

# BlueOptions

Benefit Booklet for Covered  
Plan Participants of Florida  
Community Colleges Risk  
Management Consortium  
("FCCRMC") Group Health Plan

A Self-funded Group Health  
Benefit Plan

Serviced by



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For Customer Service Assistance:  
800-255-4908



## FCCRM 2009 HEALTH BENEFIT SUMMARY

### BlueOptions Plan 1151 (PLAN D)

Benefits for Covered Services	Amount Member Pays
<b>Office Services</b>	
<b>Physician Office Services</b> In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit	CYD <sup>1</sup> + 20% Coinsurance CYD + 20% Coinsurance CYD + 30% Coinsurance \$10 Copayment CYD + 30% Coinsurance
<b>Maternity Initial Visit</b> In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Allergy Injections</b> (rendered by an In-Network Physician)	CYD + 20% Coinsurance
<b>Preventive Care</b>	
<b>Adult Wellness Benefit Maximum (PCY</b> <small><sup>2</sup> max, includes Well Woman and Routine Adult Physical Exam and Immunizations)</small>	\$250
<b>Routine Adult Physical Exam and Immunizations</b> (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	20% Coinsurance 20% Coinsurance 30% Coinsurance
<b>Well Woman Exam</b> (e.g. Annual GYN) (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	20% Coinsurance 20% Coinsurance 30% Coinsurance
<b>Mammograms</b> (Covered at 100% of Allowed Amount, In- and Out-of-Network)	\$0
<b>Well Child</b> (No PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	20% Coinsurance 20% Coinsurance 30% Coinsurance
<b>Emergency Medical Care</b>	
<b>Urgent Care Centers</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Emergency Room Facility Services (per visit) (copayment waived if admitted)</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Ambulance Services</b> (Ground travel / Air and water travel, per day maximum)	CYD + 20% Coinsurance \$400 / \$4,000

<b>Benefits for Covered Services</b>	<b>Amount Member Pays</b>
<b>Outpatient Diagnostic Services</b>	
<b>Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Independent Clinical Lab (e.g. Blood Work)</b> In-Network Out-of-Network	\$0 CYD + 30% Coinsurance
<b>Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays)</b> In-Network (Option 1 / Option 2) Out-of-Network	20%/25% CYD + 30% Coinsurance
<b>Mental Health/Substance Dependency</b>	
<b>Mental Health (PCY)</b> Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network <b>Outpatient Office Visit</b> In-Network Specialist Out-of-Network	30 Inpatient days, 20 Outpatient visits  20%/25% CYD + 30%  CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Substance Dependency (Lifetime max)</b> Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network <b>Outpatient Office Visit</b> In-Network Specialist Out-of-Network	\$2,500  20%/25% CYD + 30%  CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Other Provider Services</b>	
<b>Provider Services at Hospital and ER</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Provider Services at Locations other than Office, Hospital and ER</b> In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Other Special Services</b>	
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)</b> In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital <b>Outpatient Hospital Facility Services (per visit)</b> In-Network (Option 1 / Option 2) Out-of-Network	\$2,500  CYD + 20% Coinsurance CYD + 30% Coinsurance  20%/25% CYD + 30%
<b>Durable Medical Equipment</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Home Health Care (PCY max)</b> In-Network Out-of-Network	\$2,500 CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Skilled Nursing Facility (PCY )</b> In-Network Out-of-Network	60 days CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Hospice (Lifetime max)</b> In-Network Out-of-Network	\$7,500 CYD + 20% Coinsurance CYD + 30% Coinsurance

<b>Benefits for Covered Services</b>	<b>Amount Member Pays</b>
<b>Hospital/Surgical</b>	
<b>Ambulatory Surgical Center Facility (ASC)</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Inpatient Hospital Facility and Rehabilitation Services (per admit)</b> In-Network (Option 1 / Option 2) Out-of-Network	Rehabilitation Services limit - 21 days PCY 20%/25% CYD + 30%
<b>Outpatient Hospital Facility Services (per visit)</b> In-Network (Option 1 / Option 2) Out-of-Network	20%/25% CYD + 30%
<b>Emergency Room Facility Services (per visit) (copayment waived if admitted)</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 30% Coinsurance
<b>Financial Features</b>	
<b>Calendar Year Deductible (CYD) (per person / family aggregate)</b> In-Network/Out-of-Network <b>(CYD is the amount the member is responsible for before BCBSF pays)</b>	\$1,000 / \$3,000 Combined w/ In-Network
<b>Coinsurance</b> In-Network / Out-of-Network <b>(Coinsurance is the percentage the member pays for services)</b>	20% / 30%
<b>Out-of-Pocket Maximum (per person / family aggregate)</b> In-Network Out-of-Network <b>(Out-of-Pocket Maximum includes CYD, Coinsurance and Copayments; Excludes Prescription Drugs)</b>	\$3,000 / \$9,000 Combined w/ In-Network
<b>Total Lifetime Maximum Benefit</b>	\$5,000,000
<b>Additional Benefits and Features</b> Pharmacy: Generic Brand* Non-Preferred  Mail Order BlueScript Prescription Drug Program: Generic Brand* Non-Preferred  * If a Brand Name Prescription drug is purchased when a Generic Prescription Drug is available and the Physician has not indicated that a Brand Name Prescription Drug is Medically Necessary, you will be required to pay the difference between the cost of the Brand name and Generic Prescription Drug. This does not apply for Insulin.	\$15 \$40 \$60  \$30 \$80 \$120

1 CYD = Calendar Year Deductible

2 PCY = Per Calendar Year

Note: Out-of-Network services may be subject to balance billing.

**See Plan Document/Contract Book for all covered and/or excluded benefits.**

### **An Array of Value-Added Programs and Services\***

- Access to valuable health information and resources, including care decision support, our online provider directory at [www.bcbsfl.com](http://www.bcbsfl.com) and other interactive web-based support tools
- MyBlueService, our 24/7 online member self-service, where you can request extra ID cards, review benefits, check claims status, print forms and more
- Discounts on vision care, hearing care, alternative care, fitness clubs, bicycle helmets and more through our BlueComplements program
- Online access to participating physician offices for e-office visits, consultations, appointment scheduling or cancellation, prescription refills and much more\*\*
- A quarterly Personal Health Report, and programs to reward you for staying healthy and participating in sports

### **Access to Our Strong Networks**

NetworkBlue<sup>SM</sup> is the Preferred Provider Network designated as “In-Network” for BlueOptions. However, you will have protection from balance billing when you receive covered services from a provider<sup>®</sup> in our Traditional Program Network. You may also receive out-of-state coverage through the BlueCard<sup>®</sup> Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country. For Large Groups Health Benefit Summary Plan 1151 Page 4 of 4 63272-0307R

#### **Physician Discount**

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are not Covered Services under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, BCBSF does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician before you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at [www.bcbsfl.com](http://www.bcbsfl.com).

\* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice.

\*\* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

# Table of Contents

Section 1: How to Use Your Benefit Booklet .....	1-1
Section 2: What Is Covered? .....	2-1
Section 3: What Is Not Covered? .....	3-1
Section 4: Medical Necessity .....	4-1
Section 5: Understanding Your Share of Health Care Expenses .....	5-1
Section 6: Physicians, Hospitals and Other Provider Options .....	6-1
Section 7: BlueCard® (Out-of-State) Program .....	7-1
Section 8: BluePrint for Health Programs .....	8-1
Section 9: Pre-existing Conditions Exclusion Period .....	9-1
Section 10: Eligibility for Coverage .....	10-1
Section 11: Enrollment and Effective Date of Coverage .....	11-1
Section 12: Termination of Coverage .....	12-1
Section 13: Continuing Coverage Under COBRA .....	13-1
Section 14: The Effect of Medicare Coverage/ Medicare Secondary Payer Provisions .....	14-1
Section 15: Duplication of Coverage Under Other Health Plans/ Programs .....	15-1
Section 16: Subrogation .....	16-1
Section 17: Right of Reimbursement .....	17-1
Section 18: Claims Processing .....	18-1
Section 19: Relationship Between the Parties .....	19-1
Section 20: General Provisions .....	20-1
Section 21: Definitions .....	21-1

# Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet (“Booklet”). It describes your coverage, benefits, limitations and exclusions for the self-funded Group Health Benefit Plan (“Group Health Plan” or “Group Plan”) established and maintained by FCCRMC.

The sponsor of your Group Health Plan has contracted with Blue Cross Blue Shield of Florida, Inc. (BCBSF), under an Administrative Services Only Agreement (“ASO Agreement”), to provide certain third party administrative services, including claims processing, customer service, and other services, and access to certain of its Provider networks. BCBSF provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to Covered Persons or claims submitted for processing under this Benefit Booklet for such Services. The payment of claims under the Group Health Plan depends exclusively upon the funding provided by FCCRMC.

You should read your Benefit Booklet carefully before you need Health Care Services. It contains valuable information about:

- your BlueOptions benefits;
- what is covered;
- what is excluded or not covered;
- coverage and payment rules;
- Blueprint for Health Programs;
- how and when to file a claim;
- how much, and under what circumstances, payment will be made;
- what you will have to pay as your share; and
- other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how benefits will be coordinated with other policies or plans;

and the Group Health Plan’s subrogation rights and right of reimbursement.

You will need to refer to the Schedule of Benefits to determine how much you have to pay for particular Health Care Services.

## **When reading your Booklet, please remember that:**

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to “you” or “your” throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Covered or Eligible Employee, Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.
- references to “we”, “us”, and “our” throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as “BCBSF.”
- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the “Definitions” section or defined within the particular section where it is used.

**Where do you find information on...**

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

Read the “What Is Covered?” and “What Is Not Covered?” sections.

- **how much will be paid under your Group Health Plan and how much do you have to pay?**

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

- **how the amount you pay for Covered Services under the BlueCard® (Out-of-State) Program will be determined when you receive care outside the state of Florida?**

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

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

Read the “Enrollment and Effective Date of Coverage” section.

- **what happens if you are covered under this Benefit Booklet and another health plan?**

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

- **what happens when your coverage ends?**

Read the “Termination of Coverage” section.

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

Read the “Definitions” section.

**Overview of How BlueOptions Works**

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

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

# Section 2: What Is Covered?

## Introduction

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

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

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

1. within the Health Care Services categories in the "What is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this Benefit Booklet and for which an itemized statement or description of the procedure or Service which was rendered is received, including any applicable procedure code, diagnosis code and other information required in order to process a claim for the Service;
3. Medically Necessary, as defined in this Booklet and determined by BCBSF or FCCRMC in accordance with BCBSF's

Medical Necessity coverage criteria then in effect, except as specified in this section;

4. in accordance with the benefit guidelines listed below;
5. rendered while your coverage is in force; and
6. not specifically or generally limited (e.g., Pre-existing Condition exclusionary period) or excluded under this Booklet.

BCBSF or FCCRMC will determine whether Services are Covered Services under this Booklet after you have obtained the Services and a claim has been received for the Services. In some circumstances BCBSF or FCCRMC may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, BCBSF or FCCRMC may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. Neither BCBSF nor FCCRMC are obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service.

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

## Our Benefit Guidelines

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

1. Payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable for any such Services.
2. Payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service or the day of the week or the time of day the procedure is performed.
3. Payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

### **Covered Services Categories**

#### **Accident Care**

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

#### Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded.

#### **Allergy Testing and Treatments**

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

### **Ambulance Services**

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

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

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

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

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

### **Ambulatory Surgical Centers**

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

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. drugs and medicines administered (except for take home drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;

6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products;
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

### **Anesthesia Administration Services**

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

#### Exclusion:

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

### **Breast Reconstructive Surgery**

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

### **Child Cleft Lip and Cleft Palate Treatment**

Treatment and Services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition Services for treatment of a child under the age of 18 who has cleft lip or cleft palate are covered. In order for

such Services to be covered, your Covered Dependent's Physician must specifically prescribe such Services and such Services must be consequent to treatment of the cleft lip or cleft palate.

### **Concurrent Physician Care**

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

### **Consultations**

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

### **Contraceptive Injections**

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

### **Payment Guidelines for Medication and Administration by Injection for Contraception**

Physician office Services, rendered on the same day, in connection with the administration by injection of the contraceptive medication, for well or preventive Services, are not reimbursed separately unless adult wellness benefits are included on your Schedule of Benefits.

### **Dental**

Dental care is limited to the following:

1. Care and treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to sound natural teeth.

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

### **Diabetes Outpatient Self-Management**

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

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

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

### **Diagnostic Services**

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

1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);
2. laboratory and pathology Services;
3. Services involving bones or joints of the jaw (e.g., Services to treat temporomandibular joint [TMJ] dysfunction) or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. approved machine testing (e.g., electrocardiogram [EKG], electroencephalograph [EEG], and other electronic diagnostic medical procedures); and
5. genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

### **Dialysis Services**

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

## **Durable Medical Equipment**

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

### **Payment Guidelines for Durable Medical Equipment**

Supplies and service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Payment for Durable Medical Equipment will be based on the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) the Allowed Amount. The Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

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

#### **Exclusion:**

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

## **Enteral Formulas**

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

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

## **Eye Care**

Coverage includes the following Services:

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

#### **Exclusion:**

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

## **Home Health Care**

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

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted

in ambulation whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and

2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan that has been reviewed and renewed by the prescribing Physician every 30 days. In order to determine whether such Services are covered under this Booklet, you may be required to provide a copy of any written treatment plan.
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

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

#### Exclusions:

1. homemaker or domestic maid services;
2. sitter or companion services;
3. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
4. Speech Therapy provided for a diagnosis of developmental delay;
5. Custodial Care except for any such care covered under this subsection when provided on a part-time or intermittent basis (as defined above) by a home health aide;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

#### **Hospice Services**

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by your Physician. Your Physician may be required to certify in writing your life expectancy.

#### **Hospital Services**

Covered Hospital Services include:

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

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

**Exclusion:**

Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital:

- 1) room and board provided during the admission;
- 2) Physician visits provided while you were an inpatient;
- 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and
- 4) other Services provided while you were an inpatient.

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

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

**Inpatient Rehabilitation**

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

1. Services must be provided under the direction of a Physician and must be

provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;

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

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

**Exclusion:**

All Substance Dependency, drug and alcohol related diagnoses, Pain Management, and respiratory ventilator management Services are excluded.

**Mammograms**

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

Benefits for mammograms may not be subject to the Calendar Year Deductible, Coinsurance, or

Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

### **Mastectomy Services**

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by you and your attending Physician are covered.

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

### **Maternity Services**

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

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

#### Exclusion:

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement are excluded. This exclusion

applies to all expenses for prenatal, intra-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

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

### **Mental Health Services**

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

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

#### Exclusion:

1. Services rendered in connection with a Condition not classified in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;
3. Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. Services for marriage counseling, when not rendered in connection with a Condition

classified in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders

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; or
11. mental health Services received in a residential treatment facility.

### **Newborn Care**

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

#### Newborn Assessment:

An assessment of the newborn child is covered provided the Services were rendered at a Hospital, the attending Physician's office, a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These Services are not subject to the Calendar Year Deductible.

Ambulance Services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and

equipped to treat the newborn child's Condition, as determined by BCBSF or FCCRMC and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child, are covered.

### **Orthotic Devices**

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

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

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

#### Exclusion:

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

alternative to an internal fixation device as a result of surgery for craniosynostosis; and

Expenses for devices necessary to exercise, train, or participate in sports, e.g. custom-made knee braces.

### **Osteoporosis Screening, Diagnosis, and Treatment**

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

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

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

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

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

- b) **Occupational Therapy** Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition are covered.
- c) **Speech Therapy** Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition are covered.
- d) **Physical Therapy** Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition are covered.
- e) **Massage Therapy** Massage provided by a Physician, Massage Therapist, or Physical Therapist when the Massage is prescribed as being Medically Necessary by a Physician licensed pursuant to *Florida Statutes* Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Physician's prescription must specify the number of treatments.

### **Payment Guidelines for Massage and Physical Therapy**

- a. Payment 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. Payment for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the

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

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

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

#### **Payment Guidelines for Spinal Manipulation**

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

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

#### **Oxygen**

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

#### **Physician Services**

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

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

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

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

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

#### **Exclusion:**

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet other than through a healthcare communication services vendor that has entered into contract with BCBSF are excluded.

Expenses for online medical Services provided by a health care provider that is not a Physician

and expenses for Health Care Services rendered by telephone are also excluded.

### **Preventive Adult Wellness Services**

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

### **Preventive Child Health Supervision Services**

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

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

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

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

### **Prosthetic Devices**

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

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

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

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

### **Skilled Nursing Facilities**

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

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

A treatment plan from your Physician may be required in order to determine coverage and payment.

**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 you and/or your family members or the Provider are excluded. Expenses for any inpatient days beyond the per person per Calendar Year maximum number of days listed on the Schedule of Benefits are also excluded.

**Substance Dependency Care and Treatment**

Care and treatment for Substance Dependency includes the following:

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

approved by the state of Florida (or another state) for Detoxification or Substance Dependency.

2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency as listed in the Schedule of Benefits.

**Exclusion:**

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

**Surgical Assistant Services**

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

**Payment Guidelines for Surgical Assistant Services**

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

**Surgical Procedures**

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

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for 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; and

5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.
6. surgical procedures performed for the treatment of Morbid Obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and any associated care provided you have not previously undergone the same or a similar procedure while covered under the Group Health Plan;

#### **Payment Guidelines for Surgical Procedures**

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed. In addition, Coinsurance or Copayment (if any) indicated in your Schedule of Benefits will apply. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An “incidental surgical procedure” includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in BCBSF’s or FCCRMC’s opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in

conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example).

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

#### **Transplant Services**

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

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

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-127.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. Coverage will be provided for the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;

1. corneal transplant;
2. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

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

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

Exclusions:

Expenses for the following are excluded:

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

5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility; and
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

## Section 3: What Is Not Covered?

### Introduction

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

**Abortions** which are elective.

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

**Arch Supports**, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

### Assisted Reproductive Therapy (Infertility)

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

**Autopsy** or postmortem examination services, unless specifically requested by BCBSF or FCCRMC.

### Complementary or Alternative Medicine

including, but not limited to, self-care or self-help training; homeopathic medicine and counseling;

Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

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

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

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

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

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

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

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

### **Drugs**

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more

peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;

2. All drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to drugs dispensed to you when: (a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility; (b) you are in the outpatient department of a Hospital; (c) dispensed by a pharmacy under contract with BCBSF to provide injectable medications to you at home for self-administration, or to provide injectable medications to your Physician for administration to you in the Physician's office; or (d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills for such drugs.
3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.
4. Any drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction drugs excluded under this paragraph.

**Experimental or Investigational Services**, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category

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

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

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. Any Service to diagnose or treat any Condition resulting from or in connection with your job or employment
3. Any Health Care Services not within the service categories described in the "What is Covered?" section, any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
4. Any Health Care Services provided by a Physician or other health care Provider related to you by blood or marriage;
5. Any Health Care Service which is not Medically Necessary as defined in this Booklet and determined by BCBSF or FCCRMC. The ordering of a Service by a health care Provider does not in itself make such Service Medically Necessary or a Covered Service;
6. Any Health Care Services rendered at no charge;
7. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
8. Any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:

- a) war or an act of war, whether declared or not;
- b) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
- c) your engaging in an illegal occupation;
- d) Services received at military or government facilities; or
- e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard;
- f) Services that are not patient-specific, as determined solely by us.

9. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
10. 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; or
11. Health Care Services that are not direct, hands-on, and patient specific, including, but not limited to the oversight of a medical laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, equipment, or laboratory technicians.

**Genetic Screening** including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition.

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

**Immunizations** except those covered under the Preventive Child Health Supervision Services or Preventive Adult Wellness Services categories of the "What Is Covered?" 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-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

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

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

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

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

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

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

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;

7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the *What Is Covered?* section of this Booklet.

**Prescription Drug** Copayments, Coinsurance and Deductibles, or any part thereof, you are obligated to pay under any plan or policy.

**Private Duty Nursing Care** rendered at any location.

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

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

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

**Smoking Cessation Programs** including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not

limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

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

**Training and Educational Programs**, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation, except as provided under the Diabetes Outpatient Self Management category of the *What Is Covered* section.

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

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

**Weight Control Services** including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment.

**Wigs** and/or cranial prosthesis.

## Section 4: Medical Necessity

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

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

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. FCCRMC is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. In making coverage decisions, neither BCBSF nor FCCRMC will be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

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

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

**Note: Whether or not a Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by this Benefit Booklet) or a Covered Service. Please refer to the "Definitions" section for the definitions of "Medically Necessary" or "Medical Necessity".**

# Section 5: Understanding Your Share of Health Care Expenses

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

## Calendar Year Deductible

### 1. Individual Calendar Year Deductible:

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

### 2. Family Calendar Year Deductible:

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

## Copayment Requirements

Covered Services rendered by certain Providers or at certain locations or settings will be subject to a Copayment requirement. This is the dollar amount you have to pay when you receive these

Services. Please refer to your Schedule of Benefits for the specific Covered Services which are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your plan. If the Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you must pay the lesser of the Allowed Amount or the Provider's actual charge for the Covered Service.

### 1. Office Services Copayment:

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

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

### 2. Inpatient Facility Copayment:

The inpatient facility Copayment must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made for any claim for inpatient Covered Services. The inpatient facility Copayment applies regardless of the reason for the admission, and applies to all inpatient admissions to a Hospital,

Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals for inpatient admissions.

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

### 3. Outpatient Facility Copayment

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

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

### 4. Emergency Room Facility Copayment:

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

will still be responsible for the inpatient facility Copayment.

## Coinsurance Requirements

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

## Out-of-Pocket Calendar Year Maximum

### Out-of-Pocket Maximum Amount

#### 1. Individual Out-of-Pocket Calendar Year maximum:

Once you have reached the individual out-of-pocket Calendar Year maximum amount listed in the Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of the Calendar Year and Covered Services rendered during that Calendar Year will be paid at 100 percent of the Allowed Amount.

#### 2. Family Out-of-Pocket Calendar Year Maximum:

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

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

### **Prior Coverage Credit**

You will be given credit for the satisfaction or partial satisfaction of any Calendar Year Deductible and Calendar Year Coinsurance maximums met by you under a prior group insurance, blanket insurance, franchise insurance or group Health Maintenance Organization (HMO) policy or plan maintained by FCCRMC if the coverage provided hereunder replaces such a policy or plan. This provision only applies if the prior group insurance, blanket insurance, franchise insurance, HMO or plan coverage was in effect immediately preceding the Effective Date of the coverage provided under this Benefit Booklet. This provision is only applicable for you during the initial Calendar Year of coverage under this Benefit Booklet and the following rules apply:

1. **Prior Coverage Credit for Deductible:**

For the initial Calendar Year of coverage under this Benefit Booklet only, charges credited towards your Deductible requirement under the prior policy or plan, for Services rendered during the 90-day period immediately preceding the Effective Date of the coverage under this Benefit Booklet, will be credited to the Calendar Year Deductible requirement under this Booklet.

2. **Prior Coverage Credit for Coinsurance:**

Charges credited by FCCRMC's prior policy or plan, towards your Coinsurance Calendar Year Maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of coverage under this Benefit Booklet, will be credited to your out-of-pocket Calendar Year maximum under this Booklet.

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

4. **Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group. You and/or FCCRMC are 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 coverage under this Benefit Booklet, you were covered under a prior FCCRMC group plan insured or administered by BCBSF, amounts applied to your Calendar Year benefit maximums and lifetime maximums under the prior group plan, will be applied toward your Calendar Year benefit maximums and lifetime maximums under this Booklet.

### **Additional Expenses You Must Pay**

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

1. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., the lifetime maximums and Calendar Year maximums);

4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept the Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any contribution amount required by FCCRMC.

### **How Calendar Year Benefit Maximums and the Total Maximum Benefit Per Person Will Be Credited**

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

Under certain agreements BCBSF has with Providers, the Provider may be paid a set monthly amount per individual to cover the cost of providing Covered Services to you, whether or not care is actually provided during that month. This form of payment is called "capitation". In these instances, when you receive Covered Services from such a Provider, the amounts credited toward any applicable Calendar Year benefit maximums, and the Total Maximum Benefit per Individual, will be the amount that would have been paid (based on the Allowed Amount then in effect) had the Provider not been paid on a capitated basis.

# Section 6: Physicians, Hospitals and Other Provider Options

## Introduction

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

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

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to Traditional Program type benefits at the point of service when you receive Covered Services from Traditional Program Providers.

## Provider Participation Status

With BlueOptions, you may choose to receive Services from any Provider. However, you may be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider. Although you have the option to select any provider you choose, you are encouraged to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs. Developing and continuing a relationship with a Family Physician allows the physician to become knowledgeable

about you and your family’s health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers may result in lower out-of-pocket expenses for you. You should always determine whether a Provider is In-Network or Out-of-Network prior to receiving services to determine the amount you are responsible for paying out-of-pocket.

## Location of Service

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

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

1. If in Florida, review your current BlueOptions Provider Directory;
2. If in Florida, access the BlueOptions Provider directory at BCBSF's web-site at [www.bcbsfl.com](http://www.bcbsfl.com); and/or
3. If outside of Florida, access the on-line BlueCard<sup>®</sup> Doctor and Hospital Finder at [www.bcbs.com](http://www.bcbs.com); and/or
4. call the customer service phone number in this Booklet or on your Identification Card.

Please remember that changes to Provider network participation can occur at any time. Consequently, it is your responsibility to determine whether a specific Provider is In-Network at the time you receive Covered Services.

## In-Network Providers

When you use In-Network Providers, your out-of-pocket expenses for Covered Services may be lower. Payment will be based on the Allowed Amount and your share of the cost will be at the In-Network benefit level listed in the Schedule of Benefits.

## Out-of-Network Providers

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

Benefit Plan, the Provider is considered Out-of-Network.

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>What expenses are you responsible for paying?</b>	<ul style="list-style-type: none"> <li>• Any applicable Copayments, Deductible(s) and/or Coinsurance requirements;</li> <li>• Expenses for Services which are not covered;</li> <li>• Expenses for Services in excess of any benefit maximum limitations;</li> <li>• Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and</li> <li>• Expenses for Services which are excluded.</li> </ul>	
<b>Who is responsible for filing your claims?</b>	<ul style="list-style-type: none"> <li>• The Provider will file the claim for you and payment will be made directly to the Provider.</li> </ul>	<ul style="list-style-type: none"> <li>• You are responsible for filing the claim and payment will be made directly to the Covered Plan Participant. If you receive Services from a Provider who participates in our Traditional Program or is a BlueCard® (Out-of-State) Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.</li> </ul>
<b>Can you be billed the difference between what the Provider is paid and the Provider's charge?</b>	<ul style="list-style-type: none"> <li>• <b>NO.</b> You are protected from being billed for the difference in the Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept the Allowed Amount as payment in full for Covered Services except as otherwise permitted under the terms of the Provider's contract and this Booklet.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>YES.</b> You are responsible for paying the difference between what we pay and the Provider's charge. However, if you receive Services from a Provider who participates in our Traditional Program, the Provider will accept our Allowed Amount as payment in full for Covered Services since such Traditional Program Providers have agreed not to bill you for the difference. Further, under the BlueCard® (Out-of-State) Program, when you receive Covered Services from a BlueCard® (Out-of-State) Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.</li> </ul>

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

## **Physicians**

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

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

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

## **Hospitals**

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

In-Network Hospitals have been divided into two groups that are referred to as "options" on the Schedule of Benefits. The amount you are responsible for paying out-of-pocket is different for each of these options. Remember that there are also different out-of-pocket expenses for Out-of-Network Hospitals.

Since not all Physicians admit patients to every Hospital, it is important when choosing a Physician that you determine the Hospitals where your Physician has admitting privileges. You can find out what Hospitals your Physician

admits to by contacting the Physician's office. This will provide you with information that will help you determine a portion of what your out-of-pocket costs may be in the event you are hospitalized.

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

## **Other Providers**

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

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

Remember that the location of service can impact the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs. When Services are rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense

for the facility Provider as well as an out-of-pocket expense for other types of Providers.

### **Assignment of Benefits to Providers**

Except as set forth in the last paragraph of this section, any of the following assignments, or attempted assignments, by you to any Provider will not be honored:

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

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard<sup>®</sup> (Out-of-State) PPO Program Provider; 5) is a BlueCard<sup>®</sup> (Out-of-State) Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*; or 7) is an Ambulance Provider 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.

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

### Providers Outside the State of Florida

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

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

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating a covered individual’s liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard® method noted above in paragraph one of this section or require a

surcharge, we will then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

# Section 8: Blueprint for Health Programs

## Introduction

BCBSF has established (and from time to time establishes) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. Under the terms of the ASO Agreement between BCBSF and FCCRMC, BCBSF has agreed to make these programs available to you. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health, 2) help facilitate the management and review of coverage and benefits provided under this Booklet and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services. **Some BluePrint For Health Programs may not be available outside the state of Florida.**

## Admission Notification

The admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network.

## In-Network

Under the Admission Notification requirement, we must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric Facilities, Substance Abuse Facilities or Skilled Nursing Facilities. While it is the sole responsibility of the In-Network Provider located in Florida to comply with our Admission Notification requirements, you should ask the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) if we

have been notified of your admission. For an admission outside of Florida, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) may notify us of your admission by calling the toll free customer service number on your ID card.

## Out-of-Network

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

## Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, Skilled Nursing Facility (SNF) Services, and other Health Care Services rendered during the course of an inpatient stay or treatment program. We may conduct this review while you are inpatient or after your discharge. The review is conducted solely to determine whether coverage and/or payment should be provided for a particular admission or Health Care Services rendered during that admission. Using BCBSF's established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals.

BCBSF will provide notification to your Physician when inpatient coverage criteria is no longer met. In administering the inpatient facility program, BCBSF may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by BCBSF and any reviews or assessments of specific medical facts or information conducted, are solely for purposes of making coverage or payment decisions under this Booklet and not for the purpose of recommending or providing medical care.

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

### **Provider Focused Utilization Management Program**

Certain NetworkBlue Providers have agreed to participate in our focused utilization management program. This pre-service review program is intended to promote the efficient delivery of medically appropriate Health Care Services by NetworkBlue Providers. Under this program we may perform focused prospective reviews of all or specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit to us specific medical information relating to Health Care Services proposed for you. These NetworkBlue Providers have agreed not to bill, or collect, any payment whatsoever from you or us, or any other person or entity, with respect to a specific Health Care Service if:

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

#### Exception for Certain NetworkBlue Physicians

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

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

### **Member Focused Programs**

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

### **Personal Case Management Program**

The personal case management program focuses on members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, we may, in BCBSF's sole discretion, assign a

Personal Case Manager to you to help coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the personal case management program, you may be offered alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available on a case-by-case basis when you meet BCBSF's case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing. In addition, FCCRMC will be required to specifically agree to such treatment plan and the alternative benefits or payment.

The fact that certain Health Care Services under the personal case management program have been provided or payment has been made in no way obligates BCBSF, FCCRMC, or the Group Health Plan to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of FCCRMC's right to enforce this Booklet in strict accordance with its terms. The terms of this Booklet will continue to apply, except as specifically modified in writing in accordance with the personal case management program rules then in effect.

### **Health Information, Promotion, Prevention and Illness Management Programs**

These Blueprint for Health Programs may include health information that supports health care education and choices for healthcare issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help covered individuals with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include prenatal educational programs and illness management programs for conditions such as diabetes, cancer and heart

disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll free customer service number on your ID card for more information. Your participation in this program is completely voluntary.

### **IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS**

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely your responsibility and the responsibility of your Physicians and other health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. FCCRMC is ultimately responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Booklet. In fulfilling this responsibility, neither BCBSF nor FCCRMC will be deemed to participate in or override the medical decisions of your health care Provider.

Please note that the Hospital admission notification requirement and any Blueprint For Health Program may be discontinued or modified at any time without notice to you or your consent.

# Section 9: Pre-existing Conditions Exclusion Period

## Introduction

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

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

1. the Covered Plan Participant and each Covered Dependent who was covered under FCCRMC's prior medical plan on the date immediately preceding the Effective Date of coverage under this Booklet;
2. you if you were enrolled during the Initial Enrollment Period prior to the Effective Date of FCCRMC; or
3. you when FCCRMC has elected to waive, in writing, the Pre-existing Conditions exclusionary period for all subsequent Eligible Employees and/or Eligible Dependents;
4. pregnancy;
5. a newborn child or an adopted newborn child properly enrolled under this Booklet;
6. an adopted child;
7. Genetic Information in the absence of a diagnosis of the Condition;

8. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
9. Conditions arising from domestic violence; or
10. inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

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

## Pre-existing Condition Definition

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

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

## Reducing the Pre-existing Conditions Exclusionary Period

No matter whether you enroll when first eligible or at a later date (such as an Annual Open Enrollment Period or as a result of Special Enrollment), you may be able to reduce or even eliminate the Pre-

existing Conditions exclusionary period if you have prior Creditable Coverage.

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

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

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

### **Creditable Coverage**

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

1. a group health insurance plan;
2. individual health insurance;
3. Medicare Part A;
4. Medicare Part B;
5. Medicaid;
6. benefits to members and certain former members of the uniformed services and their dependents;
7. a medical care program of the Indian Health Service or of a tribal organization;
8. a State health benefits risk pool;

9. a health plan offered under chapter 89 of Title 5, United States Code;
10. a public health plan;
11. a health benefit plan of the Peace Corps;
12. State Children's Health Insurance Program (SCHIP);
13. public health plans established by the federal government; or
14. public health plans established by foreign governments.

### **Proving Creditable Coverage**

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

# Section 10: Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Group Health Plan, and who meets and continues to meet the eligibility requirements described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members. No changes in the eligibility requirements will be permitted except as permitted by FCCRMC. Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Eligible Employee as the legal guardian or appropriate adoption documentation described in the "Enrollment and Effective Date of Coverage" section.

## Eligibility Requirements for Covered Employees

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

1. The employee must be a bona fide employee of a member college of FCCRMC;
2. The employee's job must fall within a job classification set forth in the Group Application;
3. The employee must have completed any applicable Waiting Period set forth in the Group Application; and
4. The employee must meet any additional eligibility requirement(s) set forth in the Group Application.

The eligibility classifications may be expanded to include:

1. retired employees of a community college participating in FCCRMC;
2. additional job classifications;

3. employees of affiliated or subsidiary companies of a member college or FCCRMC; and
4. other individuals as determined by FCCRMC.

FCCRMC shall have sole discretion concerning the expansion of eligibility classifications.

## Eligibility Requirements for Dependent(s)

### Eligibility Requirements for Dependent(s)

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

1. The Covered Employee's spouse under a legally valid existing marriage;
2. The Covered Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) who:
  - a. is under the age of 25 or is still within 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 is 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;
  - 1. 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 Group Health Plan;
  - 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.

# Section 11: Enrollment and Effective Date of Coverage

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

Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Benefit Booklet. Neither BCBSF nor FCCRMC will have any obligation whatsoever to any individual who is not properly enrolled.

Any Employee or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage according to the provisions set forth below.

## Enrollment Forms/Electing Coverage

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

1. complete and submit, through the Employer, the Enrollment Form;
2. provide any additional information needed to determine eligibility, at the request of BCBSF or the Employer;
3. pay any required contribution; and
4. complete and submit, through the Employer, an Enrollment Form to add Eligible Dependents.

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

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

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

**Employee/Child(ren) Coverage** - This type of coverage provides coverage for the Covered

Employee and the employee's covered child(ren) only.

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

**Dependent Only Coverage** – This type of coverage provides coverage for the Eligible Dependents of Eligible Employees who are not covered under this Benefit Booklet because they have elected and are enrolled under a Medicare Advantage Plan offered by the Group. This type of Coverage is not available to any other Eligible Employee.

There may be additional contribution amounts for each Covered Dependent based on the coverage selected by FCCRMC.

## Enrollment Periods

The enrollment periods for applying for coverage are as follows:

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

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

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

Special circumstances are described in the Special Enrollment Period subsection.

### **Employee Enrollment**

An Eligible Employee who fails to enroll during the Initial Enrollment Period will not be covered and may only enroll under this Benefit Booklet during the next Annual Open Enrollment Period established by FCCRMC, or in the case of a Special Enrollment event, during the Special Enrollment Period. The Effective Date will be the date specified by FCCRMC. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) will be the same as the Covered Employee's Effective Date or the date specified by FCCRMC.

### **Dependent Enrollment**

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

**Newborn Child** – To enroll a newborn child who is an Eligible Dependent, the Covered or Eligible Employee must submit an Enrollment Form to BCBSF through the Employer during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

If timely notice is given, no additional contribution 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, the applicable contribution will be charged from the date of birth. The applicable contribution 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 or Eligible Employee provides notice to the Employer and an Enrollment Form is received within the 60-day period of the birth of the child and any applicable contribution is paid back to the date of birth.

If the newborn is not enrolled within sixty days of the date of birth, the newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

**Note:** The guidelines above only apply to newborns born after the Effective Date of the Covered Employee or the Effective Date of an Eligible Employee enrolled under a Medicare Advantage Plan offered by FCCRMC. If a child is born before the Effective Date of the Covered Employee or the Effective Date of an Eligible Employee enrolled under a Medicare Advantage Plan offered by FCCRMC and was not added during the Initial Enrollment Period, we must receive an Enrollment Form.

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

**Adopted Newborn Child** – To enroll an adopted newborn child, the Covered or Eligible Employee must submit an Enrollment Form through the Employer to BCBSF during the 30-day period immediately following the date of birth. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered or Eligible Employee prior to the birth of such child, whether or not such an agreement is enforceable. The Covered or Eligible Employee may be required to provide any information and/or documents that are deemed necessary in order to administer this provision.

If timely notice is given, no additional contribution will be charged for coverage of the adopted newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable

contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for an adopted newborn child if the Covered Employee provides notice to the Employer and an Enrollment Form is received within the 60-day period of the birth of the adopted newborn child and any applicable contribution is paid back to the date of birth.

If the adopted newborn child is not enrolled within sixty days of the date of birth, the adopted newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered or Eligible Employee, there shall be no coverage for the adopted newborn child. It is your responsibility to notify the Employer within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

**Note:** The guidelines above only apply to adopted newborns born after the Effective Date of the Covered Employee or the Effective Date of an Eligible Employee enrolled under a Medicare Advantage Plan offered by FCCRMC. If a child is born before the Effective Date of the Covered Employee or the Effective Date of an Eligible Employee enrolled under a Medicare Advantage Plan offered by FCCRMC and was not added during the Initial Enrollment Period, we must receive an Enrollment Form.

**Adopted/Foster Children** – To enroll an adopted or Foster Child, the Covered or Eligible Employee must submit an Enrollment Form during the 30-day period immediately following the date of placement. The Effective Date for an adopted or Foster child (other than an adopted newborn child) will be the date such adopted or Foster child is placed in the residence of the Covered or Eligible Employee in compliance with applicable law. Any Pre-existing Condition

exclusionary period will not apply to an adopted child but will apply to a Foster child. The Covered or Eligible Employee may be required to provide any information and/or documents deemed necessary in order to properly administer this section.

In the event the Employer 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 Covered or Eligible Employee provides notice to the Employer, and we receive the Enrollment Form within 60 days of the placement. If the adopted or Foster Child is not enrolled within sixty days of the date of placement, the adopted or Foster Child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the 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 through the Employer. It is the responsibility of the Covered or Eligible Employee to notify BCBSF through the Employer if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered or Eligible Employee's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered or Eligible Employee to notify BCBSF through the Employer that the Foster Child is no longer in the Covered or Eligible Employee's care. Upon receipt of this notification, coverage for the child will be terminated on the date the Covered or Eligible Employee's status as a foster parent terminated.

**Marital Status** –The Covered or Eligible Employee may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered or Eligible Employee must complete the Enrollment Form

through the Employer and forward it to BCBSF. The Covered or Eligible Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

**Court Order** – The Covered or Eligible Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under their group coverage. To apply for coverage, the Covered or Eligible Employee must complete an Enrollment Form through the Employer and forward it to BCBSF. The Covered or Eligible 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.

### **Annual Open Enrollment Period**

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

The effective date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the date established by FCCRMC.

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

### **Special Enrollment Period**

An Eligible Employee and/or the Employee's Eligible Dependents may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependents must complete the applicable Enrollment Form and forward it to the Employer within 30 days of the date of the special enrollment event. For purposes of this Benefit Booklet, the following are the special enrollment events:

1. you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance, or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:
  - a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and
  - b) you lost your other coverage under a group health benefit plan or health insurance coverage as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated.

**Note:** Loss of coverage for failure to pay your required contribution/premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior

health coverage) is not a qualifying event for special enrollment.

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

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees or Eligible Dependents who do not enroll 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 Plan Participant).

#### **Other Provisions Regarding Enrollment and Effective Date of Coverage**

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

## Section 12: Termination of Coverage

### Termination of a Covered Plan Participant's Coverage

A Covered Plan Participant's coverage under this Benefit Booklet will automatically terminate at 12:01 a.m.:

1. on the date the Group Health Plan terminates;
2. on the date the ASO Agreement between BCBSF and FCCRMC terminates;
3. on the last day of the first month that the Covered Plan Participant fails to continue to meet any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
5. on the date specified by FCCRMC that the Covered Plan Participant's coverage terminates.

### Termination of a Covered Dependent's Coverage

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

1. on the date the Group Health Plan terminates;
2. on the date the Administrative Services Only Agreement between BCBSF and FCCRMC terminates;
3. on the date the Covered Plan Participant's coverage terminates for any reason;
  - 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 in which 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.
4. 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 Plan Participant or Eligible Employee);
  5. on the date we specify that the Covered Dependent's coverage is terminated by us for cause; or
  6. on the date specified by the Group that the Covered Dependent's coverage terminates.

In the event you as the Covered Plan Participant or Eligible Employee wish to delete a Covered Dependent from coverage, an Enrollment Form must be forwarded to BCBSF through FCCRMC.

In the event you as the Covered Plan Participant or Eligible Employee wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit an Enrollment Form to FCCRMC, 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

In the event any of the following occurs, FCCRMC may terminate an individual's coverage for cause:

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

## **Notice of Termination**

It is the Employer's responsibility to immediately notify you of your termination or that of your Covered Dependents for any reason.

## **Certification of Creditable Coverage**

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

The certification of Creditable Coverage will indicate the period of time you were enrolled under FCCRMC's Group Health Plan.

Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time you had prior Creditable Coverage.

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

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

## Section 13: Continuing Coverage Under COBRA

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

You must contact FCCRMC to determine if you or your Covered Dependent(s) are entitled to COBRA continuation of coverage. FCCRMC is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Covered Persons of their rights under COBRA. If you fail to meet your obligations under COBRA and this Benefit Booklet, FCCRMC will not be liable for any claims incurred by you or your Covered Dependent(s) after termination of coverage.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below.

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

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

**\*Note:** You and/or your Covered Dependent(s) are eligible for an 11 month extension of the 18 month COBRA continuation option above (to a total of 29 months) if you or your Covered

Dependent(s) is/are totally disabled (as defined by the Social Security Administration (SSA)) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Person must supply notice of the disability determination to FCCRMC within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
  - a) the Covered Employee's entitlement to Medicare if the Covered Employee's coverage under this plan will terminate and they are not eligible for coverage under the Group's Medicare Advantage plan, if any;
  - b) divorce or legal separation of the Covered or Eligible Employee;
  - c) death of the Covered or Eligible Employee;
  - d) the employer files bankruptcy (subject to Bankruptcy Court approval); or
  - e) a dependent child may elect the 36-month extension if the dependent child ceases to be an Eligible Dependent under the terms of FCCRMC's coverage.

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

Additional requirements applicable to continuation of coverage under COBRA are set forth below:

1. The Employer and/or designated COBRA administrator must notify you of your continuation of coverage rights under COBRA within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify FCCRMC, in writing, within 60 days of any of these events. FCCRMC's 14-day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue the coverage within 60 days of the later of:
  - a) the date that the coverage terminates; or
  - b) the date the notification of continuation of coverage rights is sent by FCCRMC.
3. COBRA coverage will terminate if you become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the Social Security Administration that you are no longer disabled. You must inform FCCRMC of the Social Security Administration's determination within 30 days of such determination.
6. You must meet all contribution requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in the Group Health Plan.

7. COBRA coverage will terminate on the date FCCRMC ceases to provide group health coverage to its employees.

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

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

## Section 14: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When you become covered under Medicare and continue to be eligible and covered under this Benefit Booklet, as an active employee, coverage under this Benefit Booklet will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, coverage under this Benefit Booklet will be secondary to any Medicare benefits. To the extent the benefits under this Benefit Booklet are primary, claims for Covered Services should be filed with BCBSF first.

Under Medicare, the Employer MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you if your coverage under this group plan is by virtue of your or your spouse's current employment status. Also, the Employer MAY NOT induce you to decline or terminate your group health insurance coverage and elect Medicare as primary payer.

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

### **Individuals With End Stage Renal Disease**

If you are entitled to Medicare coverage because of ESRD, coverage under this Benefit Booklet will be provided on a primary basis for 30 months beginning with the earlier of:

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

If Medicare was primary prior to the time you became eligible due to ESRD, then Medicare

will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if coverage under this Benefit Booklet was primary prior to ESRD entitlement, then coverage hereunder will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, coverage will be provided, as described in this section, on a primary basis for 30 months.

### **Disabled Active Individuals**

If you are entitled to Medicare coverage because of a disability other than ESRD, Medicare benefits will be secondary to the benefits provided under this Benefit Booklet provided that:

FCCRMC is a part of a health plan that has covered employees of at least one employer with 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year.

### **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 this Benefit Booklet.
2. BCBSF will not be liable to the Employer or to any individual covered under this Benefit Booklet on account of any nonpayment of primary benefits resulting from any failure of

performance of the Employer's obligations  
as described in this section.

# Section 15: 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 under this Benefit Booklet.

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

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

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage with which the law permits coordination of benefits;

4. Medicare, as described in *The Effect of Medicare Coverage/Medicare Secondary Payer Provisions* section; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of payment, if any, when benefits are coordinated under this section, is based on whether or not the benefits under this Benefit Booklet are primary. When primary, payment will be made for Covered Services without regard to coverage under other plans. When the benefits under this Benefit Booklet are not primary, payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event you receive Covered Services from an In-Network Provider or an Out-of-Network Provider who participates in the Traditional Program, “total reasonable expenses” shall mean the total amount required to be paid to the Provider pursuant to the applicable agreement BCBSF or another Blue Cross and/or Blue Shield organization has with such Provider. **In the event that the primary payer’s payment exceeds the 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 you are covered as a Covered Dependent and the other plan covers you as other than a dependent, the Group Health Plan will be secondary.
2. When the Group Health Plan 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; or
  - b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than us, the Group Health Plan will be secondary.
3. When the Group Health Plan 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;
  - b) if the parent with custody has remarried, the plan of the parent with custody is primary; the stepparent'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 the Group Health Plan covers a dependent child and the dependent child is also covered under another plan:
- a) the plan of the parent who is neither laid off nor retired will be primary; or
  - b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered you the longest shall be primary.

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

6. If you are covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:
- a) first, the plan covering the person as an employee, or as the employee's Dependent;
  - b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.
7. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

#### **Non-Duplication of Government Programs and Workers' Compensation**

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

#### **Coordination of Benefits**

**Exclusion Prescription Drug Copayments, Coinsurance and Deductibles, or any part thereof, you are obligated to pay under any plan or policy.**

## Section 16: Subrogation

In the event payment is made under this Benefit Booklet to you or on your behalf for any claim in connection with or arising from a Condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, FCCRMC and/or the Group Health Plan, to the extent of any such payment, shall be subrogated to all causes of action and all rights of recovery you have against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated. BCBSF may recover, on behalf of FCCRMC and/or the Group Health Plan, the amount of any payments made on your behalf minus BCBSF or FCCRMC's pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. BCBSF may subrogate, on behalf of FCCRMC and/or the Group Health Plan, against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although FCCRMC may, but is not required to, take into consideration any special factors relating your specific case in resolving the subrogation claim, FCCRMC will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of the recovery or settlement.

You must promptly execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigation as may be requested by BCBSF or FCCRMC, and shall do whatever is necessary to enable BCBSF or FCCRMC to exercise FCCRMC's subrogation rights and shall do nothing to prejudice such rights. Additionally, you or your legal representative shall promptly notify BCBSF in writing of any settlement negotiations prior to entering into any settlement

agreement, shall disclose to BCBSF any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgement proceeds without FCCRMC's prior written consent. No waiver, release of liability, or other documents executed by you without such notice to BCBSF shall be binding upon FCCRMC.

## Section 17: Right of Reimbursement

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

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

# Section 18: Claims Processing

## Introduction

This section is intended to:

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

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

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

plan administrator is the employer who establishes and maintains the plan.

## Types of Claims

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

## Post-Service Claims

### How to File a Post-Service Claim

We have defined and described the three types of claims that may be submitted to us. Our experience shows that the most common type of claim we will receive from you or your treating Providers will likely be Post-Service Claims.

In-Network Providers have agreed to file Post-Service Claims for Services they render to you. In the event a Provider who renders Services to you does not file a Post-Service Claim for such Services, it is your responsibility to file it with us.

We must receive a Post-Service Claim within 90 days of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if we do not receive it at the address indicated on your ID Card within one year of the date the Service was rendered unless you were legally incapacitated.

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

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

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

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

#### The Processing of Post-Service Claims

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

- **Payment for Post-Service Claims**

When payment is due under the terms of the Benefit Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims

within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more or additional information, we may contest the claim within the timeframes set forth below.

- **Contested Post-Service Claims**

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. Our notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- **Denial of Post-Service Claims**

In the event we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the

claim and the reason(s) for denial. It is your responsibility to ensure that we receive all information determined by us as necessary to adjudicate a Post-Service Claim. **If we do not receive the necessary information, the claim or a portion of the claim may be denied.**

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

#### Additional Processing Information for Post-Service Claims

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

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

### **Pre-Service Claims**

#### How to File A Pre-Service Claim

This Benefit Booklet may require a Pre-Service Claim, as that term is defined herein, be received by BCBSF in order for there to be coverage, benefits, or payment (in whole or in

part), for a specific Covered Service,. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the "What Is Covered?" section and other applicable sections of this Benefit Booklet. You may also call the customer service number on your ID card for assistance.

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

#### Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

We will use our best efforts to provide notice of a decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a

coverage decision. This 15-day determination period may be extended by us one time for up to an additional 15 days. If such an extension is necessary, we will use our best efforts to provide notice of the extension and reasons for it. We will use our best efforts to provide notification of the decision on your Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by us.

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

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

### **Concurrent Care Decisions**

#### Reduction or Termination of Coverage or Benefits for Services

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

- we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of Services; and
- the reduction or termination of coverage or benefits by us was not due to an

amendment of this Benefit Booklet or termination of your coverage as provided by this Benefit Booklet.

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

#### Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of your request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: 1) we need additional information; or 2) you or your representative failed to follow proper procedures in your request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

## **Standards for Adverse Benefit Determinations**

### Manner and Content of a Notification of an Adverse Benefit Determination

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

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

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

## **How to Appeal an Adverse Benefit Determination**

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

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

- If your claim is a Claim Involving Urgent Care, you may request an expedited appeal orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method.
- If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at [www.bcbsfl.com](http://www.bcbsfl.com) or by calling the number on the back of your BCBSF ID Card.

#### Timing of Our Appeal Review on Adverse Benefit Determinations

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

- Pre-Service Claims-- within 30 days of the receipt of your appeal; or
- Post-Service Claims-- within 60 days of the receipt of your appeal; or
- Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services)-- within 72 hours of receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

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

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

#### **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

#### **Additional Claims Processing Provisions**

1. Release of Information/Cooperation:
 

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

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

### 3. Legal Actions:

No legal action arising out of or in connection with coverage under this Benefit Booklet may be brought against us within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.4. Fraud, Misrepresentation or Omission in Applying for Benefits:

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

### 5. Explanation of Benefits Form:

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

- a) The specific reason or reasons for the Adverse Benefit Determination;
- b) Reference to the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- c) A description of any additional information that would change the initial determination and why that information is necessary;

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

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

### 6. Circumstances Beyond Our Control:

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

### **ERISA Civil Action Provision**

If a federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, applies to your Group Benefit Plan. You or your Covered Dependents may be entitled, after exhaustion of the appeal procedures provided for in this section, to pursue a civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

## Section 19: Relationship Between the Parties

### **BCBSF/FCCRMC and Health Care Providers**

Neither BCBSF nor FCCRMC nor any of their officers, directors or employees provides Health Care Services to you. Rather, BCBSF and FCCRMC are engaged in making coverage and benefit decisions under this Booklet. By accepting the Group health care coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those Services are not employees or agents of BCBSF or FCCRMC. **In this regard, we and FCCRMC hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and FCCRMC do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgement or clinical decisions of any health care Provider. Any decisions made under the Group Health Plan 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 FCCRMC will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

### **Non Liability of BCBSF and FCCRMC**

Neither FCCRMC nor any person covered under this Booklet is BCBSF's agent or representative, and neither shall be liable for any acts or omissions by BCBSF's agents, servants, employees, or us. Additionally, neither BCBSF nor FCCRMC will 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 your agent, servant, or representative nor is BCBSF an agent, servant, or representative of FCCRMC and BCBSF will not be liable for any acts or omissions, or those of FCCRMC, its agents, servants, employees, or any person or organization with which FCCRMC has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

### **Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF**

Any and all decisions that require or pertain to independent professional medical judgement or training, or the need for medical Services or supplies, must be made solely by your family and your treating Physician in accordance with the patient/physician relationship. It is possible that you or your treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

## Section 20: General Provisions

### **Access to Information**

BCBSF and FCCRMC have the right to receive, from you and any health care Provider rendering Services to you, information that is reasonably necessary, as determined by BCBSF and FCCRMC, in order to administer the coverage and benefits provided, subject to all applicable confidentiality requirements listed below. By accepting coverage, you authorize every health care Provider who renders Services to you, to disclose to BCBSF and FCCRMC or to affiliated entities, upon request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit BCBSF and/or FCCRMC to copy any such records and reports so obtained.

### **Right to Receive Necessary Information**

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

### **Right to Recovery**

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

### **Compliance With State and Federal Laws and Regulations**

The terms of coverage and benefits to be provided under this Benefit Booklet shall be deemed to have been modified and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties.

### **Confidentiality**

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including BCBSF's quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or services under this Booklet. Further, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

BCBSF's arrangements with a Provider may require that we release certain claims and medical information about persons covered under this Booklet to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any

such Provider to evaluate your financial responsibility under this Booklet.

### **Benefit Booklet**

You have been provided with this Benefit Booklet and an Identification Card as evidence of your coverage under this Benefit Booklet.

### **Modification of Provider Network and the Participation Status**

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

### **Cooperation Required of You and Your Covered Dependents**

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

### **Non-Waiver of Defaults**

Any failure by BCBSF or FCCRMC at any time, or from time to time, to enforce or to require the

strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect BCBSF's or FCCRMC's right at any time to enforce any terms or conditions under this Benefit Booklet.

### **Notices**

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

If to BCBSF:

To the address printed on the Identification Card.

If to you:

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

**You must notify us immediately of any address change.**

If to FCCRMC:

To the address indicated by FCCRMC.

### **Our Obligations Upon Termination**

Upon termination of your coverage for any reason, there will be no further liability or responsibility to you under the Group Health Plan, except as specifically described herein.

### **FCCRMC as Plan Administrator**

FCCRMC, as the plan administrator, retains full, final, discretionary authority with respect to the administration of the coverage and benefits described in this Benefit Booklet, including, but not limited to, the authority to establish the benefits and scope of coverage to be provided hereunder; authority to make ultimate coverage and claims payment decisions; authority to

determine the eligibility of individuals for coverage; and authority to construe and interpret the terms of coverage under this Benefit Booklet.

### **Promissory Estoppel**

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

### **Florida Agency for Health Care Administration Performance Data**

The performance outcome and financial data published by the Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute, located at the web site address [www.floridahealthstat.com](http://www.floridahealthstat.com), may be accessed through the link provided on the Blue Cross and Blue Shield of Florida corporate web site at [www.bcbsfl.com](http://www.bcbsfl.com).

### **Third Party Beneficiary**

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of, FCCRMC and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. FCCRMC hereby specifically expresses its 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 terms of the FCCRMC Group Health Plan or this Benefit Booklet.

## Section 21: Definitions

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

**Accident** means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

**Accidental Dental Injury** means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

**Administrative Services Only Agreement or ASO Agreement** means an agreement between FCCRMC and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to BCBSF's NetworkBlue and BCBSF's network of Traditional Insurance Providers.

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

**Allowed Amount** means the maximum amount upon which payment will be based for Covered

Services. The Allowed Amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard<sup>®</sup> (Out-of-State) Program section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard<sup>®</sup> (Out-of-State) Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard<sup>®</sup> (Out-of-State) Program section for more details.
5. In the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the

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

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies,

means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much we will pay.

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

**Ambulance** means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

**Ambulatory Surgical Center** means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

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

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

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

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

**BlueCard® (Out-of-State) Traditional Program Provider** means a Provider designated as a

BlueCard® (Out-of-State) Traditional Program Provider by the Host Blue.

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

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

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

**Certified Nurse Midwife** means a person who is licensed pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state, as an advanced nurse practitioner

and who is certified to practice midwifery by the American College of Nurse Midwives.

**Certified Registered Nurse Anesthetist** means a person who is a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state.

**Claim Involving Urgent Care** means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to you with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed without the proposed Services being rendered.

**Coinsurance** means your share of health care expenses for Covered Services. After your Deductible requirement is met, a percentage of the Allowed Amount will be paid for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

**Concurrent Care Decision** means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

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

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

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

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

**Covered Employee** means an Eligible Employee who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under this Benefit Booklet other than as a Covered Dependent (See the Eligibility Requirements for Employees subsection of the Eligibility for Coverage section).

**Covered Person** means a Covered Plan Participant or a Covered Dependent.

**Covered Plan Participant** 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 this Benefit Booklet other than as a Covered Dependent.

**Covered Services** means those Health Care Services which meet the criteria listed in the *What Is Covered?* section.

**Custodial or Custodial Care** means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require

the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

**Deductible** means the amount of charges, up to the Allowed Amount, for Covered Services that are your responsibility. The term, Deductible, does not include any amounts you are responsible for in excess of the Allowed Amount, or any Coinsurance/Copay amounts, if applicable.

**Detoxification** means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

**Diabetes Educator** means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

**Dialysis Center** means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

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

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

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

**Effective Date** means, with respect to individuals covered under this Benefit Booklet, 12:01 a.m. on the date FCCRMC specifies that the coverage will commence as further described in the Enrollment and Effective Date of Coverage section of this Benefit Booklet.

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

**Refer to the "Eligibility for Coverage" section for limits on eligibility.**

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

**Endorsement** means an amendment to the Group Health Plan or this Booklet.

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

**Enrollment Forms** means those forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under this Benefit Booklet.

**Enteral Formulas** are liquid food products that are specially formulated and designed to increase the amount of various food elements and nutrients that will maintain proper physiological function of the body process.

**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 or FCCRMC:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity

as required and defined by federal regulations; or

4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

" Credible scientific evidence" shall mean (as determined by BCBSF or FCCRMC):

1. records maintained by Physicians or Hospitals rendering care or treatment to you

or other patients with the same or similar Condition;

2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

**Note: Health Care Services which are determined by BCBSF or FCCRMC to be Experimental or Investigational are excluded (see the “What Is Not Covered?” section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF or FCCRMC 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.**

**FCCRMC** means Florida Community Colleges Risk Management Consortium.

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

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

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

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

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

**Group** means the employer (member college), labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits under this Benefit Booklet are made available to you, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

**Group Health Plan or Group Plan** means the plan established and maintained by FCCRMC for the provision of health care coverage and benefits to the individuals covered under this Benefit Booklet.

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

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

**Home Health Care or Home Health Care Services** means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

**Hospice** means a public agency or private organization which is duly licensed by the State of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

**Hospital** means a facility properly licensed pursuant to Chapter 395 of the *Florida Statutes*, or a similar applicable law of another state, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and

regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

**Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.**

**Identification Card** means the card(s) issued to Covered Plan Participants under the BlueOptions Group Health Plan. The card is not transferable to another person. Possession of such card in no way guarantees that a particular individual is eligible for, or covered under, this Benefit Booklet.

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

**Independent Diagnostic Testing Facility** means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida law or laws of the State in which it operates. Further, such an entity must meet BCBSF's criteria for eligibility as an Independent Diagnostic Testing Facility.

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

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

**In Vitro Fertilization (IVF)** means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If

fertilized, the resulting embryo is transferred to the woman's uterus.

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

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

**Massage or Massage Therapy** means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Benefit Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

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

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

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

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and

3. not primarily for your convenience, or that of your Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness.

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

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

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

**Mental and Nervous Disorder** means any disorder listed in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric

Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

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

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

**Occupational Therapy** means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

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

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

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

1. did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or

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

did not have a contract with a Host Blue to participate for purposes of the BlueCard® (Out-of-State) Program as a BlueCard® (Out-of-State) Traditional Program Provider.

**Outpatient Rehabilitation Facility** means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet 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.

**Pain Management** includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are

programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

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

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

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

**Physician** means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

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

**Physician Assistant** means a person properly licensed pursuant to Chapter 458 of the *Florida Statutes*, or a similar applicable law of another state.

**Post-Service Claim** means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a

properly completed claim form or electronic format acceptable to us in accordance with the provisions of this section.

**Pre-Service Claim** means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of the Benefit Booklet condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of the Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

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

**Prosthetist/Orthotist** means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

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

**Provider** means any facility, person or entity recognized for payment by BCBSF under this Booklet.

**Psychiatric Facility** means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the

care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility, as defined herein.

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

**Registered Nurse** means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state.

**Registered Nurse First Assistant (RNFA)** means a person properly licensed to perform surgical first assisting services pursuant to Chapter 464 of the *Florida Statutes* or a similar applicable law of another state.

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

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

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

accreditation or recognition requirement has been waived by BCBSF.

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

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

**Standard Reference Compendium** means:

1) The United States Pharmacopoeia Drug Information; 2) The American Medical Association Drug Evaluation; or 3) The American Hospital Formulary Service Hospital Drug Information.

**Substance Abuse Facility** means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the purposes of this Booklet a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

**Substance Dependency** means a Condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

**Traditional Program** means, or refers to, BCBSF 's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS). For purposes of this Benefit Booklet, the term Traditional Program also refers, when applicable, to the traditional Provider contracting programs of other Blue Cross and/or Blue Shield organizations as designated under the Blue Cross and Blue Shield Association's BlueCard® Program.

**Traditional Program Providers** means, or refers to, those health care Providers who are not NetworkBlue Providers, but who or which, at

the time you received Services from them, were participating in the Traditional Program. For purposes of payment under this Benefit Booklet only, the term Traditional Program Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard® Traditional Provider under the Blue Cross and Blue Shield Association's BlueCard® Program.

**Urgent Care Center** means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For purposes of this Benefit Booklet, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

**Waiting Period** means the length of time established by FCCRMC which must be met by an individual before that individual becomes eligible for coverage under this Benefit Booklet.

**Zygote Intrafallopian Transfer (ZIFT)** means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are

retrieved and fertilized on one day and the zygote is transferred the following day.

# BlueScript<sup>®</sup> Pharmacy Program Endorsement

This Endorsement and the BlueScript<sup>®</sup> Pharmacy Program Schedule of Benefits are to be attached to, and made a part of, your Benefit Booklet. The Benefit Booklet is hereby amended by adding the following BlueScript<sup>®</sup> Pharmacy Program provisions.

References to “you” or “your” throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any reference that refers solely to you as the Covered Employee, Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.

References to “we”, “us”, and “our” throughout refer to BCBSF.

## Introduction

Under this BlueScript Pharmacy Program Endorsement, coverage is provided to you for certain Prescription Drugs and Supplies and select Over-the-Counter (“OTC”) Drugs purchased at a Pharmacy. In order to obtain benefits under this Endorsement, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the applicable Copayment or percentage of the Participating Pharmacy Allowance indicated on the BlueScript Pharmacy Program Schedule of Benefits. Please note that the Pharmacy Deductible will not apply toward Covered Prescription Drugs and Supplies purchased from a Mail Order Pharmacy.

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

Drugs rather than Non-Preferred Prescription Drugs and 3.) choosing Preferred Generic Prescription Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory at our web site at [www.bcbsfl.com](http://www.bcbsfl.com), call the customer service number on your Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

## Covered Prescription Drugs and Supplies and Covered OTC Drugs

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

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;
2. dispensed by a Pharmacist;
3. Medically Necessary;
4. in the case of a Self-Administered Injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a Covered Self-Administered Injectable Prescription Drug;
5. a Prescription Drug contained in an anaphylactic kit (e.g., Epi-Pen, Epi-Pen Jr., Ana-Kit);
6. authorized for coverage by us, if prior coverage authorization is required by us as indicated with a unique identifier in the Medication Guide, then in effect;
7. not specifically or generally limited or excluded herein or by the Benefit Booklet; and
8. approved by the FDA, and assigned a National Drug Code.

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

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

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

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

#### **Contraceptive Coverage**

All Prescription diaphragms, oral contraceptives and contraceptive patches will be covered unless indicated as not covered on the BlueScript® Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Endorsement.

##### Exclusion

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

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

Select OTC Drugs, listed in the Medication Guide, may be covered when you obtain a Prescription for the OTC Drug from your Physician. In order for there to be coverage under this Endorsement for OTC Drugs, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the Preferred Generic Prescription Drug Copayment or percentage of

the Participating Pharmacy Allowance indicated on the BlueScript Pharmacy Program Schedule of Benefits. Only those OTC Drugs listed in the Medication Guide are covered and coverage for these OTC Drugs is limited to up to a maximum of a One-Month Supply.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed on our web site at [www.bcbsfl.com](http://www.bcbsfl.com), or you may call the customer service number on your Identification Card and one will be mailed to you upon request.

**Note:** OTC Drugs are not covered when purchased at a Non-Participating Pharmacy or through the Mail Order Pharmacy.

#### **Diabetic Coverage**

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this Endorsement. Covered Prescription Supplies used to treat diabetes will not be subject to any Calendar Year Maximum or Lifetime Maximum that may apply to your benefit plan. Insulin is **only** covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting Insulin are covered only when prescribed in conjunction with Insulin.

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

##### Exclusion

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

## Mineral Supplements, Fluoride or Vitamins

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

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

### Exclusion

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

## Limitations and Exclusions

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

1. coverage will not extend beyond the maximum supply, as set forth in the BlueScript Pharmacy Program Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs;
2. you must refill your Prescription within six months or one year from the original Prescription date, depending on federal law designations;
3. certain Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.

## Exclusions

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific subsection of the "What is Covered?" section of your Benefit Booklet, which this Endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a Hospital or Physician);
2. Except as covered in the Covered Prescription Drugs and Supplies subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection regardless of the setting in which such Prescription Drug is administered or type of provider administering such Prescription Drug;
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even if a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for Covered OTC Drugs listed in the Medication Guide;
4. All Supplies other than Covered Prescription Supplies;
5. Any Prescription Drugs, OTC Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this BlueScript Pharmacy Program Endorsement;
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes); regardless of the intended use (except for Covered Prescription Supplies);
7. Prescription Drugs and Supplies and OTC Drugs that are:
  - a. in excess of the limitations specified in this BlueScript<sup>®</sup> Pharmacy Program Endorsement or on the BlueScript<sup>®</sup>

Pharmacy Program Schedule of Benefits;

- b. furnished to you without cost;
  - c. Experimental or Investigational;
  - d. indicated or used for the treatment of infertility, except when indicated as covered on the BlueScript® Pharmacy Program Schedule of Benefits;
  - e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova. (Retin-A is excluded after age 26);
  - f. prescribed by a Pharmacist;
  - g. used for smoking cessation (e.g., Zyban), except when indicated as covered on the BlueScript® Pharmacy Program Schedule of Benefits;
  - h. listed in the Homeopathic Pharmacopoeia;
  - i. not Medically Necessary;
  - j. indicated or used for sexual dysfunction (e.g., Viagra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine), except when indicated as covered on the BlueScript® Pharmacy Program Schedule of Benefits;
  - k. purchased outside of the United States; or
  - l. prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America.
8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection;
9. Any appetite suppressant, Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control, except when indicated as covered on the

BlueScript Pharmacy Program Schedule of Benefits;

10. Immunization agents, biological sera, blood and blood plasma;
11. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug 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;
12. Prescription Drugs and OTC Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce;
13. Drugs that do not have a valid National Drug Code;
14. Drugs that are compounded except Prescription Drugs that have at least one active ingredient that is an FDA-approved Drug with a valid National Drug Code;
15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:
- a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;
  - b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by: i) American Medical

Association; ii) National Heart Lung and Blood Institute; iii) American Cancer Society; iv) American Heart Association; v) National Institutes of Health; vi) American Gastroenterological Association; vii) Agency for Health Care Policy and Research; or

- c. we, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs;
16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by:
- a. American Medical Association;
  - b. National Heart Lung and Blood Institute;
  - c. American Cancer Society;
  - d. American Heart Association;
  - e. National Institutes of Health;
  - f. American Gastroenterological Association;
  - g. Agency for Health Care Policy and Research;

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

17. Any amount you are required to pay under this Endorsement as indicated on the BlueScript<sup>®</sup> Pharmacy Program Schedule of Benefits.
18. Self-prescribed Drugs or Supplies and Drugs or Supplies prescribed by any person related to you by blood or marriage.
19. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.

## Payment Rules

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

1. the participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. the terms of our agreement with the Pharmacy selected;
3. whether you have satisfied the Pharmacy Deductible, if any, and the amount of Copayment or percentage of the Participating Pharmacy Allowance set forth in the BlueScript<sup>®</sup> Pharmacy Program Schedule of Benefits;
4. whether the Prescription Drug is a Generic Prescription Drug, a Brand Name Prescription Drug or a Covered OTC Drug;
5. whether the Prescription Drug is on the Preferred Medication List;
6. whether the Prescription Drug is purchased from the Mail Order Pharmacy;
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug.

A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Non-Preferred Prescription Drugs are subject to a higher Copayment or percentage of the Participating Pharmacy Allowance set forth in the BlueScript<sup>®</sup> Pharmacy Program Schedule of Benefits.

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

## Pharmacy Alternatives

You may fill your Prescriptions for Covered Prescription Drugs and Supplies at any Pharmacy you choose. For purposes of this Endorsement, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

### Participating Pharmacies

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

With BlueScript<sup>®</sup>, there are three types of Participating Pharmacies:

1. Pharmacies in Florida that have signed a BlueScript<sup>®</sup> Participating Pharmacy Provider Agreement with us;
2. National Network Pharmacies; and
3. the Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory at our web site at [www.bcbsfl.com](http://www.bcbsfl.com), call the customer service number included in your Benefit Booklet or on your Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

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

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by a

Participating Pharmacy are less than the required Copayment, the amount you will pay depends on the agreement then in effect between the Pharmacy and us and will be one of the following:

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

### Mail Order Pharmacy

The procedure for filling a Covered Prescription Drug or Covered Prescription Supply from the Mail Order Pharmacy is as follows:

1. For the first Mail Order Pharmacy Prescription order, you must complete the Registration and Prescription Order Form included in the Mail Order Pharmacy Brochure, and mail it to the Mail Order Pharmacy with the applicable Mail Order Copayment(s). A Mail Order Pharmacy Brochure was included with the membership package provided to you. Additional Mail Order Pharmacy Brochures can be obtained by calling the customer service number included in the Certificate of Coverage Benefit Booklet or on your Identification Card.
2. You must submit a new, original 90-Day Supply Prescription with a quantity of up to a 90-Day Supply and not less than a 60-Day Supply along with the Registration and Prescription Order Form if the original Prescription was filled at a Pharmacy other than the Mail Order Pharmacy. Prescriptions may not be transferred from a Pharmacy to the Mail Order Pharmacy.
3. Once a Prescription has been filled through the Mail Order Pharmacy, you can call the Mail Order Pharmacy to order refills.

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

### **Non-Participating Pharmacies**

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

Reimbursement to you for Covered Prescription Drugs and Supplies is based upon our Participating Pharmacy Allowance. Non-Participating Pharmacies have **not** agreed to accept our Participating Pharmacy Allowance or our Pharmacy Benefit Manager's Participating Pharmacy Allowance as payment in full less any applicable cost-sharing amounts (e.g., Deductible, Copayment, percentage of the Participating Pharmacy Allowance) due from you.

You are responsible for paying the full cost of the Covered Prescription Drugs and Supplies at the time of purchase and must submit a claim to us for reimbursement. You will be reimbursed, for Covered Prescription Drugs and Supplies, 80% of the Participating Pharmacy Allowance less the Pharmacy Deductible, if any, and the Copayment or percentage of the Participating Pharmacy Allowance amount set forth in the BlueScript® Pharmacy Program Schedule of Benefits.

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

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

## **Pharmacy Utilization Review Programs**

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

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

**Note:** If coverage is not available, or is limited, this does not mean that you cannot obtain the Prescription Drug, Supply or OTC Drug from the Pharmacy. It only means that there is no coverage and payment will not be made for the Prescription Drug, Supply or OTC Drug. You are always free to purchase the Prescription Drug, Supply or OTC Drug at your sole expense.

Our pharmacy utilization review programs include the following:

### **Responsible Steps**

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

Prior to filling your Prescription, your Physician may, but is not required to, contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by

following the procedures for prior coverage authorization outlined in this section.

### **Dose Optimization Program**

Under this program, coverage may be excluded for any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

### **Prior Coverage Authorization Program**

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

#### To obtain prior coverage authorization:

1. You or your Physician must call the customer service number on the Identification Card and provide any information required by us in order to process the request for coverage authorization.
2. If you call, we may request that you have your Physician contact us regarding the Prescription Drug, Supply or OTC Drug being prescribed. If the Physician calls, specific medical documentation may be required to be provided to us. This information may also include, but is not limited to, your name, date of birth, Physician's name and Physician's telephone number.
3. Once we make a decision, you or your Physician will be informed.
4. If the decision is made to authorize coverage, you are eligible to obtain the Covered Prescription Drugs and Supplies or Covered OTC Drugs at a Participating Pharmacy subject to the amount you are required to pay as listed in the BlueScript Pharmacy Program Schedule of Benefits.

5. If the decision is made to not authorize coverage, you are still free to purchase the Prescription Drug, Supplies or OTC Drug, but you will have to pay the full cost of the medication and will not be entitled to reimbursement under this Endorsement. You have the right to request a reconsideration if coverage authorization is denied. Please refer to the How to Appeal an Adverse Benefit Determination subsection of the Claims Processing section in the current BlueOptions Benefit Booklet for information on how to file an appeal.

#### To request a reconsideration if coverage authorization is denied:

1. You or your Physician may ask us to review a denial of coverage authorization. A request for reconsideration may be initiated by calling the customer service number on your Identification Card or by writing to us at the address on your Identification Card.
2. Upon receipt of the request for reconsideration, we will review its initial coverage decision and mail you a letter setting forth our reconsideration decision.

Information on our pharmacy utilization review programs is published in the Medication Guide at [www.bcbsfl.com](http://www.bcbsfl.com), or you may call the customer service number on your Identification Card. Your Pharmacist may also advise you if a Prescription Drug requires coverage authorization.

### **Ultimate Responsibility for Medical Decisions**

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the applicable terms of the policy, contract, or Benefit Booklet. Ultimately, the final decision concerning whether a Prescription Drug, Supply or OTC Drug should be prescribed must be

made by you and the prescribing Physician. Decisions made by us under these programs are made only to determine whether coverage or benefits are available under the applicable policy, contract, or Benefit Booklet and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

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

## Definitions

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

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

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

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

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

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

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

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

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

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

**Generic Prescription Drug** means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (i) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an

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

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

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

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

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

**National Drug Code (NDC)** means the universal code that identifies the Drug

dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

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

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

**Non-Preferred Prescription Drug** means a Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect. Note: The Medication Guide is subject to change at any time. Please refer to our web site at [www.bcbsfl.com](http://www.bcbsfl.com) for the most current guide or you may call the customer service number on your Identification Card.

**One-Month Supply** means a maximum quantity per Prescription up to a 31-day supply as defined by the Drug manufacturer's dosing recommendations.

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

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

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

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

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

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

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

**Pharmacy Out-of-Pocket Maximum** means the maximum amount you will be required to pay per Calendar Year for Covered Prescription Drugs and Supplies and OTC Drugs.

**Preferred Brand Name Prescription Drug** means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Note: The Medication Guide is subject to change at any time. Please refer to our web site at [www.bcbsfl.com](http://www.bcbsfl.com) for the most current guide or

you may call the customer service number on your Identification Card.

**Preferred Generic Prescription Drug** means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. Note: The Medication Guide is subject to change at any time. Please refer to our web site at [www.bcbsfl.com](http://www.bcbsfl.com) for the most current guide or you may call the customer service number on your Identification Card.

**Preferred Medication List** means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which we provide coverage and benefits, subject to the exclusions of this Endorsement. The Preferred Medication List is contained within the Medication Guide. Note: The Medication Guide is subject to change at any time. Please refer to our web site at [www.bcbsfl.com](http://www.bcbsfl.com) for the most current guide or you may call the customer service number on your Identification Card.

**Preferred Prescription Drug** means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained within the Medication Guide. Note: The Medication Guide is subject to change at any time. Please refer to our web site at [www.bcbsfl.com](http://www.bcbsfl.com) for the most current guide or you may call the customer service number on your Identification Card.

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

**Prescription Drug** means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar

statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of this Endorsement, Insulin is considered a Prescription Drug because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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

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

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

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Blue Cross and Blue Shield of Florida, Inc.