificate of Coverage 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.

This Endorsement is effective upon receipt unless specifically stated otherwise within this Endorsement.

The **HEALTH CARE PROVIDER ALTERNATIVES AND REIMBURSEMENT RULES** section is amended as follows:

The **Assignment of Benefits to Providers** subsection is deleted in its entirety and replaced with the following:

BCBSF is not required to honor any assignment to a Provider who does not participate in any of BCBSF's Provider contracting programs including, without limitation, any of the following:

- an assignment of the benefits due the Covered Person under this Certificate of Coverage;
- an assignment of the right to receive payments due under this Certificate of Coverage; or
- an assignment of a claim for damage resulting from a breach, or an alleged breach, of the Small Employer Master Policy.

BCBSF reserves the right to honor an assignment of benefits to a non-participating Provider who 1) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required; or 2) is an Ambulance that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.

Note: For additional reimbursement rules for certain out-of-state PPO Providers, see the BlueCard Program section of this Certificate of Coverage.

The **COVERED SERVICES** section is amended as follows:

The second to the last paragraph of the **Child Health Supervision Services** category is deleted in its entirety and replaced with the following:

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.

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The **Mental Health Services** category is amended by deleting exclusion numbers one and three in their entirety and replacing them with the following:

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 the effect, of the disorder;

3. 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;

The **Orthotic Devices** category is amended by deleting the exclusion provision in its entirety and replacing it with the following:

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.

The **Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulation Services** category is amended as follows:

The **Reimbursement Guidelines for Physical Therapy** and the **Reimbursement Guidelines for Massage Therapy** subsections are deleted in their entirety and replaced with the following:

Reimbursement Guidelines for Massage and Physical Therapy

a. Reimbursement for covered Massage Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.

b. Reimbursement 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 Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.

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c. Reimbursement 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.

The **Reimbursement for Spinal Manipulations** subsection is deleted in its entirety and replaced with the following:

Reimbursement Guidelines for Spinal Manipulation

a. Reimbursement for covered spinal manipulation is limited to no more than 26 spinal manipulations per Calendar Year, **or** the maximum benefit listed in the Schedule of Benefits, whichever occurs first.

b. Reimbursement 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.

The Schedule of Benefits sets forth the maximum dollar amount that BCBSF will pay for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if a Covered Person may have only been administered two (2) spinal manipulations for the Calendar Year, any additional spinal manipulations for that Calendar Year will not be covered if the Covered Person has already met the combined therapy dollar maximum with other Services.

The **GENERAL EXCLUSIONS** section is amended as follows:

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

The following subsections describe Health Care Services for which expenses are excluded. These exclusions are in addition to any exclusions specified in the Covered Services section or any other section of this Certificate of Coverage.

The **General Exclusions** subsection is amended as follows:

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

5. Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category of the Covered Services section.

Exclusion number 12 below is added:

12. Health Care Services that are not patient-specific, as determined solely by BCBSF.

The **Additional General Exclusions** subsection is amended as follows:

Exclusion number one of the **Drugs** exclusion is deleted in its entirety and replaced with the following:

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 the Covered Person's particular cancer in a Standard Reference Compendium, or is recommended for treatment of the

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Covered Person's particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

Number four below is added to the **Drugs** exclusion:

4. Any drug which is indicated or used for sexual dysfunctional (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in item number one above does not apply to sexual dysfunction drugs excluded under this paragraph.

The following exclusions are added:

Immunizations except those covered under the Child Health Supervision Services category of the "Covered Services" section.

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-partum, and post-partum maternity/obstetrical care and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

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

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

Prescription Drug Copayments, Coinsurance and Deductibles, or any part thereof, the Covered Person is obligated to pay under any plan or policy.

The **DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS** section is amended by adding the following exclusion:

Coordination of Benefits Exclusion

Prescription Drug Copayments, Coinsurance and Deductibles, or any part thereof, the Covered Person is obligated to pay under any plan or policy.

The **CLAIMS PROCESSING** section is amended as follows:

The **How to Appeal an Adverse Benefit Determination** subsection is amended as follows:

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

Except as described below, only the Covered Person, or a representative designated by the Covered Person in writing, has the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the review process described below. The Covered Person's appeal must be submitted in writing to BCBSF for an internal appeal within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require the Covered Person to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

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The third guideline is deleted in its entirety and replaced with the following:

- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, the Covered Person 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 Certificate of Coverage to the Covered Person's medical circumstances;

The following guidelines are added:

- If the Covered Person wishes to give someone else permission to appeal an Adverse Benefit Determination on their behalf, BCBSF must receive a completed Appointment of Representative form signed by the Covered Person indicating the name of person who will represent the Covered Person with respect to the appeal. An Appointment of Representative form is not required if the Covered Person's Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available from www.bcbsfl.com or by calling the number on the back of the BCBSF ID Card.
- 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, the Covered Person has 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 in this section. The Covered Person's 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.).

The **How to Appeal an Adverse Benefit Determination** subsection is further amended by replacing the address information with the following:

Requests for an internal appeal should be sent to the address below:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

Effective **April 21, 2009**, the following subsection will be added at the end of the **How to Appeal an Adverse Benefit Determination** subsection.

How to Request External Review of Our Appeal Decision

If a Covered Person is not satisfied with BCBSF's internal review of their appeal of an Adverse Benefit Determination based on the lack of Medical Necessity or Experimental or Investigational nature of a Service they received from Physicians licensed as a Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.), the Covered Person may appeal BCBSF's decision through an External Review Organization. The BCBSF denial letter will provide information regarding this External Review Organization.

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

The External Review Organization's determination with respect to the Covered Person's appeal shall be binding upon the Covered Person, the Covered Person's Physician and BCBSF.

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The **GENERAL PROVISIONS** section is amended by adding the following subsection:

Third Party Beneficiary

The Small Employer Master Policy under which this Certificate of Coverage 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 thereunder, or under this Certificate of Coverage, 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 Certificate of Coverage.

The **GLOSSARY OF TERMS** section is amended as follows:

The term "reliable evidence" shall be replaced with the words "credible scientific evidence" in the definition of **Experimental or Investigational**.

The definitions of **Allowed Amount** and **Allowance** are both deleted in their entirety and replaced with the following:

Allowance and Allowed Amount means the maximum amount upon which payment will be based for Covered Services. Either the Allowance or Allowed Amount may be changed at any time without notice to, or consent of any Covered Person.

1. In the case of a BCBSF PPC℠ 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 a PPO 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.
3. In the case of Providers located in Florida who do not participate in BCBSF's PPC Network but 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 Providers located outside of Florida who participate in the BlueCard® Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to BCBSF, 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.
5. In the case of a Provider that has not entered into a PPC or Traditional Provider Program agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to a Covered Person, this 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 Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Provider that provided the specific Covered Services (which may

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include payment accepted by such 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 a 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, this amount for the specific Covered Services provided to the Covered Person 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 PPO Provider, as determined by BCBSF, the Allowance or 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.

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

The Covered Person may obtain an estimate of the Allowance or Allowed Amount for particular Services by calling the customer service telephone number included in the Certificate of Coverage or on the Covered Person's Identification Card. The fact that BCBSF may provide the Covered Person with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in the Certificate of Coverage apply. The Covered Person should refer to the "Covered Services" section of the Certificate of Coverage and the Schedule of Benefits to determine what is covered and how much BCBSF will pay.

The following definitions are deleted in their entirety and replaced as indicated below:

Health Care Services or Services include treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, Providers.

Medically Necessary or **Medical Necessity** means that, with respect to a Health Care Service, that a Physician, exercising prudent clinical judgment, provided the Health Care Service to the Covered Person 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 the Covered Person's illness, injury or disease; and
3. not primarily for the Covered Person's convenience, or that of the Covered Person's Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services

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at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's illness;

Note: It is important to remember that any review of Medical Necessity by BCBSF is solely for the purpose of determining coverage or benefits under this Certificate of Coverage and not for the purpose of recommending or providing medical care. In this respect, BCBSF may review specific medical facts or information pertaining to the Covered Person. 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 Certificate of Coverage as determined by BCBSF. In applying the definition of Medical Necessity in this Certificate of Coverage**,** BCBSF may apply its coverage and payment guidelines then in effect. The Covered Person is free to obtain a Service even if BCBSF denies coverage because the Service is not Medically Necessary; however, the Covered Person will be solely responsible for paying for the Service.

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.

The following definitions are <u>added</u>:

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

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 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.

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.

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.

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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 Certificate of Coverage, 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 Certificate of Coverage, 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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MediScript® Pharmacy Program Amendment

This document amends the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") MediScript Pharmacy Program Endorsement to the Certificate of Coverage issued to the Covered Employee. The MediScript Pharmacy Program Endorsement is hereby amended as follows.

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

The **BCBSF's Coverage and Benefit Guidelines for Prescription Drugs** section is amended as follows:

Beginning **April 1, 2009**, and effective on the Group Plan's first Anniversary Date occurring after this date, the following subsection is added after the first paragraph of the section:

If the Covered Person or the Covered Person's Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; the Covered Person will be responsible for: (1) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug; and (2) the Copayment, Deductible and/or Coinsurance applicable to Brand Name Prescription Drugs, as indicated in your Pharmacy Program Endorsement.

The **Exclusions** section is amended by deleting exclusion numbers 23 and 26 in their entirety and replacing them with the following:

23. 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 is 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;

26. Prescription Drugs indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number 23 does not apply to sexual dysfunction Drugs excluded under this paragraph.;

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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 Certificate of Coverage, 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 Certificate of Coverage, 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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BlueChoice Special Enrollment Period Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueChoice Certificate of Coverage including any Endorsements attached thereto. The Certificate of Coverage 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.

References to the “State Children’s Health Insurance Program (S-CHIP)” in your Certificate of Coverage and any Endorsements attached thereto are hereby changed to “Children’s Health Insurance Program (CHIP).”

The **Enrollment and Effective Date of Coverage** section is amended by deleting Endorsement 21591 0905 SR to the Certificate of Coverage and the “Special Enrollment Period” subsection in their entirety and replacing them with the following:

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 an Eligible Employee loses 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 or Florida continuation of coverage that the Eligible Employee was covered under at the time of initial enrollment provided that:

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

    b. the Eligible Employee lost their 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 they work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of their spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and

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c. the Eligible Employee submits the applicable Enrollment Form to the Small Employer within 30 days of the date their coverage was terminated

Note: Loss of coverage for an individual's failure to pay their 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, the Eligible Employee stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and the Eligible Employee gets married or obtains a dependent through birth, adoption or placement in anticipation of adoption and the Eligible Employee submits the applicable Enrollment Form to the Small Employer within 30 days of the date of the event.

   or

3. If the Eligible Employee or their 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 the Eligible Employee submits the applicable Enrollment Form to the Small Employer within 60 days of the date such coverage was terminated or the date the Eligible Employee becomes eligible for the optional state premium assistance program.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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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BlueChoice Prior Coverage Authorization and Eligibility Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueChoice Certificate of Coverage including any Endorsements attached thereto. The Certificate of Coverage 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.

This Endorsement is effective upon your Group's renewal, which occurs on or after 10/15/09.

The **INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW PROGRAMS** section is amended as follows:

The following new subsection is added:

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for the Covered Person to understand BCBSF's prior coverage authorization programs and how the Provider the Covered Person selects and the type of Service the Covered Person receives affects these requirements and ultimately how much the Covered Person is responsible for paying under this Certificate of Coverage.

The Covered Person or the Covered Person's Physician will be required to obtain prior coverage authorization from BCBSF 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 BCBSF.

Prior coverage authorization requirements vary, depending on whether Services are rendered by a BCBSF PPC℠ Provider or a Provider who is not a BCBSF PPC℠ Provider, as described below:

BCBSF PPC℠ Providers

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

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

Providers who are not BCBSF PPC℠ Providers

1. In the case of **Provider-administered drugs**, it is the Covered Person's sole responsibility to comply with BCBSF's prior coverage authorization requirements when the Covered Person uses a Provider

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who is not a BCBSF PPC[sm] Provider **before** the drug is purchased or administered. **The Covered Person's 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 the Covered Person's sole responsibility to comply with BCBSF's prior coverage authorization requirements when rendered or referred by a Provider who is not a BCBSF PPC[sm] Provider **before** the advanced diagnostic imaging Services are provided. **The Covered Person's 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, the Covered Person may call the customer service phone number on the back of the Covered Person's ID Card.

3. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is the Covered Person's sole responsibility to comply with BCBSF's prior coverage authorization or pre-service notification requirements when rendered or referred by a Provider who is not a BCBSF PPC[sm] 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 the time the claim is presented for payment to BCBSF.** The penalty applied will be the lesser of $500 or 20% of the total Allowance or 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 the Covered Person and/or the Provider, who is not a BCBSF PPC Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on BCBSF's established criteria then in effect. The Covered Person will be notified of the prior coverage authorization decision.

BCBSF will provide the Covered Person information for any Health Care Service which, when rendered by a Provider who is not a BCBSF PPC Provider, is subject to a prior coverage authorization or pre-service notification program, including how the Covered Person can obtain prior coverage authorization and/or provide the pre-service notification for such Service not already listed here. This information will be provided to the Covered Person upon enrollment, or at least 30 days prior to such Services which, when rendered by a Provider who is not a BCBSF PPC Provider, become subject to a prior coverage authorization or pre-service notification program.

See the "Claims Processing' section for information on what a Covered Person 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.

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The **ELIGIBILITY FOR COVERAGE** section is amended as follows:

The following paragraph is added at the end of the **Eligibility Requirements for Dependent(s)** subsection:

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 Certificate of Coverage 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 Certificate of Coverage.

The **GLOSSARY OF TERMS** 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.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage including any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call BCBSF toll free at 800-FLA-BLUE.

The Certificate of Coverage 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 the 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.

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;
2. Pregnancy;
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. Drugs that are covered and payable under a BCBSF Pharmacy Program Endorsement issued with and part of this Certificate of Coverage.

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT / UTILIZATION REVIEW PROGRAMS

The following **new** subsection is added:

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

The Covered Person or the Covered Person's Physician will be required to obtain prior coverage authorization from BCBSF for Mental Health and Substance Dependency Care and Treatment Services.

BCBSF PPC℠ Providers

It is the BCBSF PPC℠ Provider's sole responsibility to comply with BCBSF's prior coverage authorization requirements, and therefore the Covered Person will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

SAMPLE

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

Providers who are not BCBSF PPC℠ Providers

It is the Covered Person's sole responsibility to comply with BCBSF's prior coverage authorization requirements when rendered or referred by Providers who are not BCBSF PPC℠ Providers **before** Mental Health and Substance Dependency Care and Treatment Services are provided. **The Covered Person's 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 the back of the ID Card.

Once the necessary medical documentation has been received from a Covered Person and/or the Provider who is not a BCBSF PPC℠ Provider, BCBSF will review the information and make a prior coverage authorization decision, based on BCBSF's established criteria then in effect. The Covered Person will be notified of the prior coverage authorization decision.

See the "Claims Processing" section for information on what the Covered Person 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.

COVERED SERVICES

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 the Covered Person's Physician; and
2. the Covered Person's doctor has certified to BCBSF in writing that the Covered Person's life expectancy is 12 months or less.

Recertification is required every six months.

The **Outpatient Cardiac, Occupational, Physical, Speech, and Massage 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:

The 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 the Covered Person may have only been administered two (2) of the spinal manipulations for the

SAMPLE

Calendar Year, any additional spinal manipulations for that Calendar Year will not be covered if the Covered Person has already met the combined therapy visit maximum with other Services.

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 Certificate of Coverage:

1. The Covered Employee's spouse under a legally valid existing marriage;
2. The Covered Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee 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
3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

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

SAMPLE

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 will automatically terminate 18 months after the birth of the newborn child.

TERMINATION OF INDIVIDUAL 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 eligibility requirements;
4. on the date specified by BCBSF that the Covered Dependent's coverage is terminated by BCBSF for cause;
5. on the date specified by the Small Employer that the Covered Dependent's coverage terminates.

In the event the Covered Employee wishes to delete a Covered Dependent from coverage, a Member Status Change Request form should be forwarded to BCBSF through the Small Employer.

In the event the Covered Employee wish to terminate a spouse's coverage, (e.g., in the case of divorce), the Covered Employee must submit a Member Status Change Request 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

BCBSF reserves the right to Rescind the coverage for any individual covered under this Certificate of Coverage as permitted by law.

BCBSF may only Rescind the coverage under this Certificate of Coverage if you, or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

BCBSF will provide at least 45 days advance written notice 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 this Certificate of Coverage.

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 Certificate of Coverage 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 the Covered Person 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 the last bulleted item in the list in its entirety and replacing it with the following:

- The Covered Person has the right to an independent external review through an external review organization for certain appeals, as designated in the 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 BCBSF's Appeal Decision

If a Covered Person is not satisfied with BCBSF's internal review of his or her appeal of an Adverse Benefit Determination, the Covered Person should refer to the Adverse Benefit Determination notice or call the customer service phone number on your Identification Card for information on how to request an external review.

SAMPLE

GLOSSARY OF TERMS

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 following **new** definition is added:

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.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call BCBSF 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 Conditions Exclusion Period** in its entirety.

COVERED SERVICES

The **Introduction** is amended as follows:

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

5. 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;

SAMPLE

6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;
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.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

The **Pre-Existing Conditions 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. BCBSF may require the Covered Employee to provide any information and/or documents deemed necessary by BCBSF 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 replaced 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 Dates of coverage and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

CLAIMS PROCESSING

The Standards for Adverse Benefti Determinations subsection is amended by deleting How to Request External Review of BCBSF's Appeal Decision in its entirety and replacing it with the following:

SAMPLE

How to Request External Review of BCBSF's Appeal Decision

If BCBSF denies your appeal and BCBSF's 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 BCBSF's decision. Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with BCBSF. If you have any questions or concerns during the external review process, please contact BCBSF 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 BCBSF in order to give BCBSF 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 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 Medical 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 BCBSF 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 BCBSF in order to give BCBSF 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 BCBSF's decision, BCBSF will provide coverage or payment for your health care item or service.

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

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

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

SAMPLE

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 a Medical Emergency, 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

GLOSSARY OF TERMS

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.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call BCBSF toll free at 800-FLA-BLUE.

This Endorsement 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.

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT / UTILIZATION REVIEW PROGRAMS

The **Admission Certification Program** subsection is deleted in its entirety and replaced with the following:

Admission Notification Program

As explained below, the Admission Notification Program requirements vary depending on whether or not the Hospital utilized is a BCBSF PPC℠ Provider. A BCBSF PPC℠ Provider is a PPO Provider in the state of Florida, or in certain counties outside of Florida, that is also a "Preferred Patient Care℠" or "PPC℠" Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC℠ program). To find out about a health care Provider's participation status, you can review the Provider Directory then in effect, access BCBSF's website at www.floridablue.com and/or call the customer service phone number on this Certificate or on your Identification Card.

1. **Admission Notification Requirements for Inpatient Admissions to Facilities that are BCBSF PPC Providers**

   Under the Admission Notification Program, BCBSF must be notified of ALL inpatient admissions (i.e., elective, planned, urgent or emergency) to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility that is a BCBSF PPCsm Provider.

   The Admission Notification Program requirements for admissions to such facilities are the Provider's sole responsibility. You are not responsible for satisfying such requirement; however, you should ask the facility if BCBSF has been notified.

2. **Your Admission Notification Requirements for Admissions to Florida Hospitals that are not BCBSF PPC Providers**

   The Admission Notification Program also requires you to notify BCBSF of ANY admission (e.g., elective, planned, urgent, or emergency) to a Hospital in the state of Florida that is not a BCBSF PPC℠ Provider, by calling the customer service number on your Identification Card.

   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

SAMPLE

you choose not to participate call the customer service phone number on your ID Card and inform a service associate of your decision.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call BCBSF toll free at 800-FLA-BLUE.

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

The **Certification of Creditable Coverage** subsection is deleted from the **Termination of Individual Coverage** section in the **Table of Contents**.

TERMINATION OF INDIVIDUAL COVERAGE

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

CONTINUING COVERAGE

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

The **Florida Health Insurance Coverage Continuation Act (FHICCA) Provisions (For employers with one to 19 employees)** subsection is amended by deleting the sixth paragraph and the address under **Types of Qualifying Events** in their entirety and replacing them with the following.

When BCBSF receives the timely notice as described above, BCBSF will send to the Insured by Certified Mail a **Premium Notice and Election Form** that describes the Continuation Coverage options available. Under the law, Insureds have 30 days from the date of receipt of the **Premium Notice and Election Form** to elect Continuation Coverage. To elect Continuation Coverage, complete and return the Premium Notice and Election Form with applicable Premium payment to BCBSF. Continuation Coverage begins on the day after coverage would otherwise be terminated, only if the Premium Notice and Election Form and full Premium payment are sent and received by BCBSF 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

GLOSSARY OF TERMS

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

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto.

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

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

TABLE OF CONTENTS

The **Table of Contents** is amended by deleting the "Subrogation" and "Right of Reimbursement" sections in their entirety and adding the "Subrogation and Right of Reimbursement" subsection to the **General Provisions** section.

GENERAL EXCLUSIONS

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

3. Any Health Care Service a Covered Person renders to him or herself or those rendered by a Physician or other health care Provider related to the Covered Person by blood or marriage.

It is further amended by deleting items number "b – d" under item number 9 in their entirety and replacing them with the following:

b. the Covered Person's participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not the Covered Person was 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. the Covered Person's 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 the Covered Person's service in the armed forces, reserves and/or National Guard; or

The **Additional General Exclusions** subsection is amended by adding the following exclusion:

Motor Vehicle Accidents including any costs the Covered Person incurs 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.

SAMPLE

DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

The **Coordination of Benefits** subsection is amended by adding the following item to the numbered list in paragraph number one:

5. to the extent permitted by law, any other government sponsored health insurance program.

This section is further amended by deleting the fifth paragraph and the 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. BCBSF always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile policy available to the Covered Person.
2. When BCBSF covers the Covered Person as a Covered Dependent and the other plan covers the Covered Person as other than a dependent, BCBSF will be secondary.
3. When BCBSF covers a dependent child whose 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 BCBSF, BCBSF will be secondary.
4. When BCBSF covers 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 BCBSF covers the Covered Person as a dependent child and the other plan covers the Covered person 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 the Covered Person has 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

SAMPLE

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 Covered Person the longest shall be primary, unless the Covered Person is age 65 or older and covered under Medicare Parts A and B. In that case, this Certificate will be secondary to Medicare.
8. If the other plan does not have rules that establish the same order of benefits as under this Certificate, the benefits under the other plan will be determined primary to the benefits under this Certificate.

BCBSF 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.

SUBROGATION

The **Subrogation** section is deleted in its entirety.

RIGHT OF REIMBURSEMENT

The **Right of Reimbursement** section is deleted in its entirety

GENERAL PROVISIONS

The following subsection is added:

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 the Covered Person. 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 Certificate of Coverage for expenses incurred due to Third Party Injuries, then BCBSF retains the right to repayment of the full cost of all benefits provided under this Certificate of Coverage on the Covered Person's behalf that are associated with the Third Party Injuries. BCBSF's subrogation and reimbursement rights of recovery apply to any claim or potential claim made by a Covered Person or on a Covered Person's 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;

SAMPLE

- 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 a Covered Person for injuries resulting from an accident or alleged negligence.

By accepting benefits under this Certificate of Coverage, the Covered Person specifically acknowledges BCBSF's right of subrogation. In the event a Covered Person suffers injuries for which a Third Party is responsible (such as someone injuring a Covered Person in an accident), and BCBSF pays benefits under this Certificate of Coverage as a result of those injuries, BCBSF will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits BCBSF has paid. This means that BCBSF has the right, independently of the Covered Person, to proceed against the Third Party responsible for the Covered Person's injuries to recover the benefits BCBSF has paid. In order to secure BCBSF's recovery rights, the Covered Person agrees to assign to BCBSF any benefits or claims or rights of recovery the Covered Person has under any automobile policy or other coverage, to the full extent of BCBSF's subrogation and reimbursement claims. This assignment allows BCBSF to pursue any claim a Covered Person may have, whether or not the Covered Person chooses to pursue the claim.

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

By accepting benefits under this Certificate of Coverage, the Covered Person or the Covered Person's representatives further agree to:

- Notify BCBSF 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 the Covered Person;
- Cooperate with BCBSF and do whatever is necessary to secure BCBSF's right of subrogation and reimbursement under this Certificate of Coverage;
- Give BCBSF 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 Certificate of Coverage (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 BCBSF as reimbursement for the full cost of all benefits associated with Third Party Injuries paid under this Certificate of Coverage (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by BCBSF in writing;

SAMPLE

- Do nothing to prejudice BCBSF's 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 Certificate of Coverage; and
- Serve as a constructive trustee for the benefits under this Certificate of Coverage over any settlement. BCBSF may recover the full cost of all benefits paid by BCBSF under this Certificate of Coverage without regard to any claim of fault on the Covered Person's part, whether by comparative negligence or otherwise. In the event the Covered Person or Covered Person's representative fails to cooperate with BCBSF, the Covered Person shall be responsible for all benefits provided by BCBSF under this Certificate of Coverage in addition to costs and attorney's fees incurred by BCBSF in obtaining repayment.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

MediScript® 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") BlueChoice Certificate of Coverage. Your MediScript 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/OR COVERED SYRINGES AND NEEDLES

The **Covered Prescription Drugs and/or Covered Syringes and Needles** section is amended by deleting the first paragraph in its entirety and replacing it with the following:

All Prescription Drugs are covered under this Endorsement unless otherwise limited or excluded herein or by the Certificate of Coverage, or by any amendment to this Endorsement. In order to be covered under this Endorsement, Prescription Drugs OTC Drugs must be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license, dispensed by a Pharmacist, and be Medically Necessary as defined by BCBSF, not otherwise limited or excluded herein, approved by the FDA and assigned a National Drug Code, except for New Prescription Drugs and reviewed by our Pharmacy and Therapeutics Committee.

EXCLUSIONS

The **Exclusions** section is amended by adding the following to the numbered list:

29. New Prescription Drugs.

ADDITIONAL DEFINITIONS

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

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.

SAMPLE

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto.

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

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

COVERED PERSON'S FINANCIAL OBLIGATIONS

The **Covered Person's Financial Obligations** section has been 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.

COVERED SERVICES

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

Ambulance Services

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

1. For Medical Emergencies – it is Medically Necessary to transport you by air, ground or water, from the place a Medical Emergency 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 Medical Emergency, 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 an Insured by ground:

SAMPLE

a. from an non participating Hospital to the nearest PPO Hospital that can provide care;

b. to the nearest PPO Hospital or non participating 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 BCBSF; 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 BCBSF 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.

Limitations

Air Ambulance coverage is specifically limited to transport due to a Medical Emergency 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 an Insured's health or safety.

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

Exclusions

1. Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:
2. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
3. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
    a. the crew renders aid until a helicopter can be sent;
    b. the patient refuses care or transport; or
    c. only basic first aid is rendered.
4. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
5. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
6. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
    a. patient wants to be at a certain Hospital or facility for personal/preference reasons;

SAMPLE

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.

7. Air Ambulance Services in the absence of a Medical Emergency, unless such Services are authorized by BCBSF in advance.

The **Dental** category is amended by deleting item "b" under number 2 in its entirety and replacing it with the following:

b. the Covered Person or Covered Dependent has one or more medical Conditions that would create significant or undue medical risk for the Covered Person in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

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.

SAMPLE

GENERAL EXCLUSIONS

The **General Exclusions** section is amended by deleting the following **Exclusions** in their entirety and replacing them with the following:

9b. the Covered Person's participation in, or commission of, any act punishable by law as a felony whether or not the Covered Person was charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical condition;

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.

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

Motor Vehicle Accidents Injuries and Services an Insured incurred 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**.

GLOSSARY OF TERMS

The following definitions are deleted in their entirety: **Gestational Surrogate** and the **Gestational Surrogacy Contract or Arrangement**.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

MediScript® 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") BlueChoice Certificate of Coverage. Your MediScript 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**.

INTRODUCTION

The **Introduction** is amended by deleting the following numbered item in its entirety and replacing it with the following:

3. Medically Necessary, as defined by BCBSF and determined by BCBSF in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;

The following is added to the numbered list:

5. within the BCBSF's Coverage and Benefit Guidelines for Presription Drugs section listed in this endorsement.

BCBSF'S COVERAGE AND BENEFIT GUIDELINES FOR PRESCRIPTION DRUGS

The **BCBSF'S Coverage and Benefit Guidelines for Prescription 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 and oral contraceptive Prescription Drugs will be covered subject to the limitations and exclusions listed in this Endorsement.

ADDITIONAL DEFINITIONS

The **Additional Definitions** section is amended by replacing the following definition:

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:

SAMPLE

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 Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto.

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

This Endorsement is effective on the Group Plan's first Anniversary Date occurring on or after **January 01, 2018**.

COVERED PERSON'S FINANCIAL OBLIGATIONS

The **Additional Financial Responsibilities** subsection is amended by adding the following:

Special Payment Rules

Emergency Services in an Emergency Room

Payment for emergency Services rendered by a Provider that has not entered into an agreement with BCBSF 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 a non-PPO Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by a non-PPO Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center that are PPO Providers; and
- the Covered Person does not have the ability and opportunity to choose a PPO Provider at the Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center that is a PPO Provider, who is available to treat the Covered Person; 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 non-PPO Providers be paid more than their charges for the Services rendered.

SAMPLE

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW PROGRAMS

The **Prior Coverage Authorization/Pre-Service NotificationPrograms** subsection is amended by deleting the note at the end of the subsection in its entirety and replacing it with the following:

Note:

1. Prior coverage authorization is not required when emergency Services are rendered for the treatment of a Medical Emergency.
2. Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:
   a. the termination date of the Covered Person's policy, or
   b. the period authorized by BCBSF, as indicated in the letter the Covered Person receives from BCBSF.

Subject to BCBSF's review and approval, BCBSF may authorize continued coverage of a previously approved Service. To request a continuation BCBSF must receive appropriate documentation from the Provider. The fact that BCBSF may have previously authorized coverage does not guarantee a continued authorization.

COVERED SERVICES

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

Ambulance Services

Ground Ambulance

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

1. For Medical Emergencies– it is Medically Necessary to transport a Covered Person from the place a Medical Emergency 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 Medical Emergency, 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 the Covered Person by ground:
   a. from a non-PPO Hospital to the nearest PPO Hospital that can provide care;
   b. to the nearest PPO or non-PPO 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 BCBSF; or
   d. from an acute facility to the nearest cost-effective sub-acute setting.

SAMPLE

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 BCBSF or not) would endanger the patient's medical Condition. If another mode of transportation could be used safely and effectively, regardless of time, or mode (e.g. air, ground, water) then Ambulance transportation is not Medically Necessary.

Air and Water Ambulance

Air and water Ambulance coverage is specifically limited to transport due to a Medical Emergency 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 the Covered Person's health or safety.

Air and water Ambulance transport for non-emergency transport is excluded unless it is specifically approved by BCBSF 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 a Medical Emergency, unless such Services are authorized by BCBSF in advance.

SAMPLE

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 a Medical Emergency are covered when rendered by PPO Providers and non-PPO Providers without the need for any prior authorization from BCBSF.

Urgent Care Services

For non-critical but urgent care needs, a Covered Person may be able to reduce the out-of-pocket expenses and, in many cases, 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

GENERAL EXCLUSIONS

The **Additional General Exclusions** subsection is amended as follows:

The **Drugs** exclusion is amended by adding the following:

5. New Prescription Drug(s), as defined in the Glossary of Terms section.
6. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in BCBSF's coverage policy as an output from BCBSF's Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

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 BCBSCF covers 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;

SAMPLE

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 the Insured are covered under a plan that covers the Insured as a laid off or retired employee or as the employee's dependent and the other plan covers the Insured as a dependent:

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

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

6. If the Insured has 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 Insured the longest shall be primary.

GLOSSARY OF TERMS

The definition of **New Prescription Drug(s)** is deleted in its entirety and replaced 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 BCBSF's Pharmacy and Therapeutics Committee (or, in the case of medical benefits, BCBSF's Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by BCBSF's Pharmacy and Therapeutics Committee (or, in the case of medical benefits, BCBSF's 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 BCBSF's Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date BCBSF's Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

MediScript® 2018 Pharmacy Program Amendment

This amendment is to be attached to and made part of the Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueChoice Certificate of Coverage. The MediScript Pharmacy Program Endorsement is amended as described below.

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

This amendment is effective at the Group Plan's first Anniversary Date occurring on or after **January 01, 2018**.

PHARMACY ALTERNATIVES AND REIMBURSEMENT RULES

Paragraphs 3 through 5 are deleted in thier entirety and replaced with the following.

For reimbursement purposes, there are two types of Pharmacies: (1) "Participating Pharmacies" and (2) "Non-Participating Pharmacies." Participating Pharmacies have agreed not to charge or collect from the Covered Person, more than the Participating Pharmacy Allowance per Prescription for each Covered Prescription Drug and/or Covered Syringes and Needles.

To verify if a Pharmacy is a Participating Pharmacy, the Covered Person may refer to the provider directory then in effect at www.bcbsfl.com or call the customer service phone number on the Covered Person's ID Card.

Note: Prior to purchase, the Covered Person must present his or her BCBSF ID Card and Participating Pharmacy must be able to verify that the Covered Person is, in fact, covered by BCBSF.

The **Reimbursement Rules for Non-Participating Pharmacies** section is deleted in its entirety and replaced with the following:

Reimbursement Rules for Non-Participating Pharmacies

BCBSF's reimbursement for Covered Prescription Drugs and/or for Covered Syringes and Needles is based upon the Participating Pharmacy Allowance. Non-Participating Pharmacies have NOT agreed to accept the Participating Pharmacy Allowance; therefore, the Covered Person's financial responsibility will include the following:

1. the payment of any difference between the Participating Pharmacy Allowance and the Non-Participating Pharmacy's charge;
2. the payment of any applicable Calendar Year Deductible(s) and/or Coinsurance requirements;
3. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non-covered, limited, or excluded syringes and needles and Drugs;
4. the payment of expenses in excess of any maximum benefit limitation; and
5. the payment of any applicable benefit reductions or penalties.

SAMPLE

BCBSF's reimbursement will be:

1. made directly to the Covered Person;
2. subject to the Calendar Year Deductible; and
3. will be based on the Participating Pharmacy Allowance and payable at the Coinsurance percentage applicable to Non-PPO Providers, as set forth in the Schedule of Benefits.

ADDITIONAL DEFINITIONS

The following definitions are deleted in their entirety and replaced 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 BCBSF's Pharmacy and Therapeutics Committee (or, in the case of medical benefits, BCBSF's Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by BCBSF's Pharmacy and Therapeutics Committee (or, in the case of medical benefits, BCBSF's 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 BCBSF's Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date BCBSF's Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Participating Pharmacy means a Pharmacy that has signed an agreement with BCBSF or BCBSF's Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies are also Participating Pharmacies.

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 BCBSF to make such network and/or programs available to Covered Persons.

SAMPLE

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call BCBSF toll free at 800-FLA-BLUE.

This Endorsement is effective on your Group Plan's initial Effective Date occurring on or after **January 01, 2019**.

COVERED PERSON'S FINANCIAL OBLIGATIONS

The following **new** subsection is added below the **Benefit Maximum Carryover** subsection:

Calculation of Cost Share

A Covered Person can get an estimate on BCBSF's website at www.floridablue.com, of the cost share amount he or she will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

COVERED SERVICES

The **Transplant Services** category is amended by deleting item number 3 in its entirety and replacing it with the following:

3. heart transplant

The **Transplant Services** Exclusion items number 2 and 4 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;

The **Exclusion** is amended by deleting item number **11** in its entirety.

GENERAL EXCLUSIONS

The **Complications of Non-Covered Services** category is deleted in its entirety.

The Services to Treat Complications of Non-Covered Services category 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

SAMPLE

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 you were covered by a previous carrier or self-funded plan at any time prior to coverage under this policy even if the Service(s) were covered under the prior carrier or self-funded plan.

The **Weight Control Services** category 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. 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 a Covered Person's ability to assimilate food. Complications of any kind arising from, or related to, weight control surgery, as determined by BCBSF, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Certificate of Coverage or another BCBSF/HOI policy and it also applies if the surgery was performed while the Covered Person was covered by a previous carrier or self-funded plan at any time prior to coverage under this Policy even if the Service(s) was/were covered under the prior carrier or self-funded plan.

ELIGIBILITY FOR COVERAGE

The **Eligibility Requirements for Dependents** subsection is amended by deleting list item 2 in its entirety, and replacing it with the following:

2. The Covered Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) 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 disablity, 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;

        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.

SAMPLE

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** section is amended by adding a new bullet below bullet number 4, as follows:

- 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 following **new** subsection is added below the **Timing of Our Appeal Review on Adverse Benefit Determination** subsection:

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Certificate of Coverage 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.

GLOSSARY OF TERMS

The definition of **Small Employer Application** is deleted in its entirety and replaced with the following:

Small Employer Application means the BCBSF application form that a Small Employer must submit to BCBSF when requesting the issuance of the Policy.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

MediScript® Oral Chemotherapy Drugs Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueChoice Certificate of Coverage, including any Endorsements attached thereto. This document specifically amends the MediScript Pharmacy Program Endorsement 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 initial Effective Date occurring on or after January 1, 2019 or first Anniversary Date occurring on or after January 1, 2019 whichever occurs first.

BCBSF'S COVERAGE AND BENEFIT GUIDELINES FOR PRESCRIPTION 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 the cost share for Intravenous (IV) chemotherapy infusions when provided by a PPO Provider.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call BCBSF toll free at 800-FLA-BLUE.

This Endorsement is effective on your Group Plan's initial Effective Date occurring on or after **January 01, 2020**.

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"**.

COVERED SERVICES

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 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.

SAMPLE

Exclusion

Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.

GENERAL EXCLUSIONS

The following **new** exclusions are added in alphabetical order:

Virtual Visits, except as described in the COVERED SERVICES section. Services rendered by a Virtual Care Provider that is not designated by BCBSF to provide Virtual Visits and does not have a contract with BCBSF to provide Virtual Visits under this Certificate of Coverage.

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.

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:

In the event the Covered Employee wishes to delete a Covered Dependent from coverage, a Member Status Change Request form should be forwarded to BCBSF through the Small Employer prior to the termination date requested.

GENERAL PROVISIONS

The following **new** provision is added in alphabetical order:

Customer Rewards Program

From time to time, BCBSF may offer programs that reward Covered Persons for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. BCBSF will tell you about any available rewards programs in general mailings, newsletters and/or on BCBSF's website. Coverd Person's participation in these programs is always completely voluntary and will in no way affect the coverage available to Covered Persons under this Certificate of Coverage. BCBSF reserves 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 the Covered Persons consent.

SAMPLE

GLOSSARY OF TERMS

The definitions of **Certified Nurse Midwife** and **Certified Registered Nurse Anesthetist** are deleted 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.

The following **new** definitions are added in alphabetical order:

Virtual Care Provider is a licensed Provider that is designated by BCBSF and has a contract with BCBSF to provide Virtual Visits at the time the 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 Certificate of Coverage, 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

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2021**.

HEALTH CARE PROVIDER ALTERNATIVES AND REIMBURSEMENT RULES

The following **new** category is added after the **Reimbursement Rules for BCBSF PPC Providers** section:

Value Choice Providers

Some Providers, designated by BCBSF, may provide Services other than advanced imaging and maternity Services at a lower Cost Share. The Deductible will be waived for these Services and the Covered Person's 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* • Diagnostic Testing (such as lab work and x-rays done in the office) • Allergy Testing and Injections	$0
Specialist Physician	• Office Visits* • 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 for first 2 visits***

* Advanced imaging and maternity Services will remain at the Cost Share listed on your Schedule of Benefits.

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

*** After the first 2 visits, the urgent care Cost Share listed on the 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".

SAMPLE

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW PROGRAMS

The **Prior Coverage Authorization/Pre-Service Notification Programs** and **Prior Coverage Authorization/Pre-Service Notification Programs for Mental Health and Substance Dependency Care and Treatment Services** subsections are deleted in its entirety and replaced with the following:

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for the Covered Person to understand BCBSF's prior coverage authorization programs and how the Provider the Covered Person selects and the type of Service the Covered Person receives affects these rules and ultimately how much the Covered Person will have to pay under this Certificate of Coverage.

The Covered Person or the Covered Person's Physician will be required to obtain prior coverage authorization from BCBSF for Covered Services listed below. The Covered Person is solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by a PPO Provider or non-PPO 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

The Covered Person 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 the Covered Person does 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**.

Transplant Services

The Covered Person must obtain an authorization for all Transplant Services, including the pre-transplant evaluation **before** the transplant evaluation is scheduled. **If the Covered Person does 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, the Covered Person must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

SAMPLE

BCBSF will inform Covered Persons of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how the Covered Person can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to Covered Persons 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 Covered Persons electronically, if the Covered Person has elected the delivery of notifications from BCBSF 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.

Additional Information

Once the necessary medical documentation has been received from the Covered Person and/or the Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on BCBSF's established criteria then in effect. The Covered Person 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 the Covred Person's policy, or
    b. the period authorized by BCBSF, as indicated in the letter the Covered Person receive from BCBSF.

Subject to BCBSF's review and approval, BCBSF may authorize continued coverage of a previously approved Service. To request a continuation BCBSF must receive appropriate documentation from the Covered Person's Provider. The fact that BCBSF may have previously authorized coverage does not guarantee a continued authorization.

See the CLAIMS PROCESSING section for information on what the Covered Person can do if prior coverage authorization is denied.

SAMPLE

COVERED SERVICES

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 BCBSF. Coverage is subject to the conditions and limitations described below. Transplant includes pre-transplant, transplant and post-discharge Services and treatment of any complications after transplantation.

1. Bone Marrow Transplant, as defined herein and specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. BCBSF will cover the expenses incurred for the donation of bone marrow by a donor to the same

extent such expenses would be covered for a Covered Person and will be subject to the same limitations and exclusions as would be applicable to a Covered Person. 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.

Covered Persons may call the customer service phone number on their ID Card to determine which Bone Marrow Transplants are covered under this Certificate.

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:

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 BCBSF;
4. the transplant has been approved by BCBSF 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 Certificate, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered before BCBSF is contacted for authorization.
3. Transplant procedures which are not authorized by BCBSF 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 BCBSF

SAMPLE

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 BCBSF's 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 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 the Covered Person and/or the Covered Person's 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 BCBSF in advance and those associated with:
    a. transplants that are not covered under this Certificate;
    b. dual listing; or
    c. costs not allowed under IRS regulations.

GENERAL EXCLUSIONS

The following **new** exclusion is added in alphabetical order:

Transplant Services except as indicated in the Covered Services section, including:

1. Transplant procedures not included in the Transplant Services category of the Covered Services section, or otherwise excluded under this Certificate, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** BCBSF is contacted for authorization.
3. Transplant procedures which are not authorized by BCBSF **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 BCBSF.
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 BCBSF's Medical Necessity criteria then in effect.
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.

SAMPLE

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 a Covered Person and/or a Covered Person's family to and from the approved facility, except as indicated under the Lodging and Transportation heading of the Transplant Services category in the Covered Services section.
11. Expenses related to evaluation for registration at more than one transplant center (dual listing).
12. Travel expenses that are not authorized by BCBSF in advance and those associated with:
    a. transplants that are not covered under this Certificate;
    b. dual listing; or
    c. costs not allowed under IRS regulations.

TERMINATION OF INDIVIDUAL 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. the Covered Person intentionally misrepresents, omits or gives false information on Enrollment Forms or other forms completed for BCBSF for the purpose of obtaining coverage under this Certificate, by or on behalf of the Covered Person.
3. fraudulent misuse of the Identification Card;
4. failure to fully cooperate with BCBSF in the administration of coverage under this Certificate.

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 BCBSF may offer Covered Persons 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.

SAMPLE

Types of Rewards or Incentives

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

Types of Programs

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

- managing specific Conditions;
- preventive or wellness Services;
- certain behaviors, such as completing an annual physical; or
- optimizing this 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 Covered Persons. By logging into the rewards portal, Covered Persons will be able to track rewards they have earned and access other programs that may be available to them.

Transportation Program

BCBSF understands that access to transportation can sometimes be a barrier to getting the health care Covered Persons need. To assist Covered Persons, BCBSF may offer programs to help Covered Pesrons access health and wellness facilities and services.

Note: BCBSF will tell Covered Persons about any available rewards programs in general mailings, newsletters and/or on BCBSF's website. Covered Persons may not have access to every reward, incentive, health or transportation program. Covered Persons are not obligated to take part in any of these programs and they will not affect the coverage available under this Certificate. BCBSF reserves 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 Covered Persons should consult a tax advisor for further guidance.

SAMPLE

GLOSSARY OF TERMS

The following **new** definition is added in alphabetical order:

Designated Transplant Facility is a licensed facility that is designated by BCBSF and has a contract with BCBSF 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 A PPO Provider does not mean that it is a designated facility.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage, including any Endorsements attached thereto. This document specifically amends the MediScript Pharmacy Program Endorsement 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 1, 2021**.

BCBSF'S COVERAGE AND BENEFIT GUIDELINES FOR PRESCRIPTION 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 Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2022**.

The term **Medical Emergency** is hereby replaced with the term **Emergency Medical Condition** and the term **emergency Services** is hereby replaced with the term **Emergency Services** throughout the Certificate of Coverage.

COVERED PERSON'S FINANCIAL OBLIGATIONS

The **Emergency Room Per Visit Deductible** subsection is deleted in its entirety and replaced with the following;

Emergency Room Per Visit Deductible

The Emergency Room Per Visit Deductible is set forth in the Schedule of Benefits. The Emergency Room Per Visit Deductible applies regardless of the reason for the visit and is in addition to the Calendar Year Deductible. The Emergency Room Per Visit Deductible must be satisfied by each Covered Person for each visit. If the Covered Person is admitted to the Hospital at the time of the emergency room visit, the cost share applicable to inpatient PPO Providers will apply instead of the emergency room cost share.

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:

Special Payment Rules

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Emergency Services rendered by a Provider that has not entered into an agreement with BCBSF 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 a Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider will comply with section 627.64194(4) of the Florida Statutes when:

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HEALTH CARE PROVIDER ALTERNATIVES AND REIMBURSEMENT RULES

The **Value Choice Providers** subsection is deleted in its entirety and replaced with the following:

Value Choice Providers

Some Providers, designated by BCBSF, may provide Services other than maternity at a lower cost share. The Calendar Year Deductible will be waived for these Services and the Covered Person's 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
Family Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$0
Specialist Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Diagnostic Testing (such as lab work and x-rays done in the office) • 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 Calendar Year	$0 for first 2 visits***

* Maternity Services will remain at the cost share listed on the Covered Person's Schedule of Benefits.

** Or the Specialist Physician office cost share listed on the Covered Person's Schedule of Benefits; whichever is lower.

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*** After the first 2 visits, the urgent care cost share listed on the Covered Person's 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".

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT / UTILIZATION REVIEW 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**, the Covered Person must obtain an authorization for the transplant **before** the transplant is scheduled.
2. In the case of **Transplant Services designated by BCBSF as eligible for lodging and transportation assistance**, the Covered Person must obtain an authorization for all Services, including the pre-transplant evaluation **before** the transplant evaluation is scheduled.

If the Covered Person does not obtain prior coverage authorization, BCBSF 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 the Covered Person's ID Card.

COVERED SERVICES

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 Certificate of Coverage.

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;

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2. the transplant is a Covered Service at the time Services are rendered and is designated by BCBSF 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 Certificate of Coverage, 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 BCBSF;
5. the transplant, including pre-transplant evaluation, has been approved by BCBSF 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 BCBSF.

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:

2. Transplant evaluations for transplants designated by BCBSF as eligible for lodging and transportation assistance, rendered **before** BCBSF is contacted for authorization.
12. Travel expenses that are not authorized by BCBSF in advance and those associated with:
    a. transplants that are not covered under this Certificate;
    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

This plan covers Virtual Visits between a Covered Person and a Virtual Care Provider when rendered consistent with Florida laws, regulations and BCBSF's 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 the Covered Person know if a Condition requires a face-to-face visit with a Physician.

Coverage includes Virtual Visits between a Covered Person and a PPO Provider who offers Virtual Visits at the time the Services are rendered. The cost shares for Virtual Care Provider Services are listed in the 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 Glossary of Terms section.

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GENERAL EXCLUSIONS

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 Certificate of Coverage, 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 BCBSF as eligible for lodging and transportation assistance, rendered **before** BCBSF is contacted for authorization.

12. Travel expenses that are not authorized by BCBSF in advance and those associated with:

    a. transplants that are not covered under this Certificate;

    b. evaluation for registration at more than one transplant center (dual listing); or

    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 Covered Services section. Services rendered by a Virtual Care Provider that is not designated by BCBSF to provide Virtual Visits under this Certificate of Coverage.

EXTENSION OF BENEFITS

The **Extension of Benefits** subsection is amended as follows:

The 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).

GLOSSARY OF TERMS

The following **new** definitions are added in alphabetical order:

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

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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.

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.

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

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 **Medical Emergency** definition is deleted in its entirety.

The **Virtual Care Provider** definition is deleted in its entirety and replaced with the following:

Virtual Care Provider means (1) a PPO Provider that is designated by BCBSF and that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by BCBSF and has a contract with BCBSF 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 Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2023**.

COVERED PERSON'S FINANCIAL OBLIGATIONS

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 a Provider that has not entered into an agreement with BCBSF 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 non-PPO Providers be paid more than their charges for the Services rendered.

Non-Emergency Services

If a Covered Person receives Services from a PPO Provider in a PPO Health Care Facility (as defined below) and did not have the ability and opportunity to choose a PPO Provider that is available to treat them, 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. 116-260), as applicable. The PPO Provider in such case, should only bill the Covered Person for the applicable PPO Cost Share.

For purposes of this subsection, a PPO Health Care Facility means a PPO 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 non-PPO Providers be paid more than their charges for the Services rendered.

Air Ambulance

If a PPO air Ambulance Provider renders Covered Services under this Certificate, the PPO 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.

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In no event, subject to this Special Payment Rules subsection, will non-PPO Providers be paid more than their charges for the Services rendered.

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW PROGRAMS

The following **new** subsection is added at the end of the section:

Coverage Protocol Exemption Request

In some cases, Services under this Certificate require the Covered Person to complete use of another Prescription Drug, medical procedure, or course of treatment other than the one requested by their treating Physician, before coverage will be authorized/granted. Florida Statute 627.42393 permits Covered Persons to request a protocol exemption in order to receive coverage without completing BCBSF's coverage protocol for the Prescription Drug, medical procedure, or course of treatment. If BCBSF denies the coverage protocol exemption request, BCBSF will provide 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 the Covered Person's formal appeal of an Adverse Benefit Determination process as outlined in the CLAIMS PROCESSING section of this Certificate.

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/.

COVERED SERVICES

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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GENERAL EXCLUSIONS

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.

CLAIMS PROCESSING

The **How to Request External Review of BCBSF 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 BCBSF has denied your request for payment of a claim (in whole or in part) in the following circumstances:

1. BCBSF's 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 the Covered Person's 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 BCBSF. If you have any questions or concerns during the external review process, please contact BCBSF 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 BCBSF in order to give BCBSF 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:

SAMPLE

GLOSSARY OF TERMS

The **Allowance and Allowed Amount** definition is amended by adding number 6 below:

6. In the case of Covered Services rendered by a non-PPO 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 Certificate of Coverage, 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 Certificate of Coverage, 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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This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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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BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2024**.

COVERED PERSON'S FINANCIAL OBLIGATIONS

The **Special Payment Rule** provision is deleted in its entirety and replaced with the following:

Surprise Billing

Sometimes a Covered Person may receive Covered Services from non-PPO Providers who will not accept BCBSF's payment as payment in full. Non-PPO Providers in the specific situations described below are prohibited from balance billing Covered Persons for amounts over what BCBSF pays. Should a Covered Person receive a bill for more than the Covered Person's cost share (as described below) from the non-PPO Provider in these situations, please send that information to BCBSF at the address on the Covered Person's ID card and BCBSF will attempt to work with the non-PPO Provider to appropriately honor their obligation to not balance bill the Covered Person, if applicable.

Non-PPO Services where the Covered Person should not be balance billed

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

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

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

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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 Certificate of Coverage. Please refer to the Ambulance Services category in the Covered Services section of this Certificate of Coverage.

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 BCBSF will Pay non-PPO Providers

Generally, Florida state law prohibits non-PPO Providers rendering Covered Services subject to this Surprise Billing section from balance billing Covered Person's. If section 627.64194(4), Florida Statutes applies, then the Allowed Amount (i.e., the amount BCBSF bases payment on) will generally be calculated in accordance with the definition within this Certificate of Coverage. In certain circumstances, the Allowed Amount will be calculated for non-PPO Providers, including all Covered Services rendered by non-PPO Air Ambulance Providers, based upon the Median Contracted Rate. The term "Median Contracted Rate" as used here means, generally:

1. The rate that is the median contracted rate for all PPO Providers for the same or similar item(s) or Service(s) for all plans offered by BCBSF:
   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 the Covered Person.

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. BCBSF 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 the Covered Person's Share of the Cost

If a Covered Person receives Covered Services subject to this Surprise Billing subsection, the Covered Person's cost share (e.g., Deductibles and/or Coinsurance) will be calculated based upon the Allowed Amount BCBSF initially paid the non-PPO Provider as described above. Should BCBSF decide to pay more, or if the federal Independent Dispute Resolution Process results in BCBSF paying the non-PPO Provider more, the Covered Person's cost share will not change.

Any cost share paid by the Covered Person with respect to Covered Services identified in this subsection will be applied toward the Covered Person's PPO Deductible and out-of-pocket maximum, if applicable. BCBSF 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 the Covered Person knowingly chooses to go to a non-PPO Provider for a planned Service or have signed a consent as noted above, in advance for the Covered Services. In such a case, the Covered Person is responsible for all charges.

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HEALTH CARE PROVIDER ALTERNATIVES AND PAYMENT RULES

The **Value Choice Provider** provision is deleted in its entirety and replaced with the following:

Value Choice Providers

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

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

* Maternity Services will remain at the cost share listed on the Covered Person's Schedule of Benefits.

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** Or the Specialist Physician office cost share listed on the Covered Person's Schedule of Benefits; whichever is lower.

*** After the first 2 visits, the urgent care cost share listed on the Covered Person's 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".

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.

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COVERED SERVICES

The **Home Health Care** category is amended by deleting the first paragraph in its entirety and replacing it with the following:

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

1. the Covered Person is unable to leave their home without considerable effort and assistance because the Covered Person is bedridden or chairbound or because the Covered Person is restricted in ambulation, whether or not the Covered Person uses assistive devices; or the Covered Person is significantly limited in physical activities due to a Condition;
2. the Home Health Care Services rendered have been prescribed by a Physician;
3. the Home Health Care Services are provided by or through a Home Health Agency; and

4. the Covered Person is meeting or achieving the desired treatment goals as documented in the clinical progress notes.

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 Certificate of Coverage, 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 Certificate of Coverage, 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 the Covered Person's convenience or that of the Covered Person's family members or the Provider; and
12. inpatient (overnight) mental health Services received in a residential treatment facility.

The following **new** category is added:

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.

SAMPLE

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,
    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. The Group Plan 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 Certificate of Coverage.

Note: The Covered Person must provide proof that they are entitled to an extension of benefits.

Extension of Benefits

1. If a Covered Person is pregnant on the termination date of the Group Plan, BCBSF will provide a limited extension of the maternity benefits, as long as the pregnancy started while the Covered Person's were covered by BCBSF. 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.

SAMPLE

2. If a Covered Person is totally disabled on the termination date of the Group Plan because of a specific Accident or illness that happened while the Covered Person was covered under the Group Plan, BCBSF will provide a limited extension of benefits for that Covered Person 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, the Covered Person will be considered totally disabled only if, in our opinion, the Covered Person is unable to work at a job for which they have the education, training, or experience, and they continue to require regular care from a Physician for the disability. This applies, even if the Covered Person is not working (e.g., a student, non-working spouse, or children), if the Covered Person is unable to perform those normal day-to-day activities which they would otherwise perform.

3. If the Covered Person is receiving covered dental treatment on the termination date of the Group Plan, BCBSF 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 the Covered Person was covered by BCBSF. Additionally, the dental procedures must be for Services other than routine examinations, 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 the Covered Person becomes covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. The Covered Person is 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 “Covered Services” section for a description of the dental Services covered under this Certificate of Coverage.

SAMPLE

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 the Certificate of Coverage, BCBSF will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, BCBSF will use its 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 “Covered Person’s Financial Obligations” section of this Certificate. The Covered Person may receive notice of payment for paper claims within 30 days of receipt. If BCBSF is unable to determine whether the claim or a portion of the claim is payable because

more or additional information is needed, BCBSF may contest the claim within the timeframes set forth below.

GENERAL PROVISIONS

The following **new** subsection is added at the end of the section:

Covered Persons' Rights and Responsibilities

BCBSF is committed to providing quality health care coverage at a reasonable cost while maintaining the Covered Person's dignity and integrity. Consistent with our commitment and recognizing that PPO Providers are independent contractors and not our agents, the following statement of the Covered Person's Rights and Responsibilities has been adopted.

Rights

1. To be provided with information about BCBSF's services, coverage and benefits, the PPO Providers delivering care and members' rights and responsibilities.
2. To receive medical care and treatment from PPO Providers who have met BCBSF's credentialing standards.
3. To expect PPO Providers to:
    a) discuss appropriate or Medically Necessary treatment options for the Covered Person's Condition, regardless of cost or benefit coverage;
    b) permit the Covered Person to participate in the major decisions about their health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
    c) advise whether the Covered Person's medical care or treatment is part of a research experiment, and to give the Covered Person the opportunity to refuse any experimental treatments; and
    d) inform the Covered Person about any medications they are told to take, how to take them, and their possible side effects
4. To expect courteous service from BCBSF and considerate care from BCBSF's PPO Providers with respect and concern for the Covered Person's dignity and privacy.
5. To voice the Covered Person's complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures found in this Certificate of Coverage.
6. To inform PPO Providers that the Covered Person refuses treatment, and to expect them to honor the Covered Person's decision, if the Covered Person chooses to accept the responsibility and the consequences of the Covered Person's 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 PPO 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.

SAMPLE

7. To have access to the Covered Person's medical records and to be assured that the confidentiality of the Covered Person's medical records is maintained in accordance with applicable law.
8. To call or write to BCBSF any time with helpful comments, questions and observations whether concerning something the Covered Person likes about BCBSF's plan or something Covered Persons feel is a problem area. Covered Persons also may make recommendations regarding BCBSF's rights and responsibilities policies. Please call the phone number on the Covered Person's ID Card or write to BCBSF at the address on the Covered Person's ID Card.

Responsibilities

1. To cooperate with anyone providing the Covered Person's 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 the Covered Person's health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about the Covered Person's care and to ask questions if the Covered Person does not understand or need an explanation.
4. To provide accurate and complete information concerning the Covered Person's health problems and medical history and to answer all questions truthfully and completely.
5. To pay the cost share amounts and be financially responsible for non-covered Services and to provide current information concerning the Covered Person's coverage status to any PPO Provider.
6. To follow the process for filing an appeal about medical or administrative decisions that the Covered Person feels were made in error.
7. To request the Covered Person's medical records in accordance with BCBSF's rules and procedures and in accordance with applicable law.
8. To review information regarding Covered Services, policies and procedures as stated in this Certificate of Coverage.

GLOSSARY OF TERMS

The following **new** definition is added in alphabetical order:

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;

SAMPLE

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 BCBSF. 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 BCBSF;
2. has nursing staff on-site 24 hours per day and 7 days per week;
3. provides access to necessary medical Services 24 hours per day and 7 days per week;
4. provides appropriate access to any Physician-ordered Services required for treatment of the Covered Person's 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 the Covered Person's Condition and care needs.

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2025**.

HEALTH CARE PROVIDER ALTERNATIVES AND PAYMENT RULES

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 "find a doctor" and search for a doctor near you. When using the filter options, click on "Programs" and select "Value Choice Providers".

COVERED SERVICES

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.

SAMPLE

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.

GLOSSARY OF TERMS

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 non-PPO Provider or non-PPO 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) a PPO Provider that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by BCBSF and has a contract with BCBSF 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 Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2026**.

HEALTH CARE PROVIDER ALTERNATIVES AND PAYMENT RULES

The **Value Choice Providers** provision is deleted it in its entirety and replaced with the following:

Value Choice Providers

Some Providers, designated by BCBSF, may provide Services other than Advanced Imaging Services and maternity Services at a lower cost share. The Calendar Year Deductible will be waived for these Services and the Covered Person's 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.

Value Choice Provider Type	Services Included	Cost Share
Primary Care Provider	• Office Visits* • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • 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 Calendar Year	$0 for first 2 visits**

* Advanced Imaging Services and maternity Services will remain at the cost share listed on the Covered Person's Schedule of Benefits.

** After the first 2 visits, the urgent care cost share listed on the Covered Person's 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 BCBSF's 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".

SAMPLE

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW 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.

COVERED SERVICES

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 BCBSF, 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.

GENERAL EXCLUSIONS

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 Certificate of Coverage, reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, and hair removal/hairplasty.

SAMPLE

The following is added to the **Drugs** exclusion in numerical order:

8. 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, BCBSF may review the Drug for coverage under the terms of this Certificate of Coverage. BCBSF reserves the right to, in its sole discretion, but is 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 BCBSF's 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 Certificate, in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

SAMPLE

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

BlueChoice 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") BlueChoice Certificate of Coverage, including any Endorsements attached thereto. This document specifically amends the MediScript Pharmacy Program Endorsement 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 1, 2026**.

INTRODUCTION

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;

EXCLUSIONS

Exclusion number 20 is deleted in its entirety and replaced with the following:

20. Prescription Drugs prescribed by 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;

The following new **Exclusion** is added in numerical order.

30. 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

SAMPLE

Therapeutics Committee or clinical committees. This exclusion does not apply to accelerated approval Drugs prescribed for the treatment of cancer.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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 replacing the BlueCard Program Endorsement, form number 60656 R0523, and is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Certificate of Coverage and any Endorsements attached thereto.

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

This Endorsement is effective at your Group plan's first Anniversary Date occurring on or after **January 1, 2027**.

The Certificate of Coverage is amended by deleting the **BlueCard Program** section in its entirety and replacing it with the following:

BLUECARD® PROGRAM

Out-of-Area Services

Overview

BCBSF has 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 Covered Persons 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 Covered Persons receive care outside of Florida, Covered Persons 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, Covered Persons 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 Certificate of Coverage. BCBSF explains below how BCBSF pays 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 BCBSF to provide the specific Service or Services.

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BlueCard® Program

Under the BlueCard Program, when Covered Persons access Covered Services within the geographic area served by a Host Blue, BCBSF will remain responsible for doing what BCBSF agreed to in the contract. However, the Host Blue is responsible for handling all interactions with its Providers, including contracting with Participating Providers.

When Covered Persons receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount Covered Persons 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 BCBSF.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Covered Person's Provider. Sometimes, it is an estimated price that considers special arrangements with the Covered Person's 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 BCBSF has used for the Covered Person's claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

If Covered Persons receive Covered Services under a Value-Based Program inside a Host Blue's service area, Covered Persons 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 BCBSF 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, BCBSF will include any such surcharge, tax or other fee as part of the claim charge passed on to Covered Persons.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, BCBSF's payment will be based on the Allowance or Allowed Amount, as defined in the Glossary of Terms section of the Certificate of Coverage.

Blue Cross Blue Shield Global® Core

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), Covered Persons 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,

SAMPLE

although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard service area, Covered Persons will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these Services.

If Covered Persons need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, Covered Persons 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.

Inpatient Services

In most cases, if Covered Persons contact the service center for assistance, hospitals will not require Covered Persons to pay for inpatient Covered Services, except for the Covered Person's cost share amounts. In such cases, the hospital will submit the Covered Person's claims to the service center to begin claims processing. However, if Covered Persons paid in full at the time of Service, Covered Persons must submit a claim to receive reimbursement for Covered Services. **Covered Persons must notify BCBSF 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 Covered Persons to pay in full at the time of Service. Covered Persons must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard service area, Covered Persons must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Persons 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 the Covered Person's claim. The claim form is available from BCBSF, the service center or online at www.bcbsglobalcore.com. If Covered Persons need assistance with the Covered Person's claim submission, Covered Persons 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.

GLOSSARY OF TERMS

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.

SAMPLE

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.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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

SAMPLE

BlueChoice 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") Certificate of Coverage 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 the Group Plan's first Anniversary Date occurring on or after **January 01, 2027**.

COVERED SERVICES

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:

GENERAL EXCLUSIONS

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 Certificate of Coverage, reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, and hair removal/hairplasty.

The following is added to the **Drugs** exclusion in numerical order:

8. 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.

The **Sexual Reassignment, or Modification Services** exclusion is deleted in its entirety.

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GLOSSARY OF TERMS

The **Allowance and Allowed Amount** definition is amended as follows:

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

Allowance or **Allowed Amount** means the maximum amount upon which payment will be based for Covered Services. The Allowance or Allowed Amount may be changed at any time without notice to, or consent of any Covered Person.

Item number 2 is deleted in its entirety and replaced with the following:

2. In the case of a PPO 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 BCBSF, 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 a Provider in Florida that has not entered into a PPC or Traditional Provider Program agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to a Covered Person, this 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 Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Provider that provided the specific Covered Services (which may include payment accepted by such 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 a 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, this amount for the specific Covered Services provided to the Covered Person 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 BCBSF would make if BCBSF were paying a non-PPO provider in Florida when the Host Blue's corresponding payment may be more than BCBSF's payment to a non-PPO 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:

In no event will the Allowance or Allowed Amount be greater than the amount the Provider actually charges.

SAMPLE

If a particular Covered Service is not available from any PPO Provider, as determined by BCBSF, the Allowance or 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 received, regardless of whether such provider may be described as “in-network” or “out-of-network” elsewhere in this Certificate of Coverage.

The Covered Person may obtain an estimate of the Allowance or Allowed Amount for particular Services by calling the customer service phone number on the Covered Person’s ID Card. The fact that BCBSF may provide the Covered Person with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in the Certificate of Coverage apply. The Covered Person should refer to the “Covered Services” section of the Certificate of Coverage and the Schedule of Benefits to determine what is covered and how much BCBSF will pay.

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

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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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BlueChoice 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") BlueChoice Certificate of Coverage, including any Endorsements attached thereto. This document specifically amends the MediScript Pharmacy Program Endorsement 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 1, 2027.

EXCLUSIONS

The following new **Exclusion** is added in numerical order.

31. 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.

This amendment shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Certificate of Coverage, 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 Certificate of Coverage, 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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