

BlueSelect

Bronze (HSA) 1735

Schedule of Benefits

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

| FINANCIAL FEATURES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|--|------------------|----------------------|
| Calendar Year Deductibles (DED) - Embedded | | |
| Individual Deductible | \$6,350 | \$12,700 |
| Family Deductible | \$12,700 | \$25,400 |
| Coinsurance (The percentage of the Allowed Amount you pay for Covered Services) | 0% | 50% |
| Out-of-Pocket Maximums - Embedded | | |
| Individual Out-of-Pocket Maximum | \$6,350 | \$12,700 |
| Family Out-of-Pocket Maximum | \$12,700 | \$25,400 |
| Medical Pharmacy per person, per month | Not Applicable | Not Applicable |

Unless otherwise noted, amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column. This includes the DED and Out-of-Pocket Maximum amounts.

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

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

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

- Non-covered charges
- Charges in excess of the Allowed Amount
- Benefit penalties

MEDICAL BENEFITS

Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Provider Services.

Your Cost Share for Covered Services will vary based on the Provider's participation status. You should always verify a Provider's participation status before you receive Health Care Services. To verify a Provider's specialty or participation status, you may contact our local office or access the most recent BlueSelect provider directory at www.floridablue.com.

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

| PREVENTIVE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|--|---------------------|-------------------------|
| Adult Wellness Services (at all locations) | \$0 | 50% |
| Child Wellness Services (at all locations) | \$0 | 50% |
| Mammograms | \$0 | \$0* |
| Routine Colonoscopies (Ages 50+) | \$0 | \$0* |

* We pay 100% of our Allowed Amount; you are responsible for the difference between our Allowed Amount and the Provider's charge.

| OFFICE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---------------------|-------------------------|
| Office Visits rendered by | | |
| Blue Physician Recognition (Florida only) and Primary Care Physician | 0% after DED | 50% after DED |
| Specialist Physicians and other health care professionals licensed to perform such Services | 0% after DED | 50% after DED |
| Allergy Injections rendered by | | |
| Blue Physician Recognition (Florida only) and Primary Care Physicians | 0% after DED | 50% after DED |
| Specialist Physicians and other health care professionals licensed to perform such Services | 0% after DED | 50% after DED |
| E-Visits rendered by | | |
| Blue Physician Recognition (Florida only) and Primary Care Physicians | 0% after DED | 50% after DED |
| Specialist Physicians and other health care professionals licensed to perform such Services | 0% after DED | 50% after DED |

| OFFICE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|-------------------------|-----------------------------|
| Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) rendered by Blue Physician Recognition (Florida only) and Primary Care Physicians | 0% after DED | 50% after DED |
| Specialist Physicians and other health care professionals licensed to perform such Services | 0% after DED | 50% after DED |
| Outpatient Therapies and Spinal Manipulation rendered by Blue Physician Recognition (Florida only) and Primary Care Physicians | 0% after DED | 50% after DED |
| Specialist Physicians and other health care professionals licensed to perform such Services | 0% after DED | 50% after DED |
| Medical Pharmacy Prescription Drugs administered in a Physician's office | 0% after DED | 50% after DED |

Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered through the pharmacy program. Please refer to your Contract for a description of Medical Pharmacy.

| OUTPATIENT DIAGNOSTIC SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|--|-------------------------|-----------------------------|
| Independent Clinical Lab | 0% after DED | Not Covered |
| Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | 0% after DED | 50% after DED |
| All other diagnostic Services (e.g., X-rays) | 0% after DED | 50% after DED |
| Outpatient Hospital Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | 0% after DED | 50% after DED |
| All other diagnostic Services (e.g., X-rays) | 0% after DED | 50% after DED |

| EMERGENCY AND URGENT CARE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|-------------------------|-----------------------------|
| Ambulance Services | 0% after DED | 0% after INN DED |
| Convenient Care Center | 0% after DED | 50% after DED |
| Emergency Room Visits | | |
| Facility | 0% after DED | 0% after INN DED |
| Physician Services | 0% after DED | 0% after INN DED |
| Urgent Care Center | 0% after DED | 0% after DED |

| HOSPITAL AND SURGICAL SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---------------------------------------|-------------------------|-----------------------------|
| Ambulatory Surgical Center | | |
| Facility | 0% after DED | 50% after DED |
| Physician Services | 0% after DED | 0% after INN DED |
| Inpatient Hospital | | |
| Facility | 0% after DED | 50% after DED* |
| Physician Services | 0% after DED | 0% after INN DED |
| Outpatient Hospital | | |
| Facility | 0% after DED | 50% after DED |
| Physician Services | 0% after DED | 0% after INN DED |

* If you are admitted to an Out-of-Network facility as an inpatient as a result of an emergency room visit to the same facility, the In-Network Coinsurance will apply to that inpatient admission.

Important: Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room Physicians. We will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. If such Covered Services were rendered by a Physician who is not In-Network, you will be responsible for the difference between what we pay and the Physician's charge if the Physician is not participating in our Traditional Program. Claims paid in accordance with this note will be applied to the In-Network Deductibles and Out-of-Pocket Maximums.

| EXCLUSIVE PROVIDER SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|--|------------------|----------------------|
| Durable Medical Equipment | | |
| Motorized wheelchairs | 0% after DED | Not Covered |
| All other Durable Medical Equipment | 0% after DED | Not Covered |
| Home Health Care | 0% after DED | Not Covered |
| Independent Clinical Lab | 0% after DED | Not Covered |
| Prosthetic and Orthotic Devices | 0% after DED | Not Covered |

The Services listed in the chart above are all subject to the **Exclusive Provider Provision** explained in your Contract. If you use a Provider other than the designated Exclusive Provider for these Services you will be responsible for the full charge, except in certain situations, which are explained in your Contract.

| OTHER SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|--------------------------------------|------------------|----------------------|
| Birth Center | 0% after DED | 50% after DED |
| Dialysis Center | 0% after DED | 50% after DED |
| Enteral Formula | 0% after DED | 50% after DED |
| Outpatient Hab/Rehab Facility | 0% after DED | 50% after DED |
| Skilled Nursing Facility | 0% after DED | 50% after DED |

BENEFIT MAXIMUMS

All benefit maximums apply per person and are based on the Calendar Year.

| | |
|---|----|
| Home Health Care Visits..... | 30 |
| Inpatient Habilitative Days..... | 30 |
| Inpatient Rehabilitative Days | 30 |
| Outpatient Habilitative Therapies Visits | 35 |
| Outpatient Therapies and Spinal Manipulation Visits..... | 35 |
| Note: Spinal Manipulations are limited to 35 per Calendar Year and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum. | |
| Skilled Nursing Facility Days | 60 |

PRESCRIPTION DRUG PROGRAM

BlueSelect Pharmacy Program

Prescription Drug coverage is subject to the **Exclusive Provider Provision** explained in your Contract. If you use a Pharmacy other than a designated Exclusive Pharmacy for these Services you will be responsible for the full charge, except for Emergency Services.

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

| COST SHARE TIER | Retail Pharmacy (for <u>each</u> One-Month Supply*) | Mail Order Pharmacy (up to a Three-Month Supply) |
|---|--|---|
| Tier 1: Preventive Prescription Drugs and Supplies | \$0 Copay | \$0 Copay |
| Tier 2: Condition Care HSA Preventive Generic Prescription Drugs and Supplies | \$4 Copay | \$0 Copay |
| Tier 3: All Other Generic Prescription Drugs and Supplies | \$0 Copay after INN DED | \$0 Copay after INN DED |
| Tier 4: Condition Care HSA Preventive Brand Name Prescription Drugs and Supplies | \$30 Copay | \$75 Copay |
| Tier 5: Preferred Brand Name Prescription Drugs and Supplies | \$0 Copay after INN DED | \$0 Copay after INN DED |
| Tier 6: Non-Preferred Brand Name Prescription Drugs and Supplies | \$0 Copay after INN DED | \$0 Copay after INN DED |
| Tier 7: Specialty Generic and Brand Name Prescription Drugs, and Supplies ** | \$0 Copay after INN DED | Not Covered |

Other Important Information affecting the amount you will pay:

- * You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) from a retail Pharmacy, if the Prescription is written for a Three-Month Supply.
- ** Specialty Drugs are only covered when purchased from the Specialty Pharmacy and only up to a One-Month Supply. Some Specialty Drugs may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.

PEDIATRIC VISION BENEFITS

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

| COVERED SERVICE | YOU PAY |
|--|----------------|
| Eye exam one per Calendar Year | \$0 |
| <ul style="list-style-type: none"> • including dilation (when professionally indicated) | |
| Spectacle Lenses one pair per Calendar Year | \$0 |
| <ul style="list-style-type: none"> • Clear plastic single vision, lined bifocal, trifocal or lenticular lenses (any Rx) • Oversize lenses • Scratch-resistant coating • Standard progressive lenses • Plastic photosensitive lenses • Polycarbonate lenses (for monocular patients and patients with prescriptions +/- 6.00 diopters or greater) • Tinting of plastic lenses • Ultraviolet coating | |
| Frames one per Calendar Year from the Pediatric Frame Selection* | \$0 |
| <p>* If you choose a frame that is not in the Pediatric Frame Selection you will be responsible for the difference in cost between the price of the frame selected and those available in the Pediatric Frame Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.</p> | |
| Contact Lenses (instead of eye glasses) once per Calendar Year from the Pediatric Contact Lens Selection** including the evaluation, fitting and follow-up care | \$0 |
| <p>** If you do not select contact lenses from the Pediatric Contact Lens Selection you will be responsible for the difference in cost between the contact lenses selected and those available in the Pediatric Contact Lens Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.</p> | |
| Medically Necessary Contact Lenses (prior authorization is required)..... | \$0 |
| <ul style="list-style-type: none"> • Including the evaluation, fitting and follow-up care | |

BlueSelect

For Individuals Non-Group Contract



This Contract contains a deductible provision

Guaranteed Renewable

This Contract is guaranteed renewable, meaning that it automatically renews each year on the Anniversary Date unless terminated earlier in accordance with the terms of the Contract.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

BSEQ.IU.BB.DED 0516

BSEQ.IU.BB 0516

BlueSelect

For Individuals Non-Group Contract



Patrick J. Geraghty
Chairman of the Board
and Chief Executive Officer

For Customer Service Assistance: 800-FLA -BLUE

Contractholder Name: <John Doe>
Contract Number: <XJDH123456781>
Group Number: <99999ABC>
Contract Type: <Single>
Effective Date: <01/01/2014>
Monthly Rate: <\$0.00>

Florida Blue 

In the pursuit of health®

4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

BSEQ.IU.BB.DED 0516
BSEQ.IU.BB 0516

IMPORTANT NOTICE

In deciding to issue this Contract to you, we relied on the truthfulness and accuracy of the information provided on the application. Please carefully read your application and notify us within 10 days if any of the information on it is incorrect or incomplete. Fraudulent statements or Material Misrepresentations on your application could result in the cancellation or Rescission of your Contract.

During the term of this Contract, we agree to provide the health insurance coverage and benefits specifically provided in this Contract to covered individuals, subject to all applicable terms, conditions, limitations, and exclusions.

ARE YOU SATISFIED?

If, after examining this Contract, you are not fully satisfied for any reason, your Premium payment will be refunded provided you return the Contract and Identification Cards to us within 10 days of the delivery date.

This Contract will stay in effect as long as you remain eligible for coverage and you pay your Premiums on time. This Contract can be Rescinded or canceled if you have made a fraudulent or Material Misrepresentation. This Contract can be canceled if we terminate the policy form for everyone covered by it.

TABLE OF CONTENTS

| | |
|--|-------|
| How to Use Your Contract..... | USE-1 |
| What Is Covered? | INC-1 |
| Prescription Drug Program..... | RXO-1 |
| What Is Not Covered? | EXC-1 |
| Medical Necessity | MDN-1 |
| Your Share of Health Care Expenses | HCE-1 |
| Health Care Provider Options | PRO-1 |
| BlueCard® Program | BCD-1 |
| Blueprint for Health Programs | BPH-1 |
| Payment of Premiums..... | PRM-1 |
| Eligibility and Enrollment for Coverage..... | ELG-1 |
| Termination of Coverage..... | TRM-1 |
| Claims Processing..... | CLM-1 |
| Appeal and Grievance Process | APP-1 |
| Coordination of Benefits | COB-1 |
| General Provisions | GEN-1 |
| Other Important Information..... | OTH-1 |
| Definitions | DEF-1 |

HOW TO USE YOUR CONTRACT

This is your Contract. You should read it carefully before you need Health Care Services. It contains valuable information about:

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

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

When reading your Contract, please remember:

1. You should read this Contract in its entirety in order to determine if a particular Health Care Service is covered. Sometimes it may be necessary to change the standard language in this Contract. If changes are needed, we will create an Endorsement to this Contract, which will either be inserted after the section that it modifies, or at the end of the Contract. Be sure to always check for these additional documents before making benefit decisions.
2. The headings of sections contained in this Contract are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
3. References to “you” or “your” throughout refer to you as the Contractholder 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 Contractholder or solely to your Covered Dependents will be noted as such.
4. References to “we”, “us”, “our” and “Florida Blue” throughout refer to Blue Cross and Blue Shield of Florida, Inc.
5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the DEFINITIONS section or within the particular section where it is used.
6. Certain Health Care Services are subject to an Exclusive Provider Provision, which means those Services are only covered when provided by the Provider designated, solely by us, as the Exclusive Provider or Exclusive Pharmacy for such Services. Please refer to your Schedule of Benefits to determine which Services are subject to an Exclusive Provider Provision.

7. Health Care Services that are not subject to an Exclusive Provider Provision are subject to a Preferred Provider provision, under which you are entitled to preferred provider type benefits when you receive Covered Services from In-Network Preferred Providers. Under the Preferred Provider provision, you are also entitled to obtain Services from Out-of-Network Providers. Please refer to your Schedule of Benefits to determine which Services are subject to a Preferred Provider Provision.

| Where do I find information on... | ...go to: |
|---|---|
| What is covered ? | The WHAT IS COVERED? section. |
| What is not covered ? | The WHAT IS NOT COVERED? section, along with the WHAT IS COVERED? section. |
| What is covered under my retail pharmacy plan ? | The PRESCRIPTION DRUG PROGRAM section. |
| Which Services are subject to an Exclusive Provider Provision ? | See your Schedule of Benefits . |
| How do I know what Providers I can use, and how the Providers I use will affect my Cost Share amount? | The HEALTH CARE PROVIDER OPTIONS section along with the current Provider Directory . |
| How much do I pay for Health Care Services? | The YOUR SHARE OF HEALTH CARE EXPENSES section along with the Schedule of Benefits . |
| How do I access Services when I'm out-of-state ? | The BLUECARD® PROGRAM section. |
| How do I add or remove a Dependent ? | The ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and the TERMINATION OF COVERAGE section. |
| What if I am covered under BlueSelect and another health plan ? | The COORDINATION OF BENEFITS section. |
| What happens when my coverage ends ? | The TERMINATION OF COVERAGE section. |
| What do the terms used throughout this Contract mean ? | The DEFINITIONS section. |
| Who do I call if I have questions or complaints ? | Call our customer service department at 800-FLA-BLUE (this phone number can also be found on your ID Card). |

WHAT IS COVERED?

Introduction

This section describes the Health Care Services that are covered under this Contract. All benefits for Covered Services are subject to: 1) your share of the cost and the benefit maximums listed on your Schedule of Benefits; 2) the applicable Allowed Amount, 3) any limitations and exclusions, as well as any other provisions contained in this Contract, and 4) our Medical Necessity guidelines then in effect (see the MEDICAL NECESSITY and BLUEPRINT FOR HEALTH PROGRAMS sections).

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

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

1. Authorized in advance by us, if prior coverage authorization is required (see the BLUEPRINT FOR HEALTH PROGRAMS section);
2. within the Covered Services categories in this section;
3. actually rendered to you (not just recommended) by an appropriately licensed health care Provider who is recognized by us for payment;
4. billed to us on a claim form or itemized statement that lists the procedures and Services rendered to you. Claims and statements should include procedure codes, diagnosis codes and other information we require to process the claim;
5. Medically Necessary, as defined in this Contract and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;
6. within our benefit guidelines listed in this section;
7. rendered while your coverage is in force; and
8. not specifically or generally limited or excluded under this Contract.

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

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

In determining if Health Care Services are Covered Services under this Contract, no written or verbal representation by any employee or agent of Florida Blue or by any other person shall waive or modify the

terms of this Contract 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, we may apply the benefit guidelines listed below as well as any other applicable payment rules specific to certain types of Services:

1. Our payment is based on our Allowed Amount and not necessarily the Provider's billed charges.
2. Our payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and we will not pay additional amounts for any such Services.
3. Our payment is based on the Allowed Amount for the actual Service you received. Payment is not based on:
 - a. a Service that is more complex than the Service you actually received;
 - b. the method used to perform the Service; or
 - c. the day of the week or the time of day the procedure is performed.
4. Some Services that have several components can be described by a single procedure code. In these cases, our payment for such Services includes all components of the Service under that one procedure code. This is also true when a Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.
5. Services that are subject to an Exclusive Provider Provision are only Covered Services when rendered or authorized by the Provider designated solely by us, as the Exclusive Provider or Exclusive Pharmacy for the particular Services, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition.

Covered Services Categories

Allergy Testing and Treatments

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

Ambulance Services

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

1. For Emergency Medical Conditions – it is Medically Necessary to transport you by air, ground or water, from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or

2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
 - a. from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;
 - b. to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;
 - c. to the nearest more cost-effective acute care facility as determined solely by us; or
 - d. from an acute facility to the nearest cost-effective sub-acute setting.

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

Limitations

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

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

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

Exclusion

Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
 - a. the crew renders aid until a helicopter can be sent;
 - b. the patient refuses care or transport; or
 - c. only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).

5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
 - a. patient wants to be at a certain Hospital or facility for personal/preference reasons;
 - b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment, or for continued treatment, including patients who have recently been discharged from inpatient care; or
 - c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for and/or find such transportation.
6. Air Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Ambulatory Surgical Center

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

1. use of operating and recovery rooms;
2. respiratory therapy such as oxygen;
3. drugs and medicines administered at the Ambulatory Surgical Center (except for take-home drugs);
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as EKG;
10. chemotherapy treatment for proven malignant disease; and
11. other Medically Necessary Services.

Anesthesia Administration Services

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

Exclusion

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

Behavioral Health Services

Mental Health Services

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

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

Exclusion

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Contract, 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 intellectual disabilities;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or for intellectual disabilities;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Contract, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;
8. Services to test aptitude, ability, intelligence or interest;
9. Services required to maintain employment;
10. Services for cognitive remediation; and
11. inpatient stays that are primarily intended as a change of environment.

Substance Dependency Treatment Services

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

Care and treatment for Substance Dependency includes the following:

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

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

Exclusion

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

Breast Reconstructive Surgery

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

Child Cleft Lip and Cleft Palate Treatment

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

Clinical Trials

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

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

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

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

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

Exclusion

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

Concurrent Physician Care

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

1. the additional Physician actively participates in your treatment;
2. the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and
3. the Physicians have different specialties or have the same specialty with different subspecialties.

Consultations

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

Dental Services

Dental Services are limited to the following:

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

Exclusion

1. Dental Services rendered more than 62 days after the date of an Accidental Dental Injury even if the Services could not have been rendered within 62 days.
2. Except as described above and in the Child Cleft Lip and Cleft Palate Treatment category, any dental Service, including, but not limited to: care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dentures, dental implants, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays.

Diabetes Treatment Services

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

1. outpatient self-management training and educational Services when provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology;
2. nutrition counseling provided by a licensed dietitian;
3. equipment and supplies to treat diabetes, such as insulin pumps and tubing; and
Note: Blood glucose meters, lancets and test strips are covered under your pharmacy benefit (see the PRESCRIPTION DRUG PROGRAM section).
4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diagnostic Services

Diagnostic Services may be covered and include the following:

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

Exclusion

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

Dialysis Services

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

Durable Medical Equipment

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

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

Payment Rules for Durable Medical Equipment

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

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

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

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

Exclusion

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

Emergency Services and Urgent Care Services

Emergency Services

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

Payment Rules for Emergency Services

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

1. the amount equal to the median amount negotiated with all Florida Blue In-Network Providers for the same Services;
2. the Allowed Amount as defined in this Contract; or
3. what Medicare would have paid for the Services rendered.

In no event will Out-of-Network Providers be paid more than their charges for the Services rendered.

Urgent Care Services

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

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

Enteral Formulas

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

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

Eye Care and Vision Services

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

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

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

Pediatric Vision Benefits

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

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

1. rendered by an Exclusive Provider, as defined in this Contract;
2. not specifically or generally limited or excluded; and
3. authorized for coverage by us, if prior authorization is required.

Note: The BLUECARD PROGRAM section does not apply to these Services.

Pediatric Vision Benefits are limited to the following:

1. Eye exam including dilation (when professionally indicated), once every Calendar Year.
2. Spectacle lenses, one pair every Calendar Year, including:
 - a. clear plastic single-vision lenses;
 - b. clear plastic lined bifocal, trifocal or lenticular lenses;
 - c. polycarbonate lenses;
 - d. standard progressive lenses;
 - e. plastic photosensitive lenses;
 - f. oversize lenses;
 - g. scratch-resistant coating;
 - h. tinting of plastic lenses; and
 - i. ultraviolet coating.
3. Frames covered by this policy are limited to the Pediatric Frame Selection. The network provider will show you the selection of frames covered by this Contract. If you select a frame that is not included in the Pediatric Frame Selection covered under this Contract, you are responsible for the difference in

cost between the network provider reimbursement amount for covered frames from the Pediatric Frame Selection and the retail price of the frame you selected. Any amount paid to the provider for the difference in cost of a Non-Selection Frame will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum.

4. Elective contact lenses covered by this policy are limited to the Pediatric Contact Lens Selection and includes the evaluation, contact lens fitting and follow-up. The network provider will inform you of the contact lens selection covered by this Contract. If you select a contact lens that is not part of the Pediatric Contact Lens Selection covered under this Contract, you are responsible for the difference in cost between the network provider reimbursement amount for covered contact lenses available from the Pediatric Contact Lens Selection and the retail price of the contact lenses you selected. Any amount paid to the provider for the difference in cost of a Non-Selection Contact Lens will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum.
5. Contact lenses (with prior authorization), when glasses cannot correct your vision properly, includes materials; evaluation; fitting; and follow-up care.

Duplication of Vision Coverage

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

General Eye Care and Vision Exclusions

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

Family Planning

Family planning Services include:

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

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

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

Exclusion

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

Home Health Care

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

1. you are unable to leave your home without considerable effort and assistance because you are bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan to us;
3. the treatment plan has been reviewed and renewed by the prescribing Physician at least every 30 days until benefits are exhausted. (We reserve the right to request a copy of any written treatment plan in order to determine whether such Services are covered under this Contract);
4. the Home Health Care Services are provided by or through a Home Health Agency; and
5. 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 or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse and/or home health aide Services; (part-time is defined as less than eight hours per day and less than 40 hours a week and an intermittent visit will not exceed two hours per day);
2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and provided under the supervision of a Registered Nurse;
3. medical social Services;
4. nutritional guidance;
5. respiratory or inhalation therapy, such as oxygen; and
6. Physical Therapy, by a Physical Therapist, Occupational Therapy, by an Occupational Therapist, and Speech Therapy, by a Speech Therapist.

Exclusion

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

7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

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

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

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

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

Exclusion

1. All expenses for Hospital Services (including the Hospital charges, Physician charges and any other charges related to an inpatient stay) are excluded when Services could have been rendered without admitting you to the Hospital;
2. gowns and slippers;
3. shampoo, toothpaste, body lotions and hygiene packets;

4. take-home Drugs;
5. telephone and television;
6. guest meals or gourmet menus; and
7. admission kits.

Inpatient Habilitative and Rehabilitative Services

Inpatient Habilitative Services

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

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

Inpatient Rehabilitative Services

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

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

Exclusion

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

Mammograms

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

Mastectomy Services

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

Maternity Services

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

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

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

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

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

Medical Pharmacy

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

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

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

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

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

Newborn Care

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

Newborn Assessment

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

Newborn Ambulance Services

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

Orthotic Devices

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

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

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

Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device which meets your medical needs as determined by us.

Exclusion

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) 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, such as dynamic orthotic cranioplasty or molding helmets; except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis.
3. Expenses for devices necessary to exercise, train or participate in sports, such as custom-made knee braces.

Osteoporosis Services

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

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

Outpatient Habilitative Services

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

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 or to keep, learn or improve skills and functioning for Daily Living.

Speech Therapy Services rendered by a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition or to keep, learn or improve skills and functioning for Daily Living.

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 or to keep, learn or improve skills and functioning for Daily Living.

Exclusion

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

Payment Rules for Physical Therapy

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

Outpatient Therapies and Spinal Manipulation Services

Outpatient Therapies

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

Your Schedule of Benefits sets forth the maximum number of visits that we will cover for any combination of the outpatient therapies and spinal manipulation Services listed in this category. For example, even if you have only received two 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 visit maximum with other Services.

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

Occupational Therapy Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition or to keep, learn or improve skills and functioning for Daily Living.

Speech Therapy Services rendered by a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition or to keep, learn or improve skills and functioning for Daily Living.

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 or to keep, learn or improve skills and functioning for Daily Living.

Massage Therapy Services provided by a Physician, Massage Therapist, or Physical Therapist are covered when the Massage Therapy is prescribed as being Medically Necessary for the treatment of an acute illness or injury by a Physician licensed per Florida Statutes Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry). The Physician's Prescription must specify the number of treatments.

Exclusion

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

Payment Rules for Massage and Physical Therapy

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

Spinal Manipulation

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

Payment Rules for Spinal Manipulation

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

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

Oxygen

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

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility. Certain Physician Services can be rendered electronically through a computer via the Internet (E-Visits). E-Visits are covered when rendered in accordance with the Payment Rules below.

Payment Rules for E-Visits

Expenses for E-Visits are covered only if:

1. you are an established patient of the Physician rendering the Services at the time the Services are provided; and
2. the Services are provided in response to an online inquiry you sent to the Physician.

The term “established patient”, as used in this category, shall mean that the covered individual has received professional Services from the Physician who provided the E-Visit, or another Physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

Exclusion

Expenses for failure to keep a scheduled appointment or scheduled E-visit and for telephone consultations (except as indicated as covered under the Preventive Service category of this section) are not covered.

Preventive Services

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

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

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

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

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

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

Exclusion

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

Prosthetic Devices

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

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and Prosthetic Devices incident to a Mastectomy;
2. appliances needed to effectively use artificial limbs or corrective braces; and
3. penile prosthesis and surgery to insert penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

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

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

Exclusion

1. Expenses for microprocessor controlled or myoelectric artificial limbs, such as C-legs;
2. Expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs);and
3. Expenses for cosmetic enhancements to artificial limbs.

Self-Administered Prescription Drugs

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

Skilled Nursing Facilities

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

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

Exclusion

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

Surgical Procedures

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

1. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
2. oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;
3. surgical procedures involving bones or joints of the jaw such as temporomandibular joint (TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and
5. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

Exclusion

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

1. reduction thyroid chondroplasty;
2. liposuction;
3. rhinoplasty;
4. facial bone reconstruction;
5. face lift;
6. blepharoplasty;
7. voice modification surgery;
8. hair removal/hairplasty; or
9. breast augmentation.

Payment Rules for Surgical Procedures

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

Transplant Services

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

1. Bone Marrow Transplant, as defined herein and specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare as described in the most recently published

Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;

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

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

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Contract, such as Experimental or Investigational transplant procedures.
2. Transplant procedures involving the transplantation of any non-human organ or tissue.
3. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
4. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ.
5. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
6. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the 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.
9. Any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

PRESCRIPTION DRUG PROGRAM

Introduction

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

A Formulary list is included in the Care Choices (for HSA plans) Medication Guide (referred to as “Medication Guide”), where you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs, Covered OTC Drugs and Specialty Drugs. You may be able to reduce your out-of-pocket expenses by: 1) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; 2) choosing Generic Prescription Drugs rather than Brand Name Prescription Drugs; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

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

Covered Drugs and Supplies

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

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
2. dispensed by a Pharmacist at an Exclusive Pharmacy;
3. Medically Necessary, as defined in this Contract and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;
4. in the case of a Self-Administered Injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a Covered Self-Administered Injectable Prescription Drug;
5. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide;
6. a Prescription Drug contained in an anaphylactic kit;
7. authorized for coverage by us, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
8. not specifically or generally limited or excluded herein;
9. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs;

10. reviewed by our Pharmacy and Therapeutics Committee; and
11. within the Coverage and Benefit Guidelines category listed in this section.

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

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

Cost Share Tiers

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

Tier 1: Preventive Prescription Drugs and Supplies.

Tier 2: Condition Care HSA Preventive Generic Prescription Drugs and Supplies.

Tier 3: All Other Generic Prescription Drugs and Supplies.

Tier 4: Condition Care HSA Preventive Brand Name Prescription Drugs and Supplies.

Tier 5: Preferred Brand Name Prescription Drugs and Supplies.

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

Tier 7: Specialty Generic and Brand Name Prescription Drugs and Supplies.

Condition Care Rx Program

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

Preventive Medications

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

Coverage and Benefit Guidelines

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

Contraceptive Coverage

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

Preferred Generic Prescription oral contraceptives (including generic emergency contraceptives) and diaphragms indicated as covered in the Medication Guide, are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at an Exclusive Pharmacy.

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

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

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

Covered Over-the-Counter (OTC) Drugs

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

Diabetic Coverage

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

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

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

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

Mineral Supplements, Fluoride or Vitamins

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

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

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

Exclusion

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

Specialty Pharmacy Split Fill Option

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

Exception Process

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

Pharmacy Program Limitations and Exclusions

Limitations

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

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

4. Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids such as Retin-A and their generic or therapeutic equivalents are excluded after age 26.
6. We reserve the right to cover the Biosimilar Prescription Drug as an alternative to coverage of the referenced Brand Name Prescription Drug.

Exclusions

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

- l. prescribed by any health care professional not licensed in any state or territory of the United States of America, such as Puerto Rico, U.S. Virgin Islands or Guam;
- m. OTC Drugs not listed in the Medication Guide; and
- n. Self-Administered Injectable Prescription Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

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

- 8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines subsection.
- 9. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.
- 10. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs and Supplies subsection.
- 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 your particular cancer in a Standard Reference Compendium or recommended for such treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of your particular cancer that have not been approved for any indication are also excluded.
- 12. Drugs that have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce.
- 13. Drugs that are compounded, even when one or more active ingredients are Covered Prescription Drugs under this section.
- 14. Drugs and Supplies purchased from an Out-of-Network Pharmacy, except for Emergency Services or when authorized in advance by us.
- 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 the American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or
 - c. we, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.
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 the:
- a. American Medical Association;
 - b. National Heart Lung and Blood Institute;
 - c. American Cancer Society;
 - d. American Heart Association;
 - e. National Institutes of Health;
 - f. American Gastroenterological Association; or
 - g. Agency for Health Care Policy and Research;
- unless we, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.
17. Any amount you are required to pay under the Pharmacy Program as indicated on the Schedule of Benefits.
18. Any benefit penalty reductions.
19. Drugs or Supplies you prescribe to yourself or that are prescribed by any person related to you by blood or marriage.
20. Food or medical food products, whether prescribed or not.
21. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:
- a. the Drug is a Repackaged Drug;
 - b. the Drug is no longer marketed;
 - c. the Drug has been shown to have excessive adverse effects and/or safer alternatives;
 - d. the Drug or an effective alternative is available Over-the-Counter (OTC);
 - e. the Drug has a preferred formulary alternative;

- f. the Drug has a widely available/distributed AB rated generic equivalent formulation;
- g. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or
- h. the number of members affected by the change.

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

22. New Prescription Drug(s).

23. We reserve the right not to apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

Payment Rules

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

1. the participation status of the Pharmacy where purchased (i.e., Exclusive Pharmacy versus Out-of-Network Pharmacy);
2. the terms of our agreement with the Pharmacy selected;
3. whether you have satisfied any Deductible and the amount of Copayment or Coinsurance as set forth in the Schedule of Benefits;
4. the assigned Cost Share tier;
5. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and
6. If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
 - a. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the Cost Share amount that applies to Non-Preferred Prescription Drugs as indicated in your Schedule of Benefits; **and**
 - b. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received.

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

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.

Pharmacy Participation Status

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

Exclusive Pharmacies

Exclusive Pharmacies are Pharmacies participating in the BlueSelect Pharmacy Program which include:

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

The Pharmacy must be participating in the BlueSelect Pharmacy Program at the time Covered Prescription Drugs and Supplies and/or Covered OTC Drugs are purchased by you to be considered an Exclusive Pharmacy. Exclusive Pharmacies have agreed not to charge, or collect from, you, more than the amount set forth in the Schedule of Benefits for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug.

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

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

When charges for Covered Prescription Drugs, and Supplies or Covered OTC Drugs by an Exclusive Pharmacy are less than the required Copayment, the amount you pay will depend 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 an Exclusive Pharmacy;
2. The charge under the Pharmacy's agreement with us; or
3. The Copayment, if less than the usual and customary charge of such Pharmacy.

Specialty Pharmacy

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

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

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

Mail Order Pharmacy

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

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

Out-of-Network Pharmacies

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

An Out-of-Network Pharmacy is a Pharmacy that has not agreed to participate in our BlueSelect Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

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

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

Pharmacy Utilization Review Programs

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

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

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

Our pharmacy utilization review programs include the following:

Responsible Steps Program

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

Your Physician must contact us to request coverage for a Prescription Drug that is part of the responsible steps program prior to prescribing the Drug. In order to be covered, such Prescription Drugs and OTC Drugs prescribed by your Physician, we must receive written documentation from your Physician that the

designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Responsible Quantity Program

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

Prior Authorization Program

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

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

Information on our pharmacy utilization review programs is published in the Medication Guide which can be accessed at www.floridablue.com or you may call the customer service phone number on your ID Card. Your Pharmacist may also tell you if a Prescription Drug or OTC Drug requires prior coverage authorization.

Ultimate Responsibility for Medical Decisions

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

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

Quality Assurance

Quality assurance is a formal methodology and set of activities designed to assess the quality of Health Care Services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy identified deficiencies and evaluation of actions taken. We have a quality assurance program in place to assess the Services of Exclusive Pharmacies.

WHAT IS NOT COVERED?

Introduction

The following exclusions are in addition to any that are specified in the WHAT IS COVERED? and PRESCRIPTION DRUG PROGRAM sections, including any Endorsement that is a part of this Contract.

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

Exclusions

Abortions that are elective.

Ambulance Services for situations that are not Medically Necessary because they do not require ambulance transportation including but not limited to:

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

Air Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

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

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

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

1. Mental health Services which are (a) rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Contract, regardless of the underlying cause, or effect, of the disorder; (b) for psychological testing associated with the evaluation and diagnosis of learning disabilities or for intellectual disabilities; (c) beyond the period necessary for evaluation and diagnosis of learning disabilities or for intellectual disabilities; (d) for educational purposes; (e) for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Contract, regardless of the underlying cause, or effect, of the disorder; (f) for pre-marital counseling; (g) for court ordered care or testing, or required as a condition of parole or probation; (h) to test aptitude, ability, intelligence or interest; (i) required to maintain employment; (j) for cognitive remediation, and (k) inpatient stays that are primarily intended as a change of environment.
2. Long-term Services for alcoholism or drug addiction, including specialized inpatient units or inpatient stays that are primarily intended as a change of environment.

Clinical Trial expenses including:

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

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

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition which arises as a complication of a non-Covered Service, such as treatment for a complication of cosmetic surgery.

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

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual, including and without limitation: cosmetic surgery and procedures or Supplies to correct hair loss or skin wrinkling such as Minoxidil, Rogaine, Retin-A and hair implants/transplants, or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid

chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, and breast augmentation.

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

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

Dental Services rendered more than 62 days after the date of an Accidental Dental Injury even if the Services could not have been rendered within 62 days.

Except as described above and in the Child Cleft Lip and Cleft Palate Treatment category, any dental Service, including, but not limited to: care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dentures, dental implants, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays.

Drugs

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

7. Blood or blood products used to treat hemophilia, except when provided to you for:
 - a. emergency stabilization;
 - b. during a covered inpatient stay, or
 - c. when proximately related to a surgical procedure.

The exceptions to the exclusion for Drugs purchased or dispensed by a Pharmacy described in exclusion two above, do not apply to hemophilia Drugs excluded under this subparagraph.

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

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

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

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

16. Insurance for contact lenses.

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

Foot care (routine), including any Service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, corns, or calluses, unless determined by us to be Medically Necessary. This exclusion does not apply to Services otherwise covered under the Diabetes Treatment Services category in the WHAT IS COVERED? section.

General Exclusions include, but are not limited to:

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

9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Contract.
10. Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
11. any Health Care Service subject to an Exclusive Provider Provision rendered or supplied by or through any Provider other than the Provider designated solely by us, as the Exclusive Provider or Exclusive Pharmacy of such Services, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition. Please refer to your Schedule of Benefits to determine which Services are subject to an Exclusive Provider Provision.
12. Expenses for completion of any form and /or medical information or for copies of your records or charts including any costs associated with forwarding or mailing copies of your records or charts.

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

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

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

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

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

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

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

Inpatient Rehabilitative Services including all inpatient Rehabilitative Services for Pain Management and respiratory ventilator management Services.

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

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

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

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

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

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

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

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

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

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

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

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

Private Duty Nursing Care rendered at any location.

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

1. expenses for microprocessor controlled or myoelectric artificial limbs, such as C-legs;
2. expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs);
3. expenses for cosmetic enhancements to artificial limbs; and
4. penile prosthesis and surgery to insert penile prosthesis except when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

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

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

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

Telephone Consultations

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

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

1. Transplant procedures not included in the Transplant Services category of the WHAT IS COVERED? section, or otherwise excluded under this Contract, such as Experimental or Investigational transplant procedures.
2. Transplant procedures involving the transplantation of any non-human organ or tissue.
3. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
4. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ.
5. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
6. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the 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.
9. Any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

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

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

Weight Control Services including any Service to lose, gain or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

Wigs and/or cranial prosthesis.

MEDICAL NECESSITY

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

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

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

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

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

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

YOUR SHARE OF HEALTH CARE EXPENSES

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

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. **YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.** Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

Deductibles

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

Rules for applying charges to deductibles:

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

Overall Deductible (DED)

This deductible applies to most of the Covered Services on your plan before we begin to pay for Covered Services. When we talk about this type we just call it "Deductible" and on the Schedule of Benefits "DED". Some Covered Services, such as Preventive Services, do not apply the Deductible when you use In-Network Providers, so be sure to look at your Schedule of Benefits. After the Deductible has been met, neither you nor your Covered Dependents (if any) will have any additional Deductible amount for the rest of that Calendar Year. The Deductible starts over every year on January 1st.

There are individual and family Deductibles, both of which apply on a Calendar Year basis:

Individual Calendar Year Deductible

If you are the only person on your plan, you only have to reach the individual Deductible and the family Deductible listed on your Schedule of Benefits does not apply to you. This amount, when applicable,

must be satisfied by you each Calendar Year before any payment will be made by us. If more than one person is on your plan, the amount each person has to reach depends on the type of family Deductible described below.

Family Calendar Year Deductible

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

Embedded Deductible

If your Schedule of Benefits indicates that the Deductible is embedded, each Covered Person only needs to satisfy the individual Deductible and not the entire family Deductible, prior to us paying for Covered Services for that Covered Person. We will not begin to pay for Covered Services for the other family members until they either satisfy the individual Deductible or until the family Deductible is met. The family Deductible is met when any combination of family members' costs for Covered Services meets the family Deductible limit. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward that person's individual Deductible.

Shared Deductible

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

Copayments

A Copayment is a fixed dollar amount you must pay when you receive certain Covered Services. Listed below are the different types of Copayments and a brief explanation of how they work. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you will pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service. Not all plans have Copayments, so be sure to look at your Schedule of Benefits.

Copayments:

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

Office Services Copayment

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

Inpatient Facility Services Copayment

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

Outpatient Facility Services Copayment

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

Note: Copayments for outpatient facility Services may vary depending on the type of facility chosen and the Services received. Please see your Schedule of Benefits for more information. If your plan includes a Copayment for emergency room Services and you are admitted to the Hospital as an inpatient at the time of the emergency room visit, this Copayment will be waived, and you will pay the Cost Share that applies to inpatient facility Services.

Coinsurance

Coinsurance is a percentage of our Allowed Amount that you must pay before we will pay our portion of the Allowed Amount for Covered Services. The Coinsurance percentage is figured after all other Cost Share amounts for a given Service, such as Deductible. Not all plans have Coinsurance, so be sure to look at your Schedule of Benefits.

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

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

Application of Multiple Cost Share Types

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

Remember that when you use Out-of-Network Providers, your Cost Share amounts only apply to the Allowed Amount. Any Out-of-Network Provider charges over the Allowed Amount are not covered and do not count towards your Cost Share or Out-of-Pocket Maximums.

Out-of-Pocket Maximums

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

Individual Calendar Year Out-of-Pocket Maximum

If you are the only person on your plan, only the individual out-of-pocket maximum applies to you and the family out-of-pocket maximum listed on your Schedule of Benefits does not apply to you. After you have reached the individual out-of-pocket maximum, you will have no additional Cost Share for the rest of that Calendar Year and we will pay 100 percent of our Allowed Amount for Covered Services rendered during the rest of that Calendar Year. If more than one person is on your plan the amount each person has to reach depends on the type of out-of-pocket maximum described below.

Family Calendar Year Out-of-Pocket Maximum

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

Embedded Out-of-Pocket Maximum

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

Shared Out-of-Pocket Maximum

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

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

- Premium amounts you must pay;
- charges for Services that are not covered;
- charges that are in excess of our Allowed Amount; and
- any benefit penalties.

How We Will Credit Benefit Maximums

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

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Deductible or out-of-pocket maximums met by you under a prior Florida Blue Contract maintained by you that is replaced with this Contract during the Calendar Year. This provision only applies if the prior coverage purchased by you was in effect immediately preceding the Effective Date of this Contract.

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

Special Rule for Capitated Providers

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

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

Additional Expenses You Must Pay

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

1. charges in excess of any maximum benefit limitation listed in your Schedule of Benefits;
2. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;

3. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;
4. any benefit reductions/benefit penalties;
5. charges for Health Care Services which are non-Covered Services or excluded;
6. the Premium applicable to your Contract; and
7. charges incurred for Services you receive that are subject to an Exclusive Provider Provision rendered by or through any Provider other than the Provider designated solely by us, as the Exclusive Provider or Exclusive Pharmacy for such Services, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition.

HEALTH CARE PROVIDER OPTIONS

Introduction

This Contract was designed to help make health care more affordable by combining Exclusive Providers for select types of Health Care Services and Preferred Providers for other Health Care Services. It is important that you understand how the Providers you choose to use for medical care and the type of Service you receive will affect how much you have to pay for medical Services. This section explains payment rules when receiving Covered Services from different types of Providers under this Contract. This section does not include the specific Cost Share amounts under your plan; as you read this section, please keep in mind that you will have to check your Schedule of Benefits for those details. For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

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

In-Network Providers

BlueSelect Providers are the In-Network Providers under this Contract. You should use BlueSelect Providers whenever possible to reduce your out-of-pocket expenses. Using BlueSelect Providers will result in significant savings. There are two types of In-Network BlueSelect Providers: Exclusive Providers and Preferred Providers.

1. Exclusive Providers

In order to be covered, certain Health Care Services must be rendered by the Exclusive Provider designated solely by us, as the Exclusive Provider for the particular Service, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition. Please refer to your Schedule of Benefits to determine which Services are subject to an Exclusive Provider Provision.

2. Preferred Providers

For all other Services not subject to an Exclusive Provider Provision, we have entered into contracts with certain Providers to participate as Preferred Providers. You are entitled to preferred provider type benefits when you receive Covered Services from Preferred Providers.

Remember that using In-Network Providers will result in lower Cost Share for you. You should always check to see whether a Provider is In-Network or Out-of-Network, or whether the Service is subject to an Exclusive Provider Provision before you receive Services to find out how much of the cost you will have to pay.

We encourage you to select and develop a relationship with an In-Network Primary Care Physician. There are several advantages to selecting a Primary Care Physician. (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians):

- Primary Care Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs.
- Developing and continuing a relationship with a Primary Care Physician allows the Physician to become knowledgeable about you and your family's health history.
- A Primary Care 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 health care needs.
- Care rendered by Primary Care Physicians usually results in lower Cost Share for you.

You are responsible for checking to see if a Provider is In-Network for your plan prior to receiving Services. To find out if a Provider is in our provider network you can access the current BlueSelect Provider directory on your member account at www.floridablue.com or call the customer service phone number on your ID Card.

Out-of-Network Providers

For all services not subject to the Exclusive Provider Provision, when you use Out-of-Network Providers your Cost Share 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 Traditional Program Provider, our payment to such Provider may be under the terms of that Provider's contract. If your Schedule of Benefits and BlueSelect Provider directory do not include a Provider as In-Network under your benefit plan, the Provider is considered Out-of-Network. Remember that Services subject to an Exclusive Provider Provision, as identified on your Schedule of Benefits, are not covered when rendered by Out-of-Network Providers, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition.

You are entitled to Traditional Program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard Traditional Program Providers, in conformity with the BLUECARD PROGRAM section.

Accessing Services Outside the Service Area

In most instances, Services subject to an Exclusive Provider Provision, as identified on your Schedule of Benefits, must be provided by BlueSelect Exclusive Providers that are generally found within the Service Area. If, however, you are traveling outside the Service Area and need Emergency Services to treat an Emergency Medical Condition and BlueSelect Exclusive Providers are not reasonably available to provide Services subject to an Exclusive Provider Provision, we will cover such Services as if they had been provided by an Exclusive Provider.

Understanding Your Provider Options

| Provider Type | What benefit level is applied? | Who will file your claims? | Who is responsible for admission notification? | Are EPP ¹ Services Covered with this Provider? | Will I have to pay the difference between the billed amount and the Allowed Amount for Covered Services? |
|--------------------------------------|--|---|--|---|--|
| BlueSelect Exclusive Provider | In-Network – the highest level of coverage available. | The Provider will file claims for you. | The Provider | YES | NO |
| BlueSelect Preferred Provider | In-Network – the highest level of coverage available. | The Provider will file claims for you. | The Provider | NO | NO |
| BlueCard Provider | In-Network – when outside the state of Florida | The Provider will file claims for you. | The Provider ² | NO | NO ³ |
| Traditional Program Provider | Out-of-Network – you will share more of the cost. | The Provider will file claims for you. | The Provider ² | NO | NO |
| Out-of-Network Provider | Out-of-Network – the lowest level of coverage; you will share more of the cost. | You may have to file your claims. | You should notify us of inpatient admissions. | NO | YES |

1. “EPP” refers to Services that are subject to an Exclusive Provider Provision.
2. For Services rendered by an In-Network Provider located outside of Florida, you should notify us of inpatient admissions.
3. Please refer to the BLUECARD PROGRAM section for more information.

Provider Financial Incentive Disclosure

Health care decisions are the shared responsibility of you, your family, and your health care Providers. A Provider's decisions regarding Health Care Services may have a financial impact on you and/or the Provider. For example a Provider in his or her contract with us may agree to accept financial

responsibility for your Health Care Services. We encourage you to talk to your Providers about how, and to what extent, the acceptance of financial risk by the Provider may affect his or her Health Care Service decisions.

Location of Service

The location or setting where you receive Services can also affect the amount you pay. For example, the amount you must pay will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. 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 Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

Physicians

When you receive Covered Services from a Physician, several factors will determine your Cost Share, including whether the Physician is In-Network or Out-of-Network, the location of service, the type of Service rendered, whether the Physician participates in certain Florida Blue programs, and the Physician's specialty (as determined by us).

Blue Physician Recognition Providers

A Physician with the Blue Physician Recognition (BPR) designation means the Physician has shown a commitment to delivering quality and patient-centered care by participating in certain Florida Blue programs, such as the Patient Centered Medical Home (PCMH), Comprehensive Primary Care (CP2) or an Accountable Care arrangement. The BPR designation does not serve as a measure of the quality of care rendered by a Physician or whether the Physician will meet your health care needs. Absence of a BPR designation does not mean the Physician is of low quality. It simply means that the Physician does not participate in one of these programs. BPRs are listed in the provider directory with a special symbol. The Cost Share for Services rendered by a BPR is listed on your Schedule of Benefits.

Hospitals

Each time you receive inpatient or outpatient Covered Services at a Hospital, in addition to any Cost Share for Physician Services, you will have to pay the Cost Share related to Hospital Services.

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

Specialty Pharmacy

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

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

Other Providers

With BlueSelect you have access to other Providers in addition to the ones described in this section. Other Providers include facilities that provide alternative outpatient settings or other persons and entities that specialize in specific Services. While these Providers may be recognized for payment, they may not be In-Network Providers for your plan. Also, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Contract. Please refer to the WHAT IS COVERED? and WHAT IS NOT COVERED? sections of this Contract and your Schedule of Benefits to find out what your Cost Share may be for Covered Services rendered by these Providers.

You may be able to receive certain outpatient Services at a location other than a Hospital. Your Cost Share for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Assignment of Benefits to Providers

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

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

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is an In-Network Provider under your plan of coverage; 2) is a Traditional Program Provider; 3) is a BlueCard PPO Program Provider; 4) is a BlueCard Traditional Program Provider; or 5) when applicable honor an assignment of your right to receive payment for Covered Services to an Out-of-Network Provider in accordance with Section 627.638(2) Florida Statutes or other applicable statute then in effect. A written attestation of the assignment of benefits may be required.

Quality Assurance

Quality assurance is a formal methodology and set of activities designed to assess the quality of Health Care Services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy identified deficiencies and evaluation of actions taken. We have a quality assurance program in place to assess the Services of Exclusive Providers.

BLUECARD® PROGRAM

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside Florida, you obtain care from Providers that have a contractual agreement (“Participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from Providers in the Host Blue geographic area that do not have a contractual agreement (“Nonparticipating Providers”) with the Host Blue. We remain responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard Program

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when you access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of your liability on claims for Covered Services will be based on the lower of the Participating Provider's billed charges for Covered Services or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue’s Provider contracts. The negotiated price made available to us by the Host Blue may be represented by one of the following:

1. **An actual price.** An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
2. **An estimated price.** An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

- 3. An average price.** An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by you is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by us in determining your premiums.

Special Cases: Value-Based Programs

We have included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under this Contract. Additional information is available upon request.

Return of Overpayments

Recoveries from a Host Blue or its Participating and Nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to us, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee in determining your premium.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of his Contract.

BlueCard Worldwide® Program

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

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if you paid in full at the time of Service, you must submit a claim to obtain reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center address on the form to initiate claims processing. The claim form is available from the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submissions, you should call the BlueCard Worldwide Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

BLUEPRINT FOR HEALTH PROGRAMS

Introduction

We have established (and from time to time establish) various customer-focused health education and information programs and benefit utilization management and utilization review programs. We call all these programs Blueprint for Health Programs. The Blueprint for Health Programs, are designed to:

- 1) provide you with information that will help you make more informed decisions about your health;
- 2) help us facilitate the management and review of coverage and benefits provided under our policies; and
- 3) present opportunities, as explained below, for you and us to agree upon alternative benefits or payments for cost-effective medically appropriate Health Care Services.

Admission Notification

Our admission notification rules vary depending on whether you are admitted to a Hospital, Psychiatric, Substance Abuse, Hospice, Inpatient Rehabilitation, Long Term Acute Care (LTAC) or Skilled Nursing Facility which is In-Network or Out-of-Network. To find out if a Provider is in our network, you can:

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

In-Network

We must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospital, Psychiatric, Substance Abuse, Hospice, Inpatient Rehabilitation, LTAC and Skilled Nursing Facilities. In-Network Providers located in Florida have agreed to notify us of your admission; however, you should ask the facility if we have been notified of your admission. For an admission outside Florida, you or the facility should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the facility may notify us of your admission by calling the customer service phone number on your ID card.

Out-of-Network

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

Inpatient Facility Program

We may review Hospital stays, Hospice, Inpatient Rehabilitation, LTAC and 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, after your discharge, or as part of a review of an episode of care when you are transferred from one level of inpatient care to another for ongoing treatment. This review is conducted solely to determine whether a particular admission or Health Care Service rendered during that admission is covered under this Contract. Using our established criteria

then in effect, a concurrent review of the inpatient stay may occur at regular intervals, including before a transfer from one inpatient facility to another. We will let your Physician know when inpatient coverage criteria are no longer met. As a part of this program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Contract and not for the purpose of recommending or providing medical care.

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

Provider Focused Utilization Management Program

Certain BlueSelect 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 BlueSelect Providers. Under this program we may review all or only specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit specific medical information to us relating to Health Care Services proposed for you. These BlueSelect 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 determine from our review under the focused utilization management program that a Health Care Service is not Medically Necessary in accordance with our Medical Necessity criteria or is inconsistent with our benefit guidelines then in effect unless the following exception applies.

Exception for Certain BlueSelect Physicians

Certain BlueSelect 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 us under this focused utilization management program if, **before** you receive the Service:

- a. they give you a written estimate of what you will have to pay for the Service;
- b. they specifically identify the proposed Service that we have determined not to be Medically Necessary; and
- c. you agree to pay for such Services.

Prior Coverage Authorization/ Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these rules and ultimately how much you will have to pay under this Contract.

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

1. **Prescription Drugs**, as denoted with a special symbol in the Medication Guide;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging; and
3. **Medically Necessary Contact Lenses** as indicated in the Eye Care and Vision Services category of the WHAT IS COVERED? section;
4. Services rendered in connection with **Approved Clinical Trials**; and
5. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as then defined and administered by us.

You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

1. In the case of **Prescription Drugs**, it is your sole responsibility to obtain prior coverage authorization when you use a Provider **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, we will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

All Prescription Drugs covered under the Medical Pharmacy category in the WHAT IS COVERED? section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

2. In the case of **advanced diagnostic imaging Services** such as CT scans, MRIs, MRA and nuclear imaging, you must obtain an authorization when rendered or referred by a Provider **before** the advanced diagnostic imaging Services are provided. **If you do not obtain prior coverage authorization we will deny coverage for the Services and not make any payment for such Services.**

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

3. In the case of Services rendered in connection with **Approved Clinical Trials**, you must obtain an authorization when rendered or referred by a Provider **before** you obtain routine patient care provided in connection with an Approved Clinical Trial. **If you do not obtain prior coverage authorization we will not make any payment for such Services.**
4. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

If you do not obtain authorization or provide pre-service notification, we may:

1. deny payment of the claim; or
2. apply a benefit penalty when the claim is presented to us for payment consisting of one of the following:
 - a. \$500;
 - b. 20% of the total Allowed Amount of the claim; or
 - c. the lesser of \$500 or 20% of the total Allowed Amount of the claim.

The decision to apply a penalty or deny the claim will be made uniformly and the applicable denial/penalty will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

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

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

See the APPEAL AND GRIEVANCE PROCESS section for information on what you can do if prior coverage authorization is denied.

Member Focused Programs

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

Personal Case Management Program

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

Under the personal case management program, we may elect to offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by

us on a case-by-case basis when you meet our case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing.

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

Health Information, Promotion, Prevention and Illness Management Programs

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

IMPORTANT INFORMATION RELATING TO OUR BLUEPRINT FOR HEALTH PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and the responsibility of your health care Providers. You and your Providers are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. We are solely responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Contract. In fulfilling this responsibility, we will not be deemed to participate in or override the medical decisions of your health care Provider.

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

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

PAYMENT OF PREMIUMS

This Contract is not enforceable, and your coverage is not effective until we receive and accept the Contractholder's application and the first Premium payment, in full. All future Premium payments are due, in full, in advance or within the Grace Period. The amount of your initial monthly Premium is printed on the front page of this Contract. If we do not, for any reason, provide you with a notice of payment due, you, as the Contractholder, are still obligated under this Contract to pay Premiums on time, even if you do not receive a bill from us. You, as the Contractholder, are solely responsible for submitting the Premium to the address indicated on the bill by the end of the Grace Period.

If we accept Premium for a Covered Dependent for a period of time after such dependent no longer meets the eligibility rules, coverage for such dependent will continue during the Grace Period for which an identifiable Premium was accepted, unless such acceptance resulted from a misstatement of age or residence.

Premium payments from third-party payors, except those required by law and indicated below, may not be accepted:

1. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. An Indian tribe, tribal organization, or urban Indian organization;
3. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf;
4. Private, not-for-profit foundations if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status, do not consider enrollees' health status and are determined acceptable to us; or
5. From a designated representative acceptable to us. This includes, but is not limited to, immediate family members, domestic partners, or individuals holding a properly executed power of attorney (POA) who make payments out of your accumulated funds on your behalf.

Premium Payment Due Date

The first Premium payment is due before the Effective Date of this Contract.

For applications received on or before the 15th calendar day of the month, the initial Premium payment must be received, in full, by the last calendar day of the month of application, in order for the contract effective date to be the first calendar day of the of the following month.

For applications received after the 15th calendar day of the month, the initial Premium payment must be received, in full, by the last calendar day of the month following the month of application, in order for the Contract Effective Date to be the first calendar day of the second month following the month of application.

In the event that the initial Premium payment is dishonored, your coverage will not be effective and we will not enroll you in coverage.

Each recurring monthly Premium payment, following the initial Premium payment, is due in full on or before the due date as stated on your monthly bill.

Grace Period

This Contract has a Premium payment Grace Period which begins on the date the Premium payment is due. If any required Premium payment is not received by us on or before the due date, it may be paid during this Grace Period. The length of the Grace Period depends on whether or not you are receiving Advanced Payments of the Premium Tax Credit (APTC) as determined by the Marketplace.

If you DO receive APTC

The Grace Period is three months, as long as you have paid at least one month's Premium. We will pay all claims for Covered Services during the first month of the Grace Period. During months two and three of your Grace Period we may pend any claims incurred and received during months two and three. If we do not receive your Premium payments in full by the end of the Grace Period your coverage will terminate as of the last day of the first month of the Grace Period. Any pended claims will be denied and you will be responsible for payment of the claims.

If you DO NOT receive APTC

The Grace Period is 31 days. Coverage will stay in force during the Grace Period, however; if Premium payments are not received by the end of the Grace Period, coverage will terminate as of the Premium due date.

Partial Payments

When we bill you for different kinds of coverage, products and/or services on the same bill (such as health insurance and dental insurance) and you pay less than the total amount of the bill, the way we credit your partial payment may affect your coverage.

We have established the order in which your partial payment will be applied to the different kinds of coverage, products and/or services, which is outlined on your bill. By accepting this coverage, you agree that partial payments will be applied in the order indicated on your bill.

Changes in Premiums

The Premium may be modified each year on the Anniversary Date due to changes in the Rates. We will provide at least 45 days prior notice to the Contractholder. If you send us any payments after you receive the notice of change to your Premium, this means you, as the Contractholder, agree to the Premium changes.

In addition to the Anniversary Date changes discussed above, your Premium may change if the Risk Class of you or any Covered Dependent changes, or if the number of individuals covered under this Contract changes. For example, the Premium may change if you move to a different geographical area.

Defaults in Payments

If all Premiums required under this Contract are not paid in full when they are due, this Contract will terminate as described in this section. However, even if your coverage is terminated for non-payment, you, as the Contractholder are still obligated under this Contract to pay us any prorated portion of the Premium for the period of time during which we provided benefits, or for any amounts otherwise due us.

ELIGIBILITY AND ENROLLMENT FOR COVERAGE

Any person who meets and continues to meet the eligibility rules described in this Contract, is entitled to apply for coverage with us under this Contract. These eligibility rules are binding upon you and your eligible dependents. We may require acceptable documents proving that a person meets and continues to meet the eligibility requirements, such as a court order naming the Contractholder as the legal guardian or appropriate Adoption documents described in this section.

Contractholder Eligibility

In order to be eligible to apply for coverage as a Contractholder, you must:

1. meet the requirements for enrollment and eligibility in the Marketplace;
2. live or reside in the Service Area;
3. apply for coverage under, and be named on, the application for this Contract; and
4. pay the required Premiums.

Dependent Eligibility

A person who meets the residency standards required by the Marketplace and meets the eligibility criteria specified below is eligible to apply for coverage under this Contract as an Eligible Dependent only if the person: 1) was named on the initial application for, or properly enrolled under, this Contract; 2) pays the required Premium; and is:

1. The Contractholder's spouse under a legally valid existing marriage;
2. The Contractholder's present Domestic Partner;
3. The Contractholder's or Covered Domestic Partner's natural, newborn, Adopted, Foster or step child (or a child for whom the Contractholder or Covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30, regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan;
4. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

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

Extension of Eligibility for Dependent Children

A Covered Dependent child may continue coverage beyond the age of 30, provided he or she maintains his or her primary residence in the Service Area and is enrolled in the plan at the time he or she reaches age 30.

Children with Disabilities

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

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

Other Eligibility Rules

1. No person whose coverage with us has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll with us.
2. No person shall be refused enrollment or re-enrollment because of race, color, national origin, disability, sex, age, creed, marital status, gender, gender identity or sexual orientation (except as provided in this section).
3. The Contractholder must notify the Marketplace and Florida Blue as soon as possible when a Covered Dependent is no longer eligible for coverage. If a Covered Dependent fails to continue to meet each of the eligibility requirements, and the Contractholder does not provide timely notice to the Marketplace and Florida Blue we shall have the right to:
 - a. retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met; and
 - b. recover an amount equal to the Allowed Amount for Health Care Services and/or supplies provided after such date, less any Premium we received for such dependent for coverage after such date.

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

General Rules for Enrollment

1. Any person who is not properly enrolled with us through the Marketplace will not be covered under this Contract. We will have no obligation whatsoever to any person who is not properly enrolled.
2. All factual representations made by you to Florida Blue and the Marketplace in writing in connection with the issuance of this Contract and enrollment hereunder must be accurate and complete. Any false, incomplete or misleading information provided during the enrollment process, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right we may have, we may terminate or Rescind your coverage.
3. We will not provide coverage or benefits to any person who would not have been eligible to enroll with us, had accurate and complete information been provided to us on a timely basis. In such cases, we may require you or a person legally responsible for you, to reimburse us for any payments we made on your behalf.

4. Eligibility for coverage under this Contract is determined by the Risk Class applicable to you and your dependents. In determining eligibility for coverage under this Contract, we rely on the information provided by you prior to your enrollment.
5. You agree that if you obtain coverage through the Marketplace we may rely on information provided to us on your behalf as if they are “you” for administrative purposes including but not limited to eligibility and member data.
6. If, in applying for this Contract or in enrolling yourself or dependents you commit fraud or make an intentional misrepresentation of material fact, we may Rescind your coverage. After two years from your Effective Date your Contract may only be Rescinded for fraudulent misstatements. If, in applying for this Contract or in enrolling yourself or dependents, you make a fraudulent statement or intentional misrepresentation of a material fact including but not limited to, your demographic information including your geographical area, age, or the age of your dependents, we may elect to cancel the Contract with 45 days prior written notice. We may also elect to continue this Contract provided that the Contractholder pays us for the full amount of the Premium that would have been in effect if you had stated the true facts.

How to Enroll in Coverage

To enroll in coverage, you must:

1. complete and submit an application through the Marketplace during the Annual Open Enrollment Period or during a Special Enrollment Period;
2. provide any other information the Marketplace or Florida Blue may need to determine eligibility, at our request or the request of the Marketplace;
3. agree to pay the required Premium; and
4. complete and submit the required Enrollment Forms through the Marketplace during the Annual Open Enrollment Period or a Special Enrollment Period to add Eligible Dependents or delete Covered Dependents.

Annual Open Enrollment Period

The Annual Open Enrollment Period is the period of time each year, as designated by the Marketplace, when you can change coverage or enroll in a new QHP through the Marketplace. Any changes made to your coverage during the Annual Open Enrollment Period can be effective as early as January 1st. If you do not enroll or change coverage during the Annual Open Enrollment Period you will need to wait until the next Annual Open Enrollment Period unless you or your Eligible Dependents are eligible for a Special Enrollment Period.

Special Enrollment Periods

If you experience a life or special enrollment event as determined by the Marketplace you may be eligible to apply for coverage outside of the Annual Open Enrollment Period. A Special Enrollment Period is the period of time immediately before or after one of these life or special events, as determined by the Marketplace. The Effective Date of your new coverage will depend on what type of special event occurred.

To apply for coverage, you must complete the applicable Enrollment Form and submit it to the Marketplace within the Special Enrollment Period. The Marketplace will determine whether you qualify for a Special Enrollment Period, the length of the Special Enrollment Period and your Effective Date.

Special enrollment events are established by state and federal law . Below are examples of special enrollment events. This is not intended to be a complete list. For more detailed information on what qualifies for a Special Enrollment Period go to www.HealthCare.gov.

- Loss of minimum essential coverage (e.g., job loss, divorce, aging off parents' plan); or
- Gaining a dependent (e.g., marriage, having a baby, Adoption or placement for Adoption or foster care).

Additional Rules for Dependent Enrollment

A person may be added upon becoming an Eligible Dependent during a Special Enrollment Period. Below are special rules for certain Eligible Dependents.

Newborn Children – To enroll a newborn child who is an Eligible Dependent, you must complete and submit any required Enrollment Forms. The Effective Date of coverage for a newborn child is usually the date of birth as long as you have enrolled the newborn child in time (as indicated below). We and the Marketplace must be notified, in writing, when you are adding a newborn and the rules for Effective Date and Premiums charged for the newborn may vary depending on when the notification is received. The Special Enrollment Period to add a newborn is only 60 days. If you do not add a newborn within the 60-day period you will need to wait until the next Annual Open Enrollment Period or for a Special Enrollment Period to add a newborn.

Additional Rules for Adopted Newborn Children

In addition to the above, in order for an Adopted newborn's Effective Date to be the date of birth, a written agreement to Adopt such child must have been entered into by the Contractholder or Domestic Partner prior to the birth of such child, whether or not such an agreement is enforceable. We may require the Contractholder to provide any information and/or documents which we deem necessary in order to administer this provision. Proof of final Adoption must be submitted to us. If the Adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the Adopted newborn child. It is your responsibility as the Contractholder to notify us that the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Contractholder. If a child is born before the Effective Date of the Contractholder or Domestic Partner the newborn must be added during the application process.

Adopted/Foster Children— To enroll an Adopted child or Foster Child, you must complete and submit any required Enrollment Forms prior to or within 60 days after the date of placement and pay the additional Premium, if any. The Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Contractholder or Domestic Partner. We may need you to provide additional information and/or documents deemed necessary by us in order to properly administer this provision.

The Special Enrollment Period to add an Adopted child or Foster Child is only 60 days. If you do not add an Adopted child or Foster Child within the 60-day period you will need to wait until the next Annual Open Enrollment Period or for a Special Enrollment Period to add the child.

Adopted Children – For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for such Adopted child. As the Contractholder, you are solely responsible for notifying us and the Marketplace if the Adoption does not take place. Upon receipt of notification from the Marketplace, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

Foster Children – If your status as a foster parent is terminated, coverage will end for any Foster Child. As the Contractholder, you are solely responsible for notifying us and the Marketplace in writing that the Foster Child is no longer in your care. Upon receipt of notification from the Marketplace, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

Other Dependents — If other Eligible Dependents were not named on the application for this Contract (such as a new spouse or a new court order to provide coverage for a minor child), you may still apply for coverage for such dependents during a Special Enrollment Period. An Eligible Dependent can become covered when you submit the required Enrollment Forms to the Marketplace and pay the required Premiums. The Effective Date of coverage for such dependents will be determined by the Marketplace.

Continuing Coverage on Termination of Eligibility

If coverage ceases because of termination of eligibility under this Contract, you shall be entitled to be issued a Contract in your name without evidence of insurability, provided that application is made and Premiums are paid within 31 days after termination. There will be continuous coverage during the 31-day period, if such coverage is selected and the Premiums are paid. See also the Notice of Ineligible Dependent subsection of the TERMINATION OF COVERAGE section.

TERMINATION OF COVERAGE

Introduction

This section describes the rules for termination of coverage. We have divided this section into two subsections: Termination of an Individual; and Termination of the Contract.

Termination of an Individual

If your coverage is terminated by us for any reason we will provide you and the Marketplace with notice at least 45 days prior to your last day of coverage under this Contract.

Contractholder

A Contractholder's coverage will automatically end at 12:01 a.m. on the termination date provided in your termination notice. A Contractholder's coverage will end for the following reasons:

1. the Contract terminates in accordance with Termination of the Contract subsection;
2. the Contractholder's coverage is terminated for cause (see Termination for Cause below);
3. the Contractholder is no longer eligible for coverage in a QHP through the Marketplace;
4. the Contractholder no longer meets any of the eligibility requirements; or
5. the Contractholder changes from one QHP to another during an Annual Open Enrollment Period or a Special Enrollment Period.

If you, as the Contractholder, wish to terminate your coverage, you must provide at least 14 days' notice to us and the Marketplace and complete any required Enrollment Forms.

Covered Dependent

A Covered Dependent's coverage will automatically end at 12:01 a.m. on the termination date provided in your termination notice. A Covered Dependent's coverage will end for the following reasons:

1. the Contractholder's coverage terminates for any reason;
2. the Covered Dependent no longer meets any of the eligibility requirements;
3. 18 months after the birth of a newborn child who is the child of a Covered Dependent child;
4. the Covered Dependent's coverage is terminated by us for cause.

If you, as the Contractholder, wish to delete a Covered Dependent from coverage, you must provide at least 14 days' notice to us and the Marketplace and complete any required Enrollment Forms.

Domestic Partner and/or Domestic Partner's Dependent Child

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

Termination for Cause

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

1. disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that your continued coverage with us impairs our ability to provide coverage and/or benefits or to arrange for the delivery of Health Care Services to you or any other Covered Person. Prior to terminating your coverage for any of the above reasons, we will:
 - a. make a reasonable effort to resolve the problem presented by you, including the use or attempted use of our Appeal and Grievance Process;
 - b. ascertain, to the extent possible, that your behavior is not related to the use of medical Services or mental illness; and
 - c. document the problems encountered, efforts made to resolve the problems, and any of your medical conditions involved.
2. fraud, intentional misrepresentation of material fact or omission in applying for coverage or benefits;
3. you intentionally misrepresent, omit or give false information on Enrollment Forms or other forms completed for us for the purpose of obtaining coverage under this Contract, by you or on your behalf; or
4. misuse of the ID Card.

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

Rescission of Coverage

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

We may only Rescind the Contract or coverage of a person covered under the Contract if you or another person on your behalf commits fraud or you make an intentional misrepresentation of material fact in applying for coverage or benefits. Only fraudulent misstatements on the Enrollment Form may be used by us to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

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

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

Notice of Ineligible Dependent

If a Covered Dependent no longer meets all of the applicable eligibility requirements specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section of this Contract, the Contractholder must notify us in writing immediately and no later than 31 days after the date the Covered Dependent ceases to be eligible for coverage. If we receive notification after the 31-day period, the change will be effective as of a current date and we will not refund any Premiums.

Our Responsibilities Upon Termination of Your Coverage

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

Certification of Creditable Coverage

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

The certification of Creditable Coverage will indicate the period of time you were enrolled with us.

Upon request, we will send you another certification of Creditable Coverage within a 24-month period after termination of coverage. You may call the customer service phone number on your ID Card to request the certification.

The succeeding carrier will be responsible for determining if our coverage meets their qualifying Creditable Coverage guidelines.

Termination of the Contract

Discontinuation of Form

We may decide to discontinue this form, but may do so only if:

1. we provide notice to each Contractholder under this policy form in the individual market at least 90 days before the date the coverage under this policy form will end;
2. we offer the option to each Covered Person to purchase any other individual health care coverage we currently offer to individuals in such market in the state; and
3. we act uniformly without regard to any health-status-related factor of Covered Persons or individuals who may become eligible for such coverage.

Discontinuation of all Policies in Individual Market

We may decide to discontinue all of the policies that we have issued in the individual market in this state (including this Contract), but may do so only if:

1. we provide notice to the Office of Insurance Regulation and each Contractholder at least 180 days before the date the coverage under such policies will end; and
2. we return any unused Premium to the Contractholder.

Defaults in Payments

If all Premiums required under this Contract are not paid in full when they are due, this Contract will terminate at the end of the Grace Period, as described in the PAYMENT OF PREMIUMS section.

Notice of Termination

If the entire Contract is terminated by us, a written notice of any termination of this entire Contract will be mailed to the Contractholder. This notice will state the reason the Contract is being terminated.

QHP Termination or Decertification

The Marketplace may at any time decertify a QHP if the Marketplace determines that the QHP issuer is no longer in compliance with the general certification criteria as determined by HHS. If the QHP is decertified by the Marketplace, the Marketplace will send you notice of the decertification and will provide you information about your right to a Special Enrollment Period.

Conditions of Renewal and Termination

This Contract is guaranteed renewable. This means that it automatically renews each year on the Anniversary Date unless terminated earlier in accordance with the terms of this Contract. We may terminate this Contract or refuse to renew it if:

1. Premiums are not paid in accordance with the terms of this Contract or we have not received timely Premium payments;
2. the Contractholder no longer meets any of the eligibility requirements;
3. you perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact; or
4. you fail to comply with a material provision of the Contract.

If we decide to terminate the Contract or not renew it, based on one or more of the actions listed above, we will provide at least 45 days advance written notice.

CLAIMS PROCESSING

Introduction

This section is intended to:

1. help you understand what your treating Providers must do, under the terms of this Contract, in order to obtain payment for Covered Services that have been rendered or will be rendered to you; and
2. 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.

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

BlueSelect Providers and Traditional Insurance Providers have agreed to file Post-Service Claims with us for Health Care 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 are legally incapacitated.

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

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

Note: Please refer to the PRESCRIPTION DRUG PROGRAM section for information on the processing of Prescription Drug claims. Special claims processing rules may apply to Health Care Services rendered outside the state of Florida, under the BlueCard Program. See the BLUECARD PROGRAM section for additional information.

Processing Post-Service Claims

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

Payment for Post-Service Claims

When payment is due under the terms of this Contract, 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 information, we may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims

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

Denial of Post-Service Claims:

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

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

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

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

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

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

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

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 Determinations described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

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

Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

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

1. the date the Service or supply was provided;
2. the Provider's name;
3. the dollar amount of the claim, if applicable;

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

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

Additional Claims Processing Provisions

Release of Information/Cooperation

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

Physical Examination and Autopsy

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. We also reserve the right, if the law permits, to have an autopsy performed on you in case of death. If you do not fully cooperate with such examination, we may deny the claim and we shall have no liability for such claim.

Legal Actions

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

Fraud, Misrepresentation or Omission in Applying for Benefits

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

Communication of Claims Decisions

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

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

Circumstances Beyond Our Control

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Services, taking into account the impact of the event. For 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.

APPEAL AND GRIEVANCE PROCESS

Introduction

This section is intended to help you understand what you need to do to appeal a claims decision.

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 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:

1. You must cooperate fully with us in our effort to promptly review and resolve an appeal. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the appeal processed within the time frames set forth in this section.
2. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The expedited appeal process only applies to Pre-Service Claims or requests for extension of Concurrent Care Services made within 24 hours before the authorization for such Services expires. An expedited appeal will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
3. You may review pertinent documents upon request and free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.
4. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Contract to your medical circumstances. This information is provided free of charge.
5. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
6. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
7. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.
8. If the claim is a Claim Involving Urgent Care, you may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method.
9. If your request for expedited review arises out of a concurrent review determination by us that a continued hospitalization is not Medically Necessary, coverage for the hospitalization will continue until you have been notified of the determination.

10. We will review the appeal and may make a decision based on medical records, additional information and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review.
11. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.
12. 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.floridablue.com or by calling the number on your ID Card.
13. If you are not satisfied with our decision you have the right to an independent external review through an external review organization for certain appeals, as described in the How to Request External Review of our Appeal Decisions subsection below.

How to Submit a Grievance Related to an Exclusive Provider Provision

The following guidelines are applicable to reviews of Grievances:

1. We must receive your Grievance in writing;
2. We may consult with appropriate Physicians, as necessary.

Appeals and Grievances must be sent to the address below:

Florida Blue
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

Timing of Our Appeal Review on Adverse Benefit Determinations

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

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

Timing of Our Review on Grievances

We will use our best efforts to review your Grievance and communicate the decision in within 60 days of receipt of your Grievance.

Your Rights under Florida Statute 627.6141

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

How to Request External Review of our Appeal Decision

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

Coordination of Benefits

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

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

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

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

1. This plan always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile policy available to you.
2. When we cover you as a dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
 - a. the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;
 - b. if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.
4. When we cover you as a dependent child whose parents are not married, or are separated or divorced:
 - a. if the parent with custody is not remarried, the plan of the parent with custody is primary;
 - b. if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;

- c. regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When we cover you as a dependent child and the other plan covers you as a dependent child:
 - a. the plan of the parent who is neither laid off nor retired will be primary;
 - b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), COBRA or FHICCA would be primary.
7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary, unless you are age 65 or older and covered under Medicare parts A and B. In that case, this Contract will be secondary to Medicare.
8. If the other plan does not have rules that establish the same order of benefits as under this Contract, the benefits under the other plan will be determined primary to the benefits under this Contract.

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

Facility of Payment

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

Non-Duplication of Government Programs

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

GENERAL PROVISIONS

Access to Information

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

Amendment

The terms of coverage and benefits to be provided by us under this Contract may be amended, without your consent or that of any other person, upon 45 days prior written notice to the Contractholder. In the event the amendment is unacceptable to the Contractholder, the Contractholder may terminate this Contract upon prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to benefits and coverage under this Contract prior to the date of such amendment. No agent or other person, except our duly authorized officer, has the authority to modify the terms of this Contract, or to bind us in any manner not expressly set forth herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us under this Contract may not be amended by the Contractholder unless such amendment is evidenced in writing and signed by our duly authorized officer.

Assignment and Delegation

The obligations arising hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however that we may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without your consent, at any time.

Any assignment, delegation, or transfer made in violation of this provision shall be void.

Care Profile Program – A Payer-Based Health Record Program

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

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

4. Coordination of care among your authorized treating health care Providers.
5. More efficient health care delivery for you.

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

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

Compliance with State and Federal Laws and Regulations

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

Confidentiality

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

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

Cooperation Required of Covered Persons

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

Customer Rewards and Incentive Programs

From time to time, we may offer you rewards or incentives for participating in certain Florida Blue activities and programs. For plans available through the Federally Facilitated Marketplace, this includes programs offered as part of Florida Blue's Quality Improvement Strategy ("QIS") as required under Section 1311(g) of the Affordable Care Act.

The rewards and incentives available may exceed \$25 per year and may include a premium credit, reduction to copayments, coinsurance or deductibles, cash equivalents or other incentives such as gift cards, debit cards, provision of transportation, discounts, contributions to a health savings account and memberships to gyms or other programs. Such rewards and incentives may be one-time awards, available periodically or related to the completion of specific activities under a particular program. Not all rewards and incentive programs will be targeted and available to all members.

Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Contract. We reserve the right to discontinue or modify the features of any reward program or promotional offer at any time without your consent. The rewards may be taxable income and you should consult a tax advisor for further guidance.

Enrollment Records

Reporting Changes

You, as the Contractholder must provide any information required for the purpose of recording changes in family status or other information relative to eligibility or coverage status. All records relevant to eligibility or coverage status under this Contract shall be made available by you.

Errors or Delays

Clerical errors or delays by us in keeping or reporting enrollment records will not make any coverage invalid if it would otherwise be validly in force, or continue coverage which would otherwise be validly terminated. If you intentionally omit information that you should have provided, or provided incorrect information, it may be corrected if it is determined that any such correction will not be prejudicial to us. You agree that you will be liable to us for any claims payments we make on behalf of any individual who was not eligible for coverage at the time the Service or supply was rendered.

Entire Agreement

This Contract, including the application for coverage and any Enrollment Forms, sets forth the exclusive and entire understanding and agreement between you and Florida Blue and shall be binding upon all Covered Persons, Florida Blue, and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this Contract, which includes the terms of coverage and/or benefits set forth herein, your Schedule of Benefits and/or any Endorsements.

Evidence of Coverage

You have been provided with this Contract and an Identification Card as evidence of coverage.

Florida Agency for Health Care Administration (AHCA) Performance Data

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

Governing Law

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

Identification Cards

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

Indemnification

You shall hold harmless and indemnify Florida Blue against all claims, demands, liabilities, or expenses (including reasonable attorney's fees and court costs), which are related to, arise out of, or are in connection with any acts or omissions by you or any of your agents, in the performance of your obligations under this Contract.

Membership Provision

As a holder of an insurance policy issued by us, you are a member of our parent company, GuideWell Mutual Holding Corporation ("GuideWell"). As such you have all the rights, privileges, and obligations provided in the Articles of Incorporation and Bylaws of GuideWell as currently in force and as may be amended from time to time, including the right to elect GuideWell's Board of Directors. You will not be able to transfer your membership interest in GuideWell and your membership interest in GuideWell will terminate automatically upon the lapse or termination of your insurance policy. Separate certificates evidencing your membership interests in GuideWell will not be issued.

An annual meeting of the members shall be held for the purpose of electing the Board of Directors and transacting such other business as may be properly brought before the meeting. At all meetings of our members, each member shall be entitled to cast a number of votes equal to the amount of Premiums attributed to such member in the month immediately preceding the meeting's record date, as determined by us (e.g., a Premium of \$27.36 in that month will be equal to 27.36 votes). Members may vote in person or by submitting a proxy in accordance with the voting instructions provided by us before the meeting.

Misstatement of Age, Residence, or Tobacco Use

If any written information relevant to determining your Premium has been misstated by you, the Premium amount you owe under this Contract will be changed based on the corrected information provided to us. Other than for a misstatement related to tobacco use, if we accepted Premiums based on such misstatement that we would not have accepted Premium for if the correct information had been stated,

our only liability will be the return of any unearned Premium. We will not provide any coverage for that time period. This right is in addition to any other rights we may have under this Contract and applicable laws.

Modification of Provider Network

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

Non-Waiver of Defaults

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

Notices

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

If to us:

To the address printed on the ID Card.

If to you:

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

You must notify us immediately of any address change.

Our Obligations Upon Termination

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

Promissory Estoppel

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

Relationships Between the Parties

Florida Blue and Health Care Providers

Neither Florida Blue nor any of its officers, directors or employees provides Health Care Services to you. By accepting this coverage and benefits, you agree that health care Providers rendering Health Care Services are not our employees or agents. **In this regard, we hereby expressly disclaim any agency**

relationship, actual or implied, with any health care Provider. We do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care Provider. Any decisions made by us concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for the purpose of determining whether such Services are covered, and not for the purpose of recommending any treatment or non-treatment. We assume no liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

Florida Blue and the Contractholder

You are not our agent or representative and shall not be liable for any acts or omissions of Florida Blue, its agents, servants, or employees. Additionally, neither you nor Florida Blue shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which Florida Blue has made or hereafter makes arrangements for the provision of Covered Services. **Florida Blue is not your agent, servant, or representative and shall not be liable for any acts or omissions of yours or any person or organization with which you have entered into any agreement or arrangement. By acceptance of Covered Services hereunder, you agree to the foregoing.**

Medical Treatment Decisions

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

Reservation of Right to Contract

We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities for assistance with the servicing of coverage and benefits to be provided by us or obligations due, under this Contract.

Right of Recovery

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

Right to Receive and Release Necessary Information

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

Service Mark

You hereby expressly acknowledge that this Contract constitutes a contract solely between you and us. We are an independent corporation operating under a license with the Blue Cross and Blue Shield

Association, an association of independent Blue Cross and/or Blue Shield Plans (the "Association"), permitting us to use the Blue Cross and Blue Shield Service Mark in the State of Florida and that we are not contracting as the agent for the Association. You further acknowledge and agree that you have not entered into this Contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Contract.

Subrogation and Right of Reimbursement

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

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

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

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

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

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

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

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

Third Party Beneficiary

This Contract was issued by Florida Blue to the Contractholder, and was entered into solely and specifically for the benefit of Florida Blue and the Contractholder. The terms and provisions of this Contract shall be binding solely upon, and inure solely to the benefit of, Florida Blue and the Contractholder, and no other person shall have any rights, interest or claims hereunder, or be entitled to sue for a breach hereof as a third-party beneficiary or otherwise. Florida Blue and the Contractholder hereby specifically express their intent that health care Providers that have not entered into contracts with us to participate in our Provider networks shall not be third-party beneficiaries under this Contract.

OTHER IMPORTANT INFORMATION

Your Rights and Responsibilities

We are committed to providing quality health care coverage at a reasonable cost while maintaining your dignity and integrity. Consistent with our commitment and recognizing that In-Network Providers are independent contractors and not our agents, the following statement of your Rights and Responsibilities has been adopted.

Rights

1. To be provided with information about our services, coverage and benefits, the In-Network Providers delivering care and members' rights and responsibilities.
2. To receive medical care and treatment from In-Network Providers who have met our credentialing standards.
3. To expect In-Network Providers to:
 - a. discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage;
 - b. permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements;
 - c. advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments; and
 - d. inform you about any medications you are told to take, how to take them, and their possible side effects.
4. To expect courteous service from us and considerate care from our In-Network Providers with respect and concern for your dignity and privacy.
5. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures found in this Contract.
6. To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision. In the event, members are encouraged (but not required) to:
 - a. complete an advance directive, such as a living will and provide it to the contracting plan providers; and
 - b. have someone help make decisions, or to give another person the legal responsibility to make decisions about medical care on a member's behalf.
7. To have access to your medical records and to be assured that the confidentiality of your medical records is maintained in accordance with applicable law.

8. To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding our rights and responsibilities policies. Please call the phone number on your ID Card or write to us at the address on your ID Card.

Responsibilities

1. To cooperate with anyone providing your care and treatment.
2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about your care and to ask questions if you do not understand or need an explanation.
4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
5. To pay your Cost Share amounts and be financially responsible for non-covered Services and to provide current information concerning your coverage status to any In-Network Provider.
6. To follow the process for filing an appeal about medical or administrative decisions that you feel were made in error.
7. To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
8. To review information regarding Covered Services, policies and procedures as stated in the Contract.

Statement on Advance Directives

The following information is provided in accordance with the Patient Self-Determination Act to advise you of your rights under Florida law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to prepare an advance directive, and explain our policy on advance directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes your right as a competent adult to make an advance directive instructing your Physician to provide, withhold, or withdraw life-prolonging procedures, or to name someone to make treatment decisions for you in the event that you are found to be incompetent and suffering from a terminal Condition. Advance directives provide patients with a way to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own health care decisions.

An "advance directive" is a witnessed oral or written statement which indicates your choices and preferences with respect to medical care made by you while you are still competent. An advance directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care Provider should consult in making treatment decisions.

There are three types of documents recognized in Florida that are commonly used to express an individual's advance directives: a Living Will, a Health Care Surrogate Designation and a Durable Power of Attorney for Health Care.

A Living Will is a declaration of a person's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal Condition and is not able to express his or her wishes. It does not become effective until the patient's Physician and one other Physician determine that the patient suffers from a terminal Condition and is incapable of making decisions.

Another common form of advance directive is the Health Care Surrogate Designation. When properly executed, a Health Care Surrogate Designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient's wishes. The surrogate's authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions the surrogate cannot make, by law, such as consent to abortion or electroshock therapy, any specific limits on the surrogate's power to make decisions should be clearly expressed in the Health Care Surrogate Designation document.

Finally, there is the Durable Power of Attorney for Health Care. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical Condition.

A suggested form of Living Will and Designation of Health Care Surrogate is contained in Chapter 765 of the Florida Statutes. There is no requirement that you have an advance directive and your health care Provider cannot condition treatment on whether or not you have one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. a judicially appointed guardian;
2. a spouse;
3. an adult child or a majority of the adult children who are reasonably available for consultation;
4. a parent;
5. siblings who are reasonably available for consultation;
6. an adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health and religious or moral beliefs;
7. a close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending Physician an affidavit stating that he or she is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, religious and moral beliefs.

Deciding whether to have an advance medical directive, and if so, the type and scope of the directive, can be complex. It may be helpful for you to discuss advance directives with your spouse, family, friends, religious or spiritual advisor or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, Physician and whomever else will be faced with the task of carrying out those wishes knows what you would want.

It is our policy to recognize your right to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an advance directive to guide treatment decisions in the event you become unable to do so. We will not interfere with your decision. It is your responsibility to provide notification to your Providers that an advance directive exists. If you have a written advance directive, we recommend that you furnish your Providers with a copy so that it can be made a part of your medical record.

Florida law does not require a health care Provider or facility to commit any act which is contrary to the Provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a Provider or facility in our network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another Provider or facility.

Our Providers have varying practices regarding the implementation of an individual's advance directive, in accordance with state law. Therefore, we recommend that you have discussions about advance directives with your medical care givers, family members and other friends and advisors. Your Physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical Condition or environment.

Complaints concerning noncompliance with advance directives may be submitted to the following address:

Agency for Health Care Administration
Bureau of Managed Health Care
Building 1, Room 311
2727 Mahan Drive
Tallahassee, Florida 32308

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law.

DEFINITIONS

The following definitions will help you understand the terms that are used in this Contract, including the Schedule of Benefits and any Endorsements that are part of this Contract. As you read through this Contract you can refer to this section; we have identified defined terms in the Contract, the Schedule of Benefits and any Endorsements by capitalizing the first letter(s) of the term.

A

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

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

Adoption or Adopt(ed) means the act of creating a legal parent/child relationship where it did not exist, declaring that the child is legally the child of the adoptive parents and their heir-at-law and is entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as defined by Florida law or a similar applicable law of another state.

Advanced Payments of the Premium Tax Credit (APTC) means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a QHP through the Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.

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

1. a Pre-Service Claim or a Post-Service Claim;
2. a Concurrent Care Decision, as described in the CLAIMS PROCESSING section; or
3. Rescission of coverage, as described in the TERMINATION OF COVERAGE section.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The allowed amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and Florida Blue.
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 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 Florida Blue.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BLUECARD PROGRAM section for more details.
5. In the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the allowed amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including but not limited to: (i) payment for such Covered Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Covered Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that we determine are comparable to the Out-of-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating Providers in other Provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by us, with our Provider network strategies (e.g., does not result in payment that encourages Providers participating in a Florida Blue network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the allowed amount for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue 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.

In no event will the allowed amount be greater than the amount the Provider actually charges.

If a particular Covered Service is not available from any Provider that is in the BlueSelect Network, as determined by us, the allowed amount, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar Providers in Florida.

You may obtain an estimate of the allowed amount for particular Services by calling the customer service phone number on your ID Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Contract apply. You should refer to the WHAT IS COVERED? section of this Contract and your Schedule of Benefits to determine what is covered and how much we will pay.

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

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 similar applicable laws of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Anniversary Date means the first day of January (January 1st) following your initial Effective Date and each January 1st thereafter.

Annual Open Enrollment Period means the period of time each year as designated by the Marketplace or on the Enrollment Forms when you can change coverage or enroll in a new plan. The exact time period may change each year.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and meets one of the following criteria:

1. The study or investigation is approved or funded by one or more of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare and Medicaid Services.
 - e. cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following if the conditions described in paragraph (2) are met:
 - 1) The Department of Veterans Affairs.
 - 2) The Department of Defense.
 - 3) The Department of Energy.
2. The study or investigation is conducted under an investigational new Drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a Drug trial that is exempt from having such an investigational new Drug application.

For a study or investigation conducted by a Department, the study or investigation must be reviewed and approved through a system of peer review that the Secretary determines: (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For purposes of this definition, the term “Life-Threatening Disease or Condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Artificial Insemination (AI) means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care Provider for the purpose of producing a pregnancy.

B

Biosimilar Prescription Drug means a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (known as a reference product). A Biosimilar Prescription Drug has no clinically meaningful difference in terms of safety and effectiveness from the reference product it is compared to.

Birth Center means any facility, institution, or place, licensed pursuant to Chapter 383 of the Florida Statutes, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy. A birth center is not an Ambulatory Surgical Center or a Hospital.

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

BlueCard PPO Program Provider means a Provider designated as a BlueCard PPO Program Provider by the Host Blue.

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

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

BlueCard Traditional Program Provider means a Provider designated as a BlueCard Traditional Program Provider by the Host Blue.

BlueSelect Network means, or refers to, the Provider network comprised of both Preferred Providers and Exclusive Providers, established and so designated by us, which is available to BlueSelect members under this Contract. Please note that our Preferred Patient Care (PPC) preferred provider and NetworkBlue networks are **not** available to BlueSelect members under this Contract.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the transplantation as well as the administration of chemotherapy

and the chemotherapy Drugs. The term "bone marrow transplant" also includes any Services or Supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells, such as Hospital room and board and ancillary Services.

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

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

C

Calendar Year begins January 1st and ends December 31st of the same year.

Care Choices (for HSA Plans) Medication Guide (herein "Medication Guide") means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan. The medication guide also may designate the following categories of Prescription Drugs described in the PRESCRIPTION DRUG PROGRAM section: 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 website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card.

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 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced registered nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a properly licensed nurse who is a certified registered nurse anesthetist pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

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

Coinsurance means the sharing of health care expenses for Covered Services between you and us. After your Deductible is met, we will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your coinsurance.

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

As defined herein, a concurrent care decision shall not include any decision to deny, reduce, or terminate coverage, benefits or payment under the Case Management subsection of the BLUEPRINT FOR HEALTH PROGRAMS section.

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

Contract includes this document, your application for this contract, any Enrollment Forms signed by the Contractholder and any amendments and/or Endorsements.

Contractholder means an individual who meets and continues to meet all applicable eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under Contract other than as a Covered Dependent.

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

Copayment or **Copay** means, when applicable, the dollar amount established solely by us which you must pay to a health care Provider at the time Covered Services are rendered by that Provider. In the case of Prescription Drugs, the amount you must pay to an Exclusive Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost share may include, but is not limited to Coinsurance, Copayment and Deductible amounts. Applicable cost share amounts are identified in your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements, described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under the Contract other than as a Contractholder.

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

Covered Person means a Contractholder or Covered Dependent.

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under the Pharmacy Program.

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

Covered Prescription Supply(ies) means only the following Supplies, which are covered under the Pharmacy Program:

1. Prescription diaphragms indicated as covered in the Medication Guide;
2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage by us;
3. syringes and needles prescribed with a Prescription Drug authorized for coverage by us;
4. syringes and needles contained in anaphylactic kits; and
5. Prescription Supplies used in the treatment of diabetes, limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

Covered Services means those Health Care Services which meet the criteria listed in the WHAT IS COVERED? section.

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

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

Custodial or Custodial Care means care that serves to assist a person in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, consideration is given to the frequency, intensity and level of care and medical supervision required and

furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

D

Daily Living means age appropriate basic tasks of everyday life such as bathing, dressing, eating, toileting, transferring and walking.

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

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services that you must actually pay each Calendar Year to an appropriate licensed health care Provider who is recognized for payment under this Contract, before our payment for Covered Services begins. Not all plans include a deductible.

Dentist means a person who is properly licensed by the state of Florida, or a similar applicable law of another state, as a doctor of Dental Surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the Service is rendered, and acting within the scope of his or her license.

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

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

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

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

Domestic Partner means a person of the same or opposite gender with whom the Contractholder has established a Domestic Partnership.

Domestic Partnership means a relationship between the Contractholder and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole domestic partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;

4. the Contractholder has submitted to us acceptable proof of evidence of common residence and joint financial responsibility; and
5. the Contractholder has completed and submitted any required forms to us and we have determined the Domestic Partnership eligibility requirements have been met.

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

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

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law (or a similar applicable law of another state) to provide Durable Medical Equipment in the patient's home under a Physician's Prescription.

E

Effective Date means, with respect to eligible individuals properly enrolled, when coverage first becomes effective, 12:01 a.m. on the date printed on the first page of this Contract; and with respect to eligible individuals who are subsequently enrolled, means 12:01 a.m. on the date coverage will begin as specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may reasonably be expected to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

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

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

Endorsement means a document issued by us that changes or modifies language in this Contract. Endorsements may also be referred to as amendments.

Enrollment Date means the date of enrollment of the individual under this Contract.

Enrollment Forms means those forms, electronic or paper, used to maintain accurate enrollment files under the Contract and which are approved for use by us or if you enrolled in this plan through the Marketplace; approved by the Marketplace.

Essential Health Benefits (EHB) means Health Care Services included in the Affordable Care Act's definition and includes Services in the following ten categories:

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental Health and substance use disorder Services, including behavioral health treatment
6. Prescription Drugs
7. Rehabilitative and Habilitative Services and devices
8. Laboratory Services
9. Preventive and wellness Services and chronic disease management
10. Pediatric Services including oral and vision care

Exclusive Pharmacy means a Pharmacy that is either: 1) participating in the BlueSelect Pharmacy Program and has signed a BlueSelect Participating Pharmacy Provider Agreement; 2) a National Network Pharmacy; 3) a Specialty Pharmacy; or 4) the Mail Order Pharmacy.

Exclusive Pharmacy Allowance means the maximum amount allowed to be charged by an Exclusive Pharmacy per Prescription for a Covered Prescription Drug, Covered OTC Drug or Covered Prescription Supply under the Pharmacy Program.

Exclusive Provider means a Provider of health care or a group of Providers of health care that has entered into a written agreement with us to be the sole provider for specific Health Care Services.

Exclusive Provider Provision (EPP) means any provision that conditions payment of benefits for select Health Care Services, in whole or in part, on the use of Exclusive Providers or Exclusive Pharmacies. Health Care Services that are subject to the exclusive provider provision are identified in your Schedule of Benefits.

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, Supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, or chemical compounds if, as determined solely by us:

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

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

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

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative Medical Literature and scientific literature;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Services or Supplies which are determined by us to be experimental or investigational are excluded as described in the WHAT IS NOT COVERED? section. In making benefit determinations, we may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

F

FDA means the United States Food and Drug Administration.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Florida Blue HMO is a trade name of Health Options, Inc., an HMO affiliate of Blue Cross and Blue Shield of Florida, Inc. D/B/A Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association. Health Options, Inc. is a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

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

G

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

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

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

Grace Period means the period immediately following the Premium due date as indicated on the Contractholder's billing statement.

Grievance means a written expression of dissatisfaction that is not an Adverse Benefit Determination.

H

Habilitative Services means Health Care Services that help a person keep, learn or improve skills and functioning for Daily Living.

Health Care Services or Services means evaluations, treatments, therapies, devices, procedures, techniques, equipment, Supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds and other services rendered or supplied, by or at the direction of, a licensed Provider.

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

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

Hospice means a public agency or private organization duly licensed pursuant to Florida Statutes, or a similar applicable law 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 Birth Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or rehabilitative care.

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

I

Identification (ID) Card means the cards we issue to Contractholders. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Contract.

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

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

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on your Schedule of Benefits under the heading "In-Network". Otherwise, In-Network means, when used in reference to a Provider, any health care Provider who, at the time Covered Services are rendered to you, is an In-Network Provider under the terms of this Contract.

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to participate in the BlueSelect Network:

1. as an Exclusive Provider for Services subject to an Exclusive Provider Provision; or
2. as a Preferred Provider for Services not subject to an Exclusive Provider Provision. (Please refer to your Schedule of Benefits).

For payment purposes under this Contract 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 are rendered to you, participates as a BlueCard PPO Program Provider under the Blue Cross and Blue Shield Association's BlueCard Program.

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

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to a woman's uterus.

L

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

M

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

Marketplace means the Health Insurance Marketplace, which is a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and implementing regulations and makes QHPs available to qualified individuals and qualified employers.

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 Contract, the term massage or massage therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

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

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

Material Misrepresentation means the omission, concealment of facts or incorrect statements made on any application or Enrollment Forms by an applicant, Covered Person or Contractholder which would have affected your eligibility under this Contract, issuance of different benefits, or issuance of this Contract at a different Premium rate had they been known.

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

Medical Literature means peer reviewed literature included in the PubMed/Medline database of the National Library of Medicine.

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

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, disease or symptoms;
3. not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider; and
4. not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

When determining whether a Service is not more costly than the same or similar Service as referenced above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

- a. the Allowed Amount for Service at the location for the delivery of the Service versus an alternate setting;
- b. the amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or,
- c. an analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

Note: The distance you have to travel to receive a Health Care Service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

Reviews we perform of medical necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular Service. In performing medical necessity reviews, we may take into consideration and use cost data which may be proprietary.

It is important to remember that any review of medical necessity by us is solely for the purpose of determining coverage or benefits under this Contract 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 Contract as determined by us. In applying the definition of medical necessity in this Contract, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not medically necessary; however, you will be solely responsible for paying for the Service.

Medically Necessary Orthodontic Treatment means treatment as a result of a handicapping malocclusion and congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip.

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

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

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD10-CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

N

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

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

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee. Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee, resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee.
- or
2. December 31st of the following calendar year.

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. A New Prescription Drug is not a Non-Preferred Prescription Drug.

O

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

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

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

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

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on your 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 to you, is not an In-Network Provider under the terms of this Contract.

Out-of-Network Pharmacy means a Pharmacy that has not agreed to participate in our BlueSelect Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

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

1. does not have a contract with us to participate in the BlueSelect Network as either an Exclusive Provider or Preferred Provider; or
2. does not have a contract with us to participate in the BlueSelect Network but is participating in our Traditional Program; or
3. does not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard PPO Program but is participating, for purposes of the BlueCard Program, as a BlueCard Traditional Program Provider; or
4. does not have a contract with us to participate in the BlueSelect Network or our Traditional Program; or
5. does not have a contract with a Host Blue to participate for purposes of the BlueCard Program as a BlueCard Traditional Program Provider.

Outpatient Facility for Habilitative and Rehabilitative Therapy (Outpatient Hab/Rehab Facility)

means an entity which renders, through Providers properly licensed pursuant to Florida law or a similar applicable law of another state: outpatient Physical Therapy; Speech Therapy; Occupational Therapy; Cardiac Therapy; and Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition or to keep, learn or improve skills and functioning for Daily Living. Further, such an entity must meet our criteria for eligibility as an outpatient facility for habilitative and rehabilitative therapy. The term outpatient facility for habilitative and rehabilitative therapy, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical habilitative and rehabilitative inpatient Services, or habilitative or rehabilitative outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

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

P

Pain Management includes, but is not limited to, Services for pain assessment, medication, Physical Therapy, biofeedback, and/or counseling. Pain management programs feature multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

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

Per Admission Deductible (PAD) means the amount of charges, up to the Allowed Amount, for inpatient Covered Services, which you must actually pay, for each Hospital admission to an appropriately licensed Hospital recognized for payment under this Contract, before our payment for any inpatient Covered Services begins. The Hospital PAD applies, when indicated in the Schedule of Benefits, regardless of the reason for the admission and is in addition to the Deductible requirement, if applicable.

Per Visit Deductible (PVD) means the amount of charges, up to the Allowed Amount, for Covered Services rendered in an outpatient facility, which you must actually pay, for each visit to an appropriately licensed outpatient facility recognized for payment under this Contract, before our payment begins. The PVD applies, when indicated in the Schedule of Benefits, regardless of the reason for the visit and is in addition to the Deductible requirement, if applicable.

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

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

Pharmacy Benefit Manager means an organization that has established, and manages, 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 network and/or programs available to you.

Pharmacy Deductible means the amount of charge, up to the Exclusive Pharmacy Allowance for Covered Prescription Drugs and Supplies that you must actually pay per Calendar Year, in addition to any applicable Copayment or Coinsurance, to a Pharmacy, who is recognized for payment under this Contract, before our payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs begins.

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

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

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

Physician Assistant means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

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

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

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

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

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

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

Preferred Provider means a Provider of health care or a group of Providers of health care that has entered into a written agreement with us to render Health Care Services under this Contract.

Premium means the total amount required to be paid by the Contractholder to us in order to be covered under this Contract. The Premium is determined on the basis of the applicable Rates, Risk Class and certain demographics of individuals covered under this Contract.

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

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

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

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

Primary Care Physician (PCP) means a Physician who specializes in internal medicine, family practice, general practice, or pediatrics.

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

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

Provider means any facility, person or entity recognized for payment by us under this Contract.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Contract, 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.

Q

Qualified Health Plan (QHP) means a health plan that is certified by the Marketplace.

R

Rate means the amount we charge for coverage. The rate will vary depending on the Risk Class of each covered individual.

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

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

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

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

Rescission or **Rescind** refers to Florida Blue's action to retroactively cancel or discontinue coverage under this Contract. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

Residential Treatment Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide care and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

- has Mental Health Professionals on-site 24 hours per day and 7 days per week;

- provides access to necessary medical services 24 hours per day and 7 days per week;
- provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- provides a level of skilled intervention consistent with patient risk;
- is not a wilderness treatment program or any such related or similar program, school and/or education service;

With regard to Substance Dependency treatment, in addition to the above, must meet the following:

- if Detoxification Services are necessary, provides access to necessary on-site medical services 24 hours per day and 7 days per week, which must be actively supervised by an attending Physician;
- ability to assess and recognize withdrawal complications that threaten life or bodily function and to obtain needed Services either on site or externally;
- is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation;

Residential Treatment Services means treatment in which an individual is admitted by a Physician overnight to a Hospital, Psychiatric Hospital or Residential Treatment Facility and receives daily face to face treatment by a Mental Health Professional for at least 8 hours per day, each day. The Physician must perform the admission evaluation with documentation and treatment orders within 48 hours and provide evaluations at least weekly with documentation. A multidisciplinary treatment plan must be developed within 3 days of admission and must be updated weekly.

Risk Class is a grouping of Covered Persons who have similar characteristics. For example, Covered Persons who: are the same age; use tobacco products; live in the same geographical area; and who have elected the same benefit plan may be grouped into a Risk Class. The Risk Class of each Covered Person is determined by Florida Blue.

S

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

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

Service Area means either 1) the geographic area certified by the Marketplace through QHP Certification, or 2) if not a QHP, the geographic area approved by the Agency for Health Care Administration (AHCA); and in which rates have been approved by the Florida Office of Insurance Regulation (OIR). A list of Florida counties in the service area is available at: <https://consumer.websales.floridablue.com/cws/plan-counties>.

Skilled Nursing Facility means an institution or part thereof which meets our 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; 2) is accredited as a skilled nursing facility by The Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us.

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

Special Enrollment Period means the period of time immediately before or after a life or special event.

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

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to provide specific Prescription Drug products, as determined by us. In-Network specialty Pharmacies are listed in the Medication Guide. The fact that a Pharmacy is a participating Pharmacy does not mean that it is a specialty Pharmacy.

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

Speech Therapy means Health Care Services provided for the treatment of speech and language disorders by a Physician, Speech Therapist or licensed audiologist, including language assessment and language restorative therapy Services.

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

Standard Reference Compendium means (a) the United States Pharmacopoeia Drug Information; (b) the American Medical Association Drug Evaluation; and/or (c) the American Hospital Formulary Service Hospital Drug Information.

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

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

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

T

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

Traditional Program means, or refers to, Florida Blue's Provider contracting program called Payment for Professional Services (PPS). Traditional program **does not** include those health care Providers who have entered into the Payment for Hospital Services (PHS) contracting program.

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

U

Urgent Care Center means a properly licensed facility that: 1) is available to provide Services to patients at least 60 hours per week with at least 25 of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the urgent care center is closed; 3) employs or contracts with at least one or more board certified or board eligible Physician and Registered Nurse (RN) who are physically present during all hours of operation. (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations. For purposes of this Contract, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Hab/Rehab Facility.

V

Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Z

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

