SUWANNEE COUNTY SCHOOL DISTRICT

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Live Oak, Florida 32064
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TED L. ROUSH
Superintendent of Schools

Addendum II

12/15/2022

Suwannee County School Board
Request For Proposals #23-202
Questions from Aon

1. Who is currently covered for benefits? Benefits are offered to active employees, COBRA participants and retired employees.

2. How many lives are currently eligible for benefits? For December, there are currently 793 active employees, 1 COBRA participant, and 35 retired employees.

3. When was the last time you changed consultants? The District has been with Gallagher Benefit Services, formerly Parks Johnson Agency, for 30+ years.

4. Who is your current consultant? Gallagher Benefit Services How many years has this relationship existed? The District has been with Gallagher Benefit Services, formerly Parks Johnson Agency, for 30+ years.

5. Please provide a breakdown of your current consultant's services, fees and compensation or a copy of the contract/agreement with your current consultant. Gallagher Benefit Services provides the following services on an "as needed" basis:

Renewal Analysis:
- Review and evaluate carrier projections
- Prepare "Shadow" renewal projection
- Create financial modeling reports
- Coordinate carrier negotiations
- Create employee contribution modeling reports
- Review identified benchmarks of projected plan costs
- Develop "working" rates for SCSD's analysis and approval
- Assist with budget projections
- Provide renewal alternatives with cost impact of benefit plan changes

Periodic Plan Financial Reports: (Frequency to be Mutually Agreed Upon)
- Summary of plan costs
- Analysis of actual vs. budget
- Employee contributions
- Large claims tracking
- Identification of costs for specific line of coverage
- Comparison of plan costs to aggregate stop-loss projections, if applicable
- Utilization review
- Comparison to prior claim period
- Plan trends

Annual Financial Reports (End of Year Accounting):
- Actuarial valuation for required reserves and annual filing with State Office of Insurance
- Executive summary of program expenses
- Comparison of current costs to renewal costs
- Incurred But Not Reported (IBNR) claims analysis

- Overview of specific Stop-loss projections
- Future plan costs projections
- Dollars saved by contract negotiation
- Percent of benefit dollars paid by employee
- Claims by size
- Physician visit details
- Benefits paid by type of service
- Plan funding/budget comparison
- Fixed expense comparison

Benefit Plan Design (or Redesign)

- Help SCSD identify business and HR objectives that impact benefits
- Review with SCSD possible benefit strategies to meet their objectives
- Help SCSD evaluate/review current scope of benefits package (e.g. types and levels of coverage)
- Work with SCSD to develop funding and contribution strategies
- Assist with budget projections for design alternatives

Carrier Marketing and Negotiations, as Directed by SCSD

- Work with SCSD to develop a strategy to identify goals, analyze program costs and review both current and alternative funding arrangements
- Manage the renewal process with current carrier to control costs
- Implement carrier renewal strategies with SCSD
- Develop timeline covering every aspect from RFP preparation to the delivery of employee communications
- Provide analysis of employee disruption report and preparation on geo-access report, when applicable
- Provide analysis of discounts offered by various carriers by using CPT codes and carrier pricing data
- Manage RFP development that tailors RFP to the desires, needs and financial directions provided by SCSD
- Explore alternative funding solutions
- Evaluate vendor responses to track variations in coverage and costs as they are identified
- Conduct finalist interviews to investigate and document intangibles, such as personalities, service orientation and responsiveness
- Draft renewal analysis report, based on renewal negotiation, coverages program and claims cost projections, as well as complete information on benefit designs
- Facilitate decision process by coordinating close collaboration and discussions amount the Gallagher team and SCSD

Legislative and Corporate Compliance Support:

- Provide legislative updates, including Compliance Alerts, Webinars, technical bulletins and Directions newsletters
- Evaluate plan design to assist with compliance with state and federal regulations
- Provide general information and guidance to assist with compliance with ERISA, ACA, COBRA, HIPPA and other Federal legislation that direcly affects the administration of plan benefits
- Provide template or sample compliance notices, Certificates of Creditable Coverage and enrollment forms as reasonably requested by SCSD

Day to Day Administrative Assistance

- Provide assistance to SCSD to help with resolving carrier service issues
- Coordinate and participate in annual service meetings with SCSD and select carriers (as requested)

Employee Education Programs:
- Provide on-site educational meetings as a part of annual open enrollment
- Provide annual on-site educational meeting during new hire orientation
- Provide local team for support, including individual in person meetings as requested, to review benefits questions, claims resolution, etc. This is in addition to Gallagher's BAC.

Communication Materials:
- Assist with the drafting and distribution of participant Satisfaction Surveys (as requested)
- Assist with the drafting and distribution of Open Enrollment-New Member Orientation summary information and any other communications pertaining to the health and welfare program
- Provide annual Open Enrollment guidance and employee meeting materials
- Assist with marketing and oversight of Customized Enrollment Materials (if elected)
- Assist with participant wellness initiatives, as direct by SCSD

Benefit Administration Assessment:
- Periodic evaluation of internal plan enrollment and benefit termination processes
- Review, coordinate and implement SCSD agreed upon plan "best practices" to help limit plan liability and increase participant satisfaction
- Help identify opportunities for streamlining and improving administration procedures

Benefit Administration Service through Third Party/Explain My Benefits:
- EMB cooperates and coordinates with SCSD to obtain the information necessary to enable the use of the Web-Based Applications by SCSD and the participants in the Benefit Plan;
- Provide Internet enrollment setup and inquiries or transactions processed through eElect software and the PlanSource database
- Report results of interactions with SCSD
- Integrate Benefit Administration Service with Payroll
- Integrate Benefit Administration Service with Insurance Carriers
- Administer New Hire Processing, New Hires learn about and elect benefits online. Automatically calculates and communicates effective dates to employees.
- Online Open Enrollment system process annual Open Enrollment.
- Provide termination processing. Terminations are fed through the system and are passed along to carriers and providers
- Provide face to face/call center enrollment and pre-enrollment communications

Coordinate and Manage Explain My Benefits Services:
- Gather information and assist SCSD with accessing and using EMB services
- Serve as the primary liaison between SDSD and EMB
- Coordinate EMB services
- Gallagher shall coordinate payment on behalf of SCSD of all uncontested and properly documented fees associated with EMB as outlined in the contract between SCSD and EMB from compensation received by Gallagher pursuant to this Agreement

Benefit Advocacy Center (BAC):

- Dedicated toll free number and email address for benefits inquiries
- Team of advocates will support SCSD with the following customer service issues:
  - Explain SCSD's Benefits
  - Provider Find
  - Resolve ID Card Problems
  - Claim Resolution
  - Confirm Eligibility
  - Enrollment Questions
  - Navigating Claims Billing Issues
  - Medicare questions
- Additional Support (including multilingual support)
- Reporting Monthly Case and NPS (Net Promoter Score)
- Advise on Claims Appeal Process Monday thru Friday, 8 a.m. to p.m. EST)

FSA Administration Through Third Party/Discovery Benefits:

- Gather information and assist SCSD with accessing and using Discovery Benefits
- Serve as the primary liaison between SCSD and Discovery Benefits
- Gallagher shall coordinate the payment on behalf of SCSD of all uncontested and properly documented fees associates with the FSA services as outlined in the contract between SCSD and Discovery Benefits from compensation received by Gallagher from SCSD.
- Gallagher and SCSD mutually agree that Gallagher shall not be liable for services to be provided by Discovery Benefits.

Coordinate and Manage Discovery Benefits Services:

- Gather information and assist SCSD with accessing and using Discovery Benefits services
- Serve as the primary liaison between SDSD and Discovery Benefits
- Coordinate Discovery Benefits services
- Gallagher shall coordinate payment on behalf of SCSD of all uncontested and properly documented fees associated with the Discovery Benefits as outlined in the contract between SCSD and Discovery Benefits from compensation received by Gallagher pursuant to this Agreement;

Market Benchmarking Studies:

- Local Area Surveys
- Industry Surveys

6. What would be the two – three main objectives SCSB is looking to improve in any possible change in its consulting relationship? Return on investment (i.e. fees), competitive medical plan proposals, reduction in MLR, aggressive plan design and pharmacy alternatives

7. What additional services are you utilizing (i.e., benefits administration technology, COBRA, FSA) and who is paying the cost? Benefits administration, COBRA, FSA, annual filing with State Office of Insurance for self-insured plan and actuarial valuation for required reserves, regulatory updates and compliance assistance in areas such as Cafeteria Plans, SBCs, Medicare Creditable Coverage, COBRA, HIPPA, ACA including PCORI, Qualifying Life Event compliance

8. Are funds received from any vendors for services such as wellness, communications, or technology? Yes, Wellness funds are received from Florida Blue. A percentage of commission offsets PEPM expense of the

enrollment platform Explain My Benefits, and the balance is paid by SCSD through wellness funds received from Florida Blue.

9. Can you provide details for each of your current benefits (i.e., enrollment guide, benefit summaries, certificates of coverage, contracts/agreements), renewal dates, and costs for each eligible class of participants (i.e., full time employees, retirees, COBRA)? See attached.

10. When is your next open enrollment and what assistance to you require from your consultant? Open Enrollment is effective on 5/1/23, and the open enrollment process is historically held for 7-10 days in March. The expected window is 3/6/23 -3/17/23, with our Senior Client Manager and Area VP with Gallagher Benefit Services holding twice daily Information Meetings at each SCSD location 2/27/23-3/3/23. Although SCSD plans to use the Open Enrollment dates of 3/6/23-3/10/23, SCSD Employee Benefits Specialists ("EBS") will continue enrolling employees through 3/17/22. SCSD EBS will make corrections, changes and upload documentation through 3/31/23, then release the file to Explain My Benefits ("EMB") for auditing.

    In preparation of Open Enrollment, we begin weekly calls with EMB mid-January, with our Senior Client Manager with Gallagher Benefit Services participating in each call. These calls result in EMB Open Enrollment Operations and Enroll documents that are used with all carriers, as well as to assist in training Call Center representatives.

    In addition, our Senior Client Manager and Gallagher publishing team produce our Employee Benefits Guide digitally, then deliver 800 color copies to SCSD for distribution during our Open Enrollment Information Meetings.

11. When is the last time that coverages were marketed and the last time there was a change in vendors? The District's last RFP for medical plan options was released to carriers 11/7/18 for the 2019 Plan Year. The District's last change for dental and vision was for the 2018 Plan Year, and other Voluntary Benefits for the 2020 Plan Year.

12. Assist SCSB Legal Counsel in preparation of defense if any litigation should result from benefits contracting and testify in court as needed/requested. What type of litigation does SCSB consider itself potentially at risk of having to defend? {8.3.1 (f) ACA compliance, HSA compliance, Cafeteria 125 compliance.

13. When marking material that is believed to be exempt from public records, is there a particular location that it must be marked, or is it okay for the notation to be in the bottom footer? It is okay to be in bottom footer.

2022-2023

Benefits for

you • your family • your life

Suwannee County School District SCSD

At Suwannee County School District, your health, happiness, and wellbeing **matter**

We're committed to making sure you get the benefits package that's right for both you and your family.

Open Enrollment is your chance to ensure that your benefits package is right for you. Medical coverage, dental and vision care, and financial protection options are built around you and created to keep you in great shape, physically and financially.

Please take the time to understand all the options available to you. As a whole, we think we've created a benefit package that gives you the support you need whether you're at work, at home or even on vacation.

Finding what you need

If you or your dependents are enrolled in or are eligible for Medicare in the next 12 months, Federal law gives enrollees more choices about prescription drug coverage. Please see page 27 for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department. This guide is meant to serve as a summary. If there are differences between this guide and the carrier contract, the contract will govern.

Making your Selections

Choosing your Benefits

There are up to **three** times during the year when you'll be able to select your benefits. Choose carefully! The choices you make now will be in effect through April 2023.

When you're first hired

Your coverage begins on your **benefit eligibility date**, which is the first day of the month following 30 days of full-time employment.

If you have a life change

Certain life events like marriage, divorce, birth or adoption of a child, or a change in employment status may allow you to change your coverage during the year.

If this occurs, you have **30 days** from the date of the event to request applicable changes to your benefits.

At Open Enrollment

Open Enrollment is your opportunity once each year to evaluate your benefit options and make selections for the following year.

Benefits selected at Open Enrollment are effective **May 1st through April 30th**.

Covering Your Family

Your Spouse

You may cover your legal spouse on your medical, dental, vision, life insurance, and additional coverage plans.

Your Children

Medical	through the end of the **calendar year** in which they reach age **30**.
Dental	until age **30.**
Vision	until age **30.**
Child Life	through age **21** if unmarried; through age **26** if a full-time student.

Disabled dependents: children who became disabled before age 26 and rely on you for support are also eligible for health coverage.

Dependent Information

In addition to providing the Date of Birth and Social Security Number, employees MUST furnish proper documentation to verify dependent eligibility.

What documents do I need to verify my dependent's eligibility? The following documents meet the criteria for verification of dependent eligibility:

- **Spouse** - Original or copy of government issued Marriage Certificate.
- **Birth Child** - Original or copy of government issued Birth Certificate that shows proof of relationship.
- **Step Child** - Original or copy of government issued Birth Certificate that shows proof of relationship AND Marriage Certificate to child's parent.
- **Adopted Child** - Legal Adoption records naming employee as parent. If the spouse (not employee) is the adoptive parent, a Marriage Certificate is also required.
- **Child born outside of the USA** - Naturalization papers that show proof of relationship.
- **Legal Guardianship** - Original or copy of government issued Birth Certificate AND Court order naming employee as legal guardian. If the spouse (not employee) is the guardian, a Marriage Certificate is required. Educational guardianship is not sufficient documentation.
- **Grandchild** (newborn to 18 months of age) - Original or copy of government issued Birth Certificate that shows proof of relationship AND Original or copy of government issued Birth Certificate of parent who is also enrolled in the plan. If a grandchild is older than 18 months, Legal Guardianship must be obtained and provided in order to remain on the plan.

Medical Insurance

Important Terms

Insurance can sometimes sound like a foreign language. Take a moment to review the meaning of these common terms to best understand your benefit plans.

Copay
A flat fee you pay whenever you use certain medical services, like a doctor visit.
Accrues toward your out-of-pocket maximum.

Coinsurance
The percentage of covered expenses you continue to pay after you've met your deductible and before you reach your out of pocket maximum.
Accrues toward your out-of-pocket maximum.

Network
A specific group of doctors, facilities, hospitals, and providers who contract with the insurance plan. In-network providers are your lowest cost for care.

Deductible
The annual dollar amount you pay before your insurance begins paying deductible-eligible claims.
Accrues toward your out-of-pocket maximum.

Out-of-Pocket Maximum
The most you will pay during the calendar year for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Balance Billing
The amount you are billed to make up the difference between what your **out-of-network** provider charges and what insurance reimburses.

Balance Billing is in addition to, and does not count toward your out-of-pocket maximum.

VISIT WWW.EXPLAINMYBENEFITS.COM/SCSD FOR MORE INFORMATION ON THE BENEFIT PLANS AVAILABLE TO YOU.

FLORIDA BLUE

Florida Blue

78170

www.floridablue.com

800.352.2583

Download the Florida Blue Mobile app for claims information, to access your ID card, find a doctor, and more!

Download on the App Store

GET IT ON Google Play

Cost Saving Strategies

You've heard the saying "you get what you pay for", but that doesn't always apply with medical care.

There are many ways to save money and get better care using your Florida Blue medical plan through Suwannee County School District. Take a look!

Stay in-network

This is the easiest way to save money!

Visit www.floridablue.com to find an in-network doctor or hospital.

Know before you go

Contact a Care Consultant to find out if your prescription or services require prior authorization. They can also help you compare cost of services at various facilities to ensure you are getting the most value from your plan.

888-476-2227

Check the price!

Before elective surgery or an MRI / CT scan, search facilities and providers on www.floridablue.com to find the most bang for your buck.

Stick with lower-cost labs

Quest Diagnostics can get you the same quality service with big savings!

LabCorp is out of network

Use free-standing facilities

Using an independent radiology center over an outpatient hospital for things like CT scans and MRIs can save you hundreds of dollars.

Use outpatient surgery

For a colonoscopy, GI endoscopy, or other outpatient procedure, try an outpatient surgery center and save hundreds or thousands of dollars.

Compare your Options

Choose between four medical plans, plus a hospital indemnity option, to best meet your needs. The Hospital Indemnity option is available to employees only, and is not a substitute for major medical coverage. Please see page 21 for additional information on your Hospital Indemnity Plan options.

HDHP with HSA Plans

	HMO Low (Plan 122/2123)	PPO Low (Plan 5192/5193)	HMO High (Plan 54)	PPO High (Plan 5781)
Provider Choice	**In-Network care only** *Except in the case of a true emergency, this plan only covers care through in-network **BlueCare** providers.*	**Use any provider** *However, you will pay less for care if you use in-network (**BlueOptions**) providers.*	**In-Network care only** *Except in the case of a true emergency, this plan only covers care through in-network **BlueCare** providers.*	**Use any provider** *However, you will pay less for care if you use in-network (**BlueOptions**) providers.*
Paying for Care	**Deductible then Coinsurance** *Most care is subject to the deductible. You then pay a percentage of the cost of care until your expenses meet the out-of-pocket maximum.*		**Copays** *You pay a copay for most services until your expenses meet the out-of-pocket maximum.*	
Prescription Drugs	**Deductible then Copay** *Your medical deductible must be met before copays apply. Once your medical deductible is met, you pay a copay for prescriptions until your expenses meet the out-of-pocket maximum.*		**Copays** *You pay a copay for prescriptions until your expenses meet the out-of-pocket maximum. Brand name medications have a deductible before your copays apply.*	

Your per-paycheck cost for coverage

HDHP with HSA Plans

	HMO Low (Plan 122/2123)	PPO Low (Plan 5192/5193)	HMO High (Plan 54)	PPO High (Plan 5781)
Employee Only	$48.84	$103.14	$132.93	$228.49
+ Spouse	$466.30	$612.32	$692.43	$908.92
+ Child(ren)	$300.48	$413.37	$475.28	$642.68
Family	$693.56	$884.97	$989.97	$1,273.80
Dual Spouse *(family coverage)*	$428.98	$620.39	$725.39	$1,009.22

$529.16

Did you know? Suwannee County School District contributes $529.16 per month ($264.58 each pay period) towards the cost of your SCSD group major medical insurance.

Medical Plan Summaries

HDHP with HSA Plans

	HMO Low **(Plan 122/2123)**	PPO Low **(Plan 5192/5193)**	HMO High **(Plan 54)**	PPO High **(Plan 5781)**
In-Network Coverage				
Deductible DED	$5,000 single coverage $10,000 family coverage	$3,500 per person $7,000 max. per family	$5,000 per person $10,000 max. per family	$1,500 per person $4,500 max. per family
Out-of-Pocket Maximum	$6,550 single $13,100 family	$6,500 per person $13,000 max. per family	$6,350 per person $12,700 max. per family	$5,500 per person $11,000 max. per family
Preventive Care	100% covered	100% covered	100% covered	100% covered
Primary Doctor Visit	DED then 10%	DED then 30%	$50 copay	$30 copay
Specialist Visit	DED then 10%	DED then 30%	$65 copay	$55 copay
Independent Labs	DED	DED	100% covered	100% covered
Outpatient X-Rays	DED then 10%	DED then 30%	Facility: $65 copay Hospital: DED then 30%	Facility: $50 copay Hospital: DED then 30%
Imaging: MRI / CT	DED then 10%	DED then 30%	Facility: $500 copay Hospital: DED then 30%	Facility: $250 copay Hospital: DED then 30%
Urgent Care Center	DED then 10%	DED then 30%	$85 copay	$60 copay
Emergency Room	DED then 10%	DED then 30%	$350 copay	$250 copay
Hospital Admission	DED then 10%	Opt 1: DED then 30% Opt 2: DED then 35%	DED then 30%	DED then 30%
Outpatient Surgery	DED then 10%	DED then 30%	DED then 30%	Surgical Center: $200 Hospital: DED then 30%
	If you elect family coverage on the HMO Low Plan, the annual out-of-pocket maximum for any one person is $6,850			
Out-of-Network Coverage *(plus balance billing)*				
Deductible	Not covered	$5,000 | $10,000	Not covered	$4,500 | $13,500
Coinsurance	Not covered	40% after deductible	Not covered	50% after deductible
Out-of-Pocket Max	Not covered	$11,600 | $24,200	Not covered	$11,000 | $22,000
Hospital Deductible	*Not Applicable*	$500 per admission	*Not Applicable*	$500 per admission
Pharmacy Coverage				
Rx Deductible DED	Combined with Medical	Combined with Medical	$300 *(Brand Drugs)*	$300 *(Brand Drugs)*
Retail Prescriptions *(up to 30 days)*				
Generic	DED then $10	DED then $10	$10 copay *(no deductible)*	$10 copay *(no deductible)*
Preferred Brand	DED then $50	DED then $50	DED then $50	DED then $60
Non-Preferred	Not covered	DED then $80	DED then $80	DED then $100
Mail Order Prescriptions *(90 days)*				
Generic	DED then $25	DED then $25	$25 copay *(no deductible)*	$25 copay *(no deductible)*
Preferred Brand	DED then $125	DED then $125	DED then $125	DED then $150
Non-Preferred	Not covered	DED then $200	DED then $200	DED then $250

growSCSB Wellbeing Program

Grow, Thrive, and Prosper with SCSB

All benefit-eligible employees of Suwannee County School District are automatically enrolled in the **growSCSB Wellbeing Program**.

What's here:

Offered through Navigate Wellbeing Solutions, growSCSB is full of resources for you to enjoy:

- healthy recipes
- workout videos
- meal planning
- challenges
- and more!

Track your activities throughout the year, sign up for challenges, and watch your progress grow!

Three steps to success

Wellbeing Survey

When you answer questions about your health and habits through our private **Wellbeing Survey**, you'll get a personalized report with recommendations to help you address your wellbeing needs and make real, positive changes.

Biometrics

When you get your biometric screening, enter your results to get a better understanding of your total health picture.

Challenge yourself

Participate in the wellbeing challenges that are offered to you throughout the year. You can sign up with a team or as an individual and test yourself against friends to achieve your goals. Track your activities online or connect your favorite device and get moving.

NAVIGATE WELLBEING SOLUTIONS

navigate Wellbeing Solutions

www.growSCSB.com

888.282.0822

Wellbeing, defined

Wellbeing is more than the number on a scale or the size of your clothes.

Our lives are complex, and our state of wellbeing is defined by multiple components working together to feed our minds, our bodies, and our spirits. We have designed this program to provide you with the resources and motivation that allows you be the best version of yourself.

- Purpose
- Physical
- Mindfulness
- Social
- Balance
- Nutrition
- Financial
- Community

If you are unable to participate in any of the health-related activities to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Becky Skipper at becky.skipper@suwannee.k12.fl.us.

Register Online

Visit www.growSCSB.com and click **Join Now;** follow the instructions to create your account.

Once you're registered, you can:

- Sync apps and devices
- Browse the exercise, yoga, and meditation library
- Search recipes,
- and more!

Please note: rewards are considered taxable income

Benefit Advocate

We offer you and your family access to our **no-cost**, **confidential** benefit advocate to help you make the best of your Suwannee County School District benefit plans.

Contact our team of advocates for assistance on items such as:

- **Explanation of benefits.** Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
- **Prescription/pharmacy problems.** Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help getting an authorization on a medication?
- **Benefits questions.** Are you unsure if the insurance will pay for a certain procedure?
- **Claim issues.** Did you receive a bill from a doctor, but don't know why?
- **Difficult situations.** Are you having difficulty getting a referral? Has the insurance carrier denied a procedure, and you want to appeal their decision?

Assistance is **free** and **confidential**!

Contact Information

Team of Advocates

844.781.8500
toll-free

Monday through Friday
8:00am - 6:00pm EST

bac.suwannee@ajg.com

Telehealth

MDLIVE®

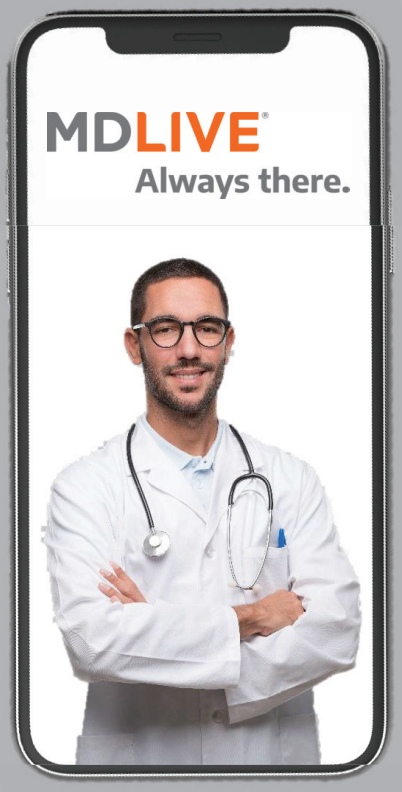
Suwannee County School District SCSD

Have You Heard?

You've Got MDLIVE

Virtual Doctor Visits Are Now Part of Your Health Plan…All You Need To Do Is Register for MDLIVE

- ✓ No Waiting Room
- ✓ No Sick People
- ✓ No Paperwork
- ✓ Hassel-free Medical Care
- ✓ $0 Doctor Visits



In order to properly activate your account, the information you input must match the information given to MDLIVE by SCSD exactly:

- FIRST NAME
- LAST NAME
- EMAIL
- PHONE NUMBER
- DOB
- GENDER
- ZIP-CODE

Activate For Free Today

(800) 400-6354

Or Visit

MDLIVE.com/TO

***When prompted, please select Telehealth Options as your Benefit Provider.**

Join for free. Visit a doctor. Call **800-400-6354** or visit MDLIVE.com/TO to get started. You can also download the app from the app store.

Health Savings Account (HSA)

Savings when you need care

When you enroll in one of our HDHP plans, the HSA is a great way to handle any medical, prescription, dental, and vision expenses not covered by insurance.

Enrolling in one of our **HDHP with HSA** plans allows you to make regular, tax-free contributions to your Health Savings Account through payroll, **and that's not all**:

- You own the account, even if you change plans or jobs;
- There are federal, state and FICA tax savings;
- Your funds roll over from year to year;
- You may change your contribution any time during the year, as long as you don't exceed the maximum;
- Any withdrawal for qualified health expenses is tax-free; and
- Monthly account administrative fees are waived for SCSD employees.

2022 Maximum Annual HSA Contribution

If you cover only yourself

$3,650

If you cover any dependents

$7,300

Age 55 or older?

You may contribute an extra **$1,000** per year in catch-up contributions.

Contribution maximums are set by the IRS ,include contributions from all sources, and assume 12 months of coverage in the HDHP Plan. Maximums may be pro-rated on a monthly basis for coverage lasting less than 12 months.

Opening your HSA for the first time

APPLICATION

Complete the First Federal account application available when you enroll online.

BRANCH

Bring your application to your nearest First Federal branch to complete your setup and receive your debit card.

PAYROLL

Submit your account information to payroll to begin your payroll deductions.

FIRST FEDERAL BANK

First Federal BANK of FLORIDA

www.ffbf.com

386.362.3433 ext 1985

The HSA Advantage

Sara has an individual HSA

She saves directly from her paycheck into her HSA

$900 annually ($37.50 per paycheck)

-$0 (No income tax is applied)

$900

Tax-free money to cover medical expenses

Jeff doesn't have an HSA

He saves for medical expenses from his paycheck

$900 annually ($37.50 per paycheck)

- $225 (25% federal income tax)

$675

Post-tax money to cover medical expenses

Good to know:

Your funds are available as soon as they are deposited and you can use your money in two ways:

1. Pay for out-of-pocket costs when you receive medical, prescription, dental, or vision care

OR

2. Leave the money in your account so it will carry over from year-to-year and grow tax-free

Please remember that you'll need to enroll in one of our HDHP plans to join our HSA. Also, you can't contribute to an HSA if you're in another medical plan (including Medicare or TRICARE) or are a dependent on someone else's tax return. In these cases, you can still enroll in the HDHP plan, but you'll need to opt out of the HSA.

VISIT WWW.EXPLAINMYBENEFITS.COM/SCSD FOR MORE INFORMATION ON THE BENEFIT PLANS AVAILABLE TO YOU.

Do you have questions about your eligibility or how an HSA might affect your taxes? Contact your tax professional for advice.

Flexible Spending Accounts (FSA)

Healthcare FSA

Pay for qualifying medical, pharmacy, dental, and vision expenses using pre-tax funds with a Healthcare FSA.

Note:
This plan does not include a debit card. You may easily file a claim for reimbursement online or using the mobile app.

By the numbers:

Maximum Contribution	**$1,500 annually**
Incur claims *The date the service (doctor visit, rx fill, test, etc.) actually happens*	**May 1st** through **April 30th**
Submit claims *The date you provide the claim information to Discovery Benefits*	through **July 31, 2023**

Good to know:

If you enroll in the **HDHP plan** and are eligible to contribute to an HSA, you are **not eligible** for a Healthcare FSA. You may use the funds in your HSA to pay for eligible expenses.

Estimate carefully! Any leftover funds at the end of the plan year will be forfeited per IRS requirements. Changes cannot be made to your contribution election during the year without a qualifying life change. **(Use it or lose it)**

Did you know....

For each dollar you contribute to a Flexible Spending Account, you save about **$0.30** in taxes (your actual amount depends on your tax bracket).

DISCOVERY BENEFITS

Discovery Benefits®

160-157141-1

www.discoverybenefits.com

866.451.3399

Dependent Care FSA

Pay for qualifying dependent care on behalf of an eligible individual using pre-tax funds with a Dependent Care FSA.

Did you know....

For each dollar you contribute to a Flexible Spending Account, you save about **$0.30** in taxes (your actual amount depends on your tax bracket).

By the numbers:

Maximum Contribution	**$5,000** annually *married filing separately: $2,500*
Incur claims **The date the care actually occurs**	**May 1st** through **April 30th**

Good to know:

- Expenses must be necessary for you and your spouse (if applicable) to work or attend school.
- Only the amount you've contributed year to date is available at any one time.
- Eligible individuals are typically defined as a dependent child under the age of 13 or a spouse / adult tax dependent who is incapable of self-care.

Estimate carefully! Any leftover funds at the end of the year will be forfeited per IRS requirements. Changes cannot be made to your contribution election during the year without a qualifying life change. (**Use it or lose it**)

DISCOVERY BENEFITS

Discovery Benefits®

27561

www.discoverybenefits.com

866.451.3399

Dental Insurance

Dental care that makes you smile

Visit any licensed dentist you like; but choose an in-network dentist and you'll make the most of your plan.

QUALITY ASSURANCE
In-network dentists are monitored for proper licensing, cleanliness, and safety.

NO PRE-PAYMENT
You'll pay only your portion of the bill – The Standard pays your in-network dentist directly.

NO BALANCE BILLING
You won't be charged more than the rate negotiated by your in-network provider.

LOWER PRICES
Through reduced fees when you choose an in-network provider

Dental network options	Your cost for care
In-Network *Provides greater savings and* **no balance billing**	$
Out-of-Network *You pay based on full price (no discounts) and* **balance billing applies**	$ $ $ $

THE STANDARD

TheStandard® Positively different.

160-157141-1

www.standard.com

800.547.9515 M-Th 8:00 a.m. - midnight EST, Friday 8:00 a.m. - 6:30 p.m. EST

Plan Summaries

	Low Plan	High Plan
Deductible DED	$50 single coverage $150 family coverage	$50 single coverage $150 family coverage
Annual Benefit Maximum	$750 per person	$1,250 per person
In-Network Care		
Preventive Care *(cleanings, exams, x-rays)*	100% Covered (no DED)	100% Covered (no DED)
Basic Care *(endodontics, periodontics, composite fillings on all teeth)*	DED then 20%	DED then 20%
Major Care *(crowns and dentures)*	DED then 50%	DED then 50%
Child & Adult Orthodontia	50% *($1,000 lifetime maximum per person)*	50% *($1,000 lifetime maximum per person)*
Out-of-Network Care		
Preventive Care *(cleanings, exams, x-rays)*	100% Covered (no DED) *Plus balance billing*	100% Covered (no DED) *Plus balance billing*
Basic Care *(endodontics, periodontics, composite fillings on all teeth)*	DED then 20% *Plus balance billing*	DED then 20% *Plus balance billing*
Major Care *(crowns and dentures)*	DED then 50% *Plus balance billing*	DED then 50% *Plus balance billing*
Child & Adult Orthodontia	50% *($1,000 lifetime maximum per person)* *Plus balance billing*	50% *($1,000 lifetime maximum per person)* *Plus balance billing*

Our dental plan uses the Ameritas dental network. To locate an in-network provider:

- Visit dentalnetwork.ameritas.com
- Enter your location and select the **Classic (PPO)** Network

Balance billing is the amount you are billed to make up the difference between what your **out-of-network** provider charges and what insurance reimburses.

Your per-paycheck cost for coverage

	Low Plan	High Plan
Employee Only	$16.55	$19.47
+ Spouse	$43.66	$51.37
+ Child(ren	$36.77	$43.24
Family	$62.01	$72.98

Vision Insurance

Focus on your vision

Vision care through **The Standard** helps keep your eyes healthy and your vision sharp. Look for a provider who participates in the **VSP Choice** network.

	In-Network	Out-Of-Network
Eye Exam *(every 12 months)*	$10 copay	$10 copay then up to $45 allowance
Materials *(lenses and/or frames)*	$10 copay	$10 copay Not applicable
Lenses: Single / Bifocal / Trifocal *(every 12 months)*	Covered after copay	Up to $30 / $50 / $65 allowance
Frames *(every 24 months)*	$150 allowance after copay	Up to $75 allowance
Elective Contact Lenses *(every 12 months)*	**Exam**: you pay up to $60 **Lenses**: $150 allowance	**Exam**: No Benefit **Lenses**: Up to $120 allowance
Medically Necessary Contact Lenses	Covered 100%	Up to $210 allowance

Elective contact lenses are available in lieu of glasses (lenses and/or frames). You are not eligible for glasses for 12 months after you receive elective contacts, and vice-versa.

Your per-paycheck cost for coverage

	Vision Coverage
Employee Only	$3.34
Employee + One	$6.65
Family	$8.91

Our vision plan uses the VSP Choice network. To locate an in-network provider:

- Visit www.vsp.com/eye-doctor
- Enter your location and search for providers in the Choice Network

THE STANDARD

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157141

www.standard.com

800.877.7195 M-F 8:00 a.m. - 9:00 a.m. EST, Saturday 9:00 a.m. - 5:00 p.m. EST

Life and AD&D Insurance

Coverage for the unexpected

Providing your family with peace of mind and financial security.

Basic Life and AD&D Insurance

SCSD provides **life insurance** and **accidental death and dismemberment (AD&D)** coverage in the amount of **$5,000** at no cost to you through **The Standard**. Make sure you designate a beneficiary who will receive your life insurance payment if you pass away while covered under this policy.

Additional Supplemental Term Life Insurance

To supplement the life insurance coverage provided by Suwannee County School District, you have the option to purchase additional term life insurance for yourself and your dependents through **The Standard**. Your cost depends on your age and coverage level. Rates are reflected in your benefit enrollment system. **You must cover yourself to purchase coverage for your dependents.**

We also offer a Universal Life Insurance option; see page 22 for details.

Employee Coverage

Available increments	**$10,000**
Coverage maximum	**5 times salary to $250,000**
Medical question limit	*$150,000*

Spouse Coverage

Available increments	**$5,000**
Coverage maximum	**50% of employee amount**
Medical question limit	*$25,000 (ages 60-69: $1,000)*

Child Coverage

Policy amount	**$10,000 -** *Covers all eligible children (14 days to 6 months: $500)*
Coverage maximum	**50% of employee amount**

Your monthly cost for life insurance

Your age	**Cost** per **$1,000** of coverage
0-24	$0.124
25-29	$0.174
30-34	$0.204
35-39	$0.270
40-44	$0.360
45-49	$0.482
50-54	$0.622
55-59	$0.694
60-64	$1.054
65-69	$2.224
70 +	$3.564

Medical Question Limit

As a **newly eligible employee**, you may elect up to the medical question limit with no medical questions required. **Initial** requests to purchase coverage over the medical question limit amount will be subject to medical questions and approval by The Standard. **Future** requests to purchase this coverage after your initial opportunity will be subject to medical questions and approval by The Standard.

If your Life Insurance election requires medical questions, your coverage will be effective and paycheck deductions will begin when approval is received from The Standard.

Disability Insurance

Protecting your income

Insurance for your paycheck if you become unable to work due to disability.

Disability Insurance Matters

How long can you pay the bills without an income? A few weeks? Maybe a month? What happens if you get sick or have an accident and can't work? How will the rent or mortgage get paid? What about groceries, insurance, and shoes for the kids?

Disability happens. Studies estimate that just over **one in four** of today's 20-year olds will become disabled before they retire[1]. **Do you have a rainy day fund?** More than half of Americans have **less than $1,000** in savings[2]. What would you do if your income stopped because you couldn't work?

Short-term disability insurance is designed to fill the financial gap while you get better. Or, in the event you can't return to work, **long-term** disability insurance can help provide you and your family with a continuing source of income. You may purchase one or both of these policies through The Standard. Cost information is available when you enroll online.

[1]U.S. Social Security Administration, Fact Sheet 2017
[2]GoBankingRates Savings Survey, 2017

VISIT WWW.EXPLAINMYBENEFITS.COM/SCSD FOR MORE INFORMATION ON THE BENEFIT PLANS AVAILABLE TO YOU.

Short-Term Disability Insurance

Short-Term Disability insurance is designed to provide you with income protection on a more immediate basis if you are unable to work due to a covered, non work-related injury or illness. You have two options available for purchase through The Standard: **Option One** and **Option Two**. Your cost for coverage depends on your benefit choice and your income.

	Option One	Option Two
Benefits begin:	after the **7th day** of your inability to work due to an illness or injury	after the **14th day** of your inability to work due to an illness or injury
Benefit amount	**60%** of your earnings to a maximum of **$1,500** per week	
How long payments last	up to **12 weeks**	up to **11 weeks**

As a newly eligible employee, you may elect either Short-Term disability plan with no medical questions required. Any future enrollment or increase requests *(i.e. Option Two to Option One)* **will be subject to medical questions and approval by The Standard.**

See pages 21-24 in this guide for more information on this benefit.

Long-Term Disability Insurance **New Increased Benefit**

Long-Term Disability insurance is designed to provide you with lasting income protection in the event you're unable to return to work. You may purchase this plan through The Standard; your cost for coverage depends on your income.

Benefits begin:	after the **90th day** of your inability to work due to an illness or injury
Benefit amount	**60%** of your earnings to a maximum of **$5,000** per month
How long payments last	until **age 65** (*later if you become disabled after age 62)*

This policy has a **pre-existing condition limitation** which means that conditions you received treatment for during the **three months** prior to the start of the coverage are excluded for the first **12 months** of coverage.

As a newly eligible employee, you may elect Long-Term disability insurance with no medical questions required. Any future enrollment requests will be subject to medical questions and approval by The Standard.

If your disability plan election requires medical questions, your coverage will be effective and paycheck deductions will begin when approval is received from The Standard.

Additional Benefit Options

Extra protection for you and your family

We offer additional benefit options for purchase to provide you and your family with the protection you need. These benefit plans pay directly to you - not a doctor or a hospital - and most are portable, which means you can take them with you if you leave Suwannee County School District. Please see the benefit summaries available online for all of these plans.

Hospital Indemnity Plan Options

American Public Life (APL)

The **APL** Hospital Indemnity Plan can help offset your out-of-pocket costs for care including deductible, coinsurance, copays, and services not covered under your medical plan for hospitalization and inpatient surgery.

Choose between two plans:

- **High plan:** $2,500 initial hospital admission benefit
- **Low plan**: $1,500 initial hospital admission benefit

Your per paycheck cost for coverage

	High Plan	Low Plan
Employee Only	$16.45	$10.90
Employee + Spouse	$30.44	$20.19
Employee + Child(ren)	$23.69	$15.44
Employee + Family	$37.42	$24.52

Florida Combined Life (FCL)

FCL policy is **employee only coverage** that pays $100 per day of hospitalization up to 365 days and includes a $50,000 life insurance policy. May not be purchased with one of the major medical plans. This is a supplement to health insurance and is NOT a substitute for major medical coverage.

NOTE: **These plans are not portable.**

Cost per pay period

$10.00

Identity Theft Protection

IDShield monitors your social security number, bank accounts, credit cards, even your social media accounts to watch for status changes and alert you. In the event your identity is compromised, IDShield partners with Kroll, a leader in theft investigative services, to help restore your identity to the way it was.

If you cover your family, IDShield also monitors the credit and social security numbers of your minor children.

Your per paycheck cost for coverage

Employee Only	$3.75
Family	$7.13

*If you enroll in both the IDShield and LegalShield plans, you will receive a 15% discount on your IDShield rates.

Legal Protection

LegalShield gives you access to licensed, experienced attorneys that can assist you with a variety of legal issues. Examples include wills and trusts, bankruptcy, divorce, speeding ticket assistance, and court representation. Your plan covers both in office visits and phone consultations with an attorney.

Your per paycheck cost for coverage

Family	$9.50

VISIT WWW.EXPLAINMYBENEFITS.COM/SCSD FOR MORE INFORMATION ON THE BENEFIT PLANS AVAILABLE TO YOU.

Accident Coverage

Accident coverage through **Trustmark** pays if you are injured in an accident on- or off-the-job (24-hour coverage). **A Health Screening benefit is included**. Benefits are paid for:

- Fractures and dislocations
- Tendon and ligament tears
- Burns and stitches
- Hospitalization
- Medical expenses & various treatments
- Doctor visits and more

Health Screening Benefit: pays **$100** per member each year for wellness screenings.

Your per paycheck cost for coverage

Employee Only	$11.37
Employee + Spouse	$16.94
Employee + Child(ren)	$21.50
Employee + Family	$27.08

Critical Illness Coverage

Critical Illness coverage through **The Standard** pays a benefit for specified diagnoses. Choose a lump sum coverage amount of $10,000, $20,000, or $30,000.

- Covered Illnesses
- Heart Attack
- Stroke
- Cancer
- End stage renal (kidney) failure
- Major organ failure
- Coma
- Paralysis of two or more limbs
- Loss of sight
- Occupational HIV
- Occupational hepatitis
- 21 childhood diseases

Severe coronary artery disease with recommendation for bypass surgery, and carcinoma in situ (cancer that has not metastasized) are covered at 25% of your coverage amount.

- **Family coverage** is available. Your spouse may be covered $5,000, $10,000, or $15,000 as long as the amount does not exceed 50% of employee's coverage amount. Children are covered at 50% of employee's coverage amount
- **Health Screening Benefit**: pays $50 per member per year for routine screenings.

Your **cost** depends on your age and the coverage elected, and is shown in the benefit system when you enroll.

Universal Life Insurance

Universal Life Term Insurance through **Trustmark** is designed to match your needs throughout your lifetime. Coverage is available for employees, spouses, and children.

Death benefit is paid upon your passing if you remain covered by the policy.

- **Long-Term Care (Living) benefit** pays 4% of your death benefit per month for 25 months, with the remaining amount (if any) paid as a death benefit.

Your **cost** depends on your age and the coverage elected and is shown in the benefit system when you enroll.

Annual Rights and Notices

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Human Resources with any questions you have.

Availability of Summary Health Information - Choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage ("SBC") is available, which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC and SBC Glossary is available on Launchpad under the Staff Resources. To view documents, please click on the Resources tab, and go to Staff. Other important insurance information is also available in this location, including Marketplace Notice and COBRA Continuation Coverage Rights. Paper copies of these documents are available, free of charge, by calling Teri Jones at 386.647.4616.

HIPAA Special Enrollment Rights – If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Benefits or HR Administrator.

Section 111 – Effective January 1, 2009 Group Health Plans are required by the Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. This mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help to establish who pays first. The mandate requires Group Health Plans to collect additional information such as social security numbers for all enrollees, including dependents aged six months or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998 – If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns' and Mothers' Health Act - Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection – If your group health plan requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan will make one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating healthcare professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) – If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your state for more information on eligibility.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) – State Contact Information:

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa 800.862.4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

Medicare D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Suwannee County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide a minimum standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Suwannee County School District has determined that the prescription drug coverage administered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Suwannee County School District coverage will be affected. While you are still employed, you can keep your current plan if you elect Part D, and this plan will coordinate with Part D coverage. Your Suwannee County School District plan would be your primary coverage, and Part D would be your secondary coverage.

If you do decide to join a Medicare drug plan and drop your current Suwannee County School District coverage, be aware that you and your dependents will be able to get this coverage back as an active employee. This change would be limited to annual open enrollment periods.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Suwannee County School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you have 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you leave nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the person listed below for further information or call Gallagher Benefit Services at 386.755.7275. NOTE: This notice will be updated each year. You will receive it before the next period you can join a Medicare drug plan and if this coverage through Suwannee County School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained non-creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: May 1, 2022
Name of Entity / Sender: Suwannee County School District
Contact / Title: Jillian Herron or Teri Jones, Employee Benefit Specialists
Address: 1740 Ohio Avenue, South
Live Oak, FL 32064
Phone Number: 386.647.4614 or 386.647.4616

SUWANNEE COUNTY SCHOOL DISTRICT

1740 Ohio Avenue, South
Live Oak, Florida 32064
Telephone: (386) 647-4600 • Fax: (386) 364-2635

TED L. ROUSH
Superintendent of Schools

TO: All District Employees
FROM: Suwannee County School District Insurance Department
DATE: May 1, 2022
RE: Required Notification Regarding the Patient Protection and Affordable Care Act

The attached notification is being provided to you in compliance with the Patient Protection and Affordable Care Act. This notification is strictly informational regarding the Health Insurance Marketplace.

SCSD is required to notify all employees about the Health Insurance Marketplace. The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. Open Enrollment for health insurance coverage through the Marketplace begins in October, with coverage starting as early as January 1st. Some employees may be able to get lower costs on private insurance in the Marketplace based on their income. However, because SCSB offers coverage that meets the required standards, you will not be eligible for a tax credit through the Marketplace and may therefore prefer to remain on SCSB's group health plan.

If you purchase a health plan through the Marketplace instead of accepting group health coverage offered by SCSB, then you will lose the employer contribution to the employer-offered coverage. Our employer contribution, as well as your employee contribution to SCSB group health coverage, is excluded from income for federal income tax purposes under current tax regulations. If you choose coverage through the Marketplace, your payments for coverage are made on an after-tax basis.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Visit www.HealthCare.gov for more information, including an online application. The attached document will provide you with information that you will need while on the Marketplace website.

SCSB is not able to address questions regarding the Health Insurance Marketplace. If you have questions regarding the Health Insurance Marketplace, you should visit www.HealthCare.gov.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Teri Jones (386) 647-4616 or Jillian Herron (386) 647-4614.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Suwannee County Board of Public Instruction		4. Employer Identification Number (EIN) 59-6000872
5. Employer address 1740 Ohio Avenue, South		6. Employer phone number (386) 647-4600
7. City Live Oak	8. State FL	9. ZIP code 32064
10. Who can we contact about employee health coverage at this job? Teri Jones		
11. Phone number (if different from above) (386) 647-4616	12. Email address teresa.jones@suwannee.k12.fl.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Benefit eligible employees working minimally 20 hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Covered employee's legal spouse and/or dependent child of the employee or employee's spouse. A dependent child is defined as: A natural child, a step child, a legally adopted child, a child for whom legal guardianship has been awarded to covered employee or employee's spouse, or unmarried children of any age who became mentally or physically disabled before reaching the age limit of 30.

☒

☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $48.84
b. How often? ☐ Weekly ☐ Every 2 weeks ☑ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? None
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

1740 Ohio Avenue, South
Live Oak, Florida 32064
Telephone: (386) 647-4600 • Fax: (386) 364-2635

TED L. ROUSH
Superintendent of Schools

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You are getting this notice because you recently gained coverage under a group health plan (Florida Blue Group # 78170) and/or a group dental/vision plan (The Standard Insurance Company Group # 157141). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Suwannee County Board of Public Instruction, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Please be advised there are two Plan Administrators: **Florida Blue is the Plan Administrator for FloridaBlue health coverage, and WageWork, Inc., is the Plan Administrator for The Standard dental and vision coverage. You must provide this notice to:**

Florida Blue Coverage Continuation Team **(855) 509-1678**
Email: continuationofcoverage@FloridaBlue.com

WageWorks/Health Equity Coverage Continuation Team **(877) 266-3947**
Website: https://COBRAbenefits.wageworks.com

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to Florida Blue Coverage Continuation Team at (855) 509-1678. You may be required to provide documentation from the Social Security Administration reflecting your approved disability.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to Florida Blue Coverage Continuation Team at (855) 509-1678.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Florida Blue Group # 78170
Florida Blue Coverage Continuation Team
Email: continuationofcoverage@FloridaBlue.com

Health Insurance
(855) 509-1678

The Standard Insurance Group #160-157141
WageWorks/Health Equity Coverage Continuation Team
Website: https://COBRAbenefits.wageworks.com

Dental and/or Vision Insurance
(877) 266-3947

For further information about the Plan(s) and COBRA continuation coverage, please contact:

Suwannee County Board of Public Instruction
Attn: Teri Jones, Employee Benefits Specialist
1740 Ohio Avenue, South, Live Oak, FL 32064
Phone: (386) 647-4616
e-mail: teresa.jones@suwannee.k12.fl.us

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

Effective 5/1/2022

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **https://www.suwannee.k12.fl.us/staff-resources**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.suwannee.k12.fl.us/staff-resources** or call 386-647-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,550** Per Person. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible + 10% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: Deductible/ Urgent Care Visits: Deductible + 10% Coinsurance	Not Covered	Out-of-Network only covered out-of-state.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$5,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ FEP โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiik'eh, ná hóló. Kojį' hodiilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígáí éí kojį' hodiilnih 1-800-333-2227.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **https://www.suwannee.k12.fl.us/staff-resources**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.suwannee.k12.fl.us/staff-resources** or call 386-647-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,850** Per Person/**$13,100** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible + 10% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: Deductible/ Urgent Care Visits: Deductible + 10% Coinsurance	Not Covered	Out-of-Network only covered out-of-state.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Children's eye exam	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$5,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم واليكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiik'eh, ná hóló. Kojį' hodiilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígáí éí kojį' hodiilnih 1-800-333-2227.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **https://www.suwannee.k12.fl.us/staff-resources**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.suwannee.k12.fl.us/staff-resources** or call 386-647-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Pharmacy Deductible; . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,350** Per Person/**$12,700** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: $50 Copay per Visit/ Primary Care Visits: $50 Copay per Visit/ Virtual Visits: $50 Copay per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $65 Copay per Visit/ Specialist: $65 Copay per Visit/ Virtual Visits: $65 Copay per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $65 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $65 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	$500 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$300 Pharmacy Deductible + $50 Copay per Prescription at retail, $300 Pharmacy Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$300 Pharmacy Deductible + $80 Copay per Prescription at retail, $300 Pharmacy Deductible + $200 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$350 Copay per Visit	$350 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: No Charge - Visits 1-2	Not Covered	Out-of-Network only covered out-of-state.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		$85 Copay for remaining Visits/ Urgent Care Visits: $85 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$65 Copay on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$65 Copay per Visit	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Motorized Wheelchairs: $500 Copay per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,460**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other No Charge	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,030**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other Copayment	$350

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770）。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم واليكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiik'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP **igii éí kojį' hodíilnih** 1-800-333-2227.

Florida Blue

BlueOptions 05192

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

Coverage Period: 05/01/2022 - 04/30/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **https://www.suwannee.k12.fl.us/staff-resources**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.suwannee.k12.fl.us/staff-resources** or call 386-647-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,500** Per Person. Out-of-Network: **$5,000** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,500** Per Person. Out-Of-Network: **$11,600** Per Person.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2459708

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: Deductible/ Urgent Care	Value Choice Provider: Not Covered/ Urgent Care	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Visits: Deductible + 30% Coinsurance	Visits: Deductible + 20% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 30% Coinsurance/ Specialist Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance/ Hospital: Per Admission Deductible + Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist Coinsurance	30%
Hospital (facility) Coinsurance	30%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,070**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist Coinsurance	30%
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$500
Coinsurance	$40
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,070**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist Coinsurance	30%
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم واليكم: 1-800-559-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ FEP โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákoninzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiik'eh, ná hóló. Kojį' hodiilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodiilnih 1-800-333-2227.

Florida Blue

BlueOptions 05193

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

Coverage Period: 05/01/2022 - 04/30/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **https://www.suwannee.k12.fl.us/staff-resources**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.suwannee.k12.fl.us/staff-resources** or call 386-647-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,500** Per Person/**$7,000** Family. Out-of-Network: **$10,000** Per Person/**$10,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,500** Per Person/**$13,000** Family. Out-Of-Network: **$23,200** Per Person/**$23,200** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2460143

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: Deductible/ Urgent Care	Value Choice Provider: Not Covered/ Urgent Care	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Visits: Deductible + 30% Coinsurance	Visits: Deductible + 30% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 30% Coinsurance/ Specialist Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance/ Hospital: Per Admission Deductible + Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance,

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist Coinsurance	30%
Hospital (facility) Coinsurance	30%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,070**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist Coinsurance	30%
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$500
Coinsurance	$40
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,070**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist Coinsurance	30%
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

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توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákoninzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiik'eh, ná hóló. Kojį' hodiilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP **igáí éí kojį' hodiilnih** 1-800-333-2227.

Florida Blue

BlueOptions 05781

with Rx $300 Rx Deductible $10/$60/$100

Coverage Period: 05/01/2022 - 04/30/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **https://www.suwannee.k12.fl.us/staff-resources**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.suwannee.k12.fl.us/staff-resources** or call 386-647-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person/**$4,500** Family. Out-of-Network: **$4,500** Per Person/**$13,500** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Pharmacy Deductible; **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$5,500** Per Person/**$11,000** Family. Out-Of-Network: **$11,000** Per Person/**$22,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2461251

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: $30 Copay per Visit / Primary Care Visits: $30 Copay per Visit/ Virtual Visits: $30 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $55 Copay per Visit/ Specialist: $55 Copay per Visit/ Virtual Visits: $55 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $55 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $50 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$250 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$300 Pharmacy Deductible + $60 Copay per Prescription at retail, $300 Pharmacy Deductible + $150 Copay per Prescription by mail	$300 Pharmacy Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$300 Pharmacy Deductible + $100 Copay per Prescription at retail, $300 Pharmacy Deductible + $250 Copay per Prescription by mail	$300 Pharmacy Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $200 Copay per Visit/ Hospital: Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Ambulatory Surgical Center: $55 Copay per Visit/ Hospital: Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 Copay per Visit	$250 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: $60 Copay- Visits 1-2 $60 Copay for remaining Visits/ Urgent Care Visits: $60 Copay per Visit	Value Choice Provider: Not Covered/ Urgent Care Visits: Deductible + $60 Copay per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge	Physician Services: No Charge/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$55 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	$55 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,570**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,030**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Copayment	$250

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778). اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ FEP โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jiik'eh, ná hóló. Kojį' hodiilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP igii éí kojį' hodiilnih 1-800-333-2227.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

SUWANNEE CNTY BOARD OF PUBLIC
ATTN TERESA JONES
1740 OHIO AVE S
LIVE OAK FL 32064-4500

Thanks for choosing Florida Blue! See the enclosed **Welcome brochure** for everything you need to get the most value from your health plan. For plan info on the go, download the Florida Blue app or log in to your account at floridablue.com.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of
Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

This Master Contract is for SUWANNEE CNTY BOARD OF PUBLIC

Group Number 78170

Division(s)	Package	Division	Package

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc., d/b/a/ Florida Blue, Health Options, Inc., d/b/a Florida Blue HMO, and BeHealthy Florida, Inc., d/b/a Florida Blue Preferred HMO, collectively referred to as Florida Blue in this Notice) understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:
We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information, and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:
We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.
There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:
To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to

a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
- **Note:** If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Notice Regarding Coverage for Breast Reconstruction Surgery

If you have to have a mastectomy, your breast reconstruction surgery is covered under your health coverage. It can be done at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

BlueCare

Schedule of Benefits Plan 54

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- Copayments listed in this Schedule of Benefits appear as a dollar amount only and apply per visit.
- Your Cost Share will vary depending upon the medical Service you receive, the setting of the Services and the Provider you choose to see.
- References to Deductible are abbreviated as **"DED"** and references to Benefit Period are abbreviated as **"BP"**.

Your Benefit Period (BP).....01/01 - 12/31

DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET	YOU PAY
Deductible (DED) Per person per BP	$5,000
Per family per BP	$10,000
Per Admission Deductible (PAD)	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	30%
Maximum Out-of-Pocket Per person per BP	$6,350
Per family per BP	$12,700

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

- Copayments
- Coinsurance (if applicable)
- DED (if applicable)
- PAD (if applicable)
- BlueCare Rx Cost Share

What **does not apply** to the maximum out-of-pocket?

- Charges for non-covered Services

OFFICE SERVICES	YOU PAY	
	PCP	**Specialist**
Office Visit Cost Share	$50	$65
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$500	$500
All other diagnostic Services (e.g., x-rays)	$50	$65
Allergy Injections	$10	$10
Allergy Testing	$50	$65
Maternity (due at initial visit only)	$50	$65
Therapy and Spinal Manipulation (e.g., Physical, Speech, Cardiac or Occupational)	$50	$65

VIRTUAL HEALTH	YOU PAY
Virtual Visits	
General Medicine and Urgent Care rendered by a designated Virtual Care Provider	$50
Specialized Care rendered by a designated Virtual Care Provider	$65

Please visit http://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

MEDICAL PHARMACY	YOU PAY
Medication**	20%
Maximum Out-of-Pocket per person per Month***	$200

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

PREVENTIVE HEALTH SERVICES	YOU PAY
Adult Wellness Services Physician's office and all other locations	$0
Adult Well Woman Services Physician's office and all other locations	$0
Child Health Supervision Services Physician's office and all other locations	$0
Colonoscopies (Routine)	$0
Mammograms	$0

OUTPATIENT DIAGNOSTIC SERVICES	YOU PAY
Independent Clinical Lab	$0
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$500
All other diagnostic Services (e.g., x-rays)	$65
Outpatient Hospital Facility	See **Hospital Services**

EMERGENCY AND URGENT CARE SERVICES	YOU PAY
Ambulance Services	DED + 30%
Emergency Room Visits	See **Hospital Services**
Urgent Care Center	$85

OUTPATIENT SURGICAL SERVICES	YOU PAY
Ambulatory Surgical Center	
Facility	DED + 30%
PCP	DED + 30%
Radiologists, Anesthesiologists, and Pathologists	$100
Other health care professional Services rendered by all other Providers	DED + 30%
Outpatient Hospital Facility	See **Hospital Services**

HOSPITAL SERVICES	YOU PAY
Inpatient Facility	DED + 30%
Physician and other health care professional Services	DED + 30%
Outpatient Facility	DED + 30%
Physician and other health care professional Services	DED + 30%
Therapies and Spinal Manipulation	$85
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 30%
All other diagnostic Services (e.g., x-rays)	DED + 30%
Emergency Room Visits (Facility Copayment waived if admitted) In-Network Hospital Facility	$350
Out-of-Network Hospital Facility	$350
Physician and other health care professional Services	DED + 30%

SPECIAL SERVICES	YOU PAY
Birth Center	DED + 30%
Convenient Care Center	$50
Diabetic Equipment	$0
Dialysis Center	DED + 30%
Durable Medical Equipment	
Motorized wheelchairs	$500
All other Durable Medical Equipment	$0
Enteral Formula	$0
Home Health Care	$0
Hospice Services	DED + 30%
Outpatient Rehabilitation Facility	$65
Physician Services (rendered at locations not otherwise noted in this schedule)	
PCP	DED + 30%
Specialist	DED + 30%
Prosthetic and Orthotic Devices	$0
Second Medical Opinion	
In-Network Provider	$65
Out-of-Network Provider	40%
Skilled Nursing Facility	DED + 30%

BEHAVIORAL HEALTH SERVICES	YOU PAY
Mental Health and Substance Dependency Treatment Services	
Outpatient Facility	
Emergency Room	$0
Hospital	$0
Physician Services at a Hospital and ER	
PCP	$0
Specialist	$0
Physician and other health care professionals licensed to perform such Services rendered at:	
PCP Office	$0
Specialist Office	$0
All other locations	
PCP	$0
Specialist	$0
Inpatient	
Facility	$0
Physician and other health care professional Services	$0

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Home Health Care visits.....60

Inpatient Rehabilitation days 30

Outpatient Therapies and Spinal Manipulation visits 30

Note: Spinal Manipulations are limited to 30 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum.

Skilled Nursing Facility days 45

BlueCare Rx® Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueCare Rx Pharmacy Program described in the PRESCRIPTION DRUG PROGRAM section of your Benefit Booklet, both of which should be reviewed carefully. To find a Participating Pharmacy, access the Pharmacy Program Provider Directory website at www.floridablue.com or call the customer service phone number included on the your ID Card.

Pharmacy per Calendar Year Deductible (BP).....$300

Note: The Pharmacy Deductible does not apply to Preferred Generic Prescription Drugs or Covered OTC Drugs purchased from a Participating Pharmacy.

Place of Purchase	Cost to You
Participating Retail Pharmacy Copayments or Coinsurance percentages that apply to each **One-Month Supply**	
Preferred Generic Prescription Drugs and Supplies Preferred Brand Name Prescription Drugs and Supplies Non-Preferred Prescription Drugs and Supplies	$10 DED + $50 DED + $80
Mail Order Pharmacy Copayments or Coinsurance percentages that apply to each **Three-Month Supply** unless indicated otherwise	
Preferred Generic Prescription Drugs and Supplies Preferred Brand Name Prescription Drugs and Supplies Non-Preferred Prescription Drugs and Supplies	$25 DED + $125 DED + $200
Specialty Pharmacy Copayments or Coinsurance percentages that apply to each **One-Month** Supply	
Preferred Generic Prescription Drugs and Supplies Preferred Brand Name Prescription Drugs and Supplies Non-Preferred Prescription Drugs and Supplies	$10 DED + $50 DED + $80

+

Other Important Information affecting what you will pay:

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
    1. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the Cost Share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
    2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.
- Some Specialty medications 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.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

BlueCare

Benefit Booklet for Covered Plan Participants of

Suwannee County Board of Public Instruction

Effective Date: May 1, 2021

A Self-Funded Group Health Benefit Plan Serviced by Health Options, Inc.

Group 78170
Plan 54

Benefit Booklet

BlueCare

for Self-Funded Groups
Benefit Booklet

For Customer Service Assistance: 800-664-5295

Group 78170
Plan 54

Benefit Booklet

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HOW TO USE YOUR BENEFIT BOOKLET

This is your Benefit Booklet ("Booklet"). It describes your coverage and benefits for Health Care Services, as well as the limitations and exclusions that apply, under the Group Health Plan ("Plan") established and maintained by Suwannee County Board of Public Instruction. Your Plan is self-funded; this means that benefits for Covered Services under the Plan will be paid either directly from the Group's general assets or a combination of its general assets and contributions made by Covered Plan Participants. The benefits provided under the Plan are not guaranteed or insured by an insurance company or by Health Options, Inc. ("HOI").

The sponsor of your Plan has contracted with us under an Administrative Services Agreement ("ASA"), to provide certain third party administrative services, including claims processing, customer service, and other services and access to our Health Maintenance Organization ("HMO") Provider network. HOI provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to you or claims submitted for processing under this Booklet for such Services. The payment of claims under the Plan depends exclusively upon the funding provided by Suwannee County Board of Public Instruction.

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

- your BlueCare benefits;
- what is covered;
- what is not covered;
- coverage and payment rules;
- how and when to file a claim and under what circumstances the Plan 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 benefits will be coordinated with other policies or plans; our subrogation rights of the Plan; and it's right of reimbursement.

If your benefits under this Plan are subject to the Employee Retirement Income Security Act of 1974 (ERISA), you should also read the Group's Summary Plan Description (SPD) for further important details concerning your rights and responsibilities under the Plan.

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

When reading your Booklet, please remember:

You should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered. Certain coverage information may be provided in the form of an Endorsement to this Booklet, if so, an Endorsement will either be inserted after the section that it modifies, or at the end of the Booklet. Be sure to always check for these additional documents before making benefit decisions.

The headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.

References to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Covered Plan Participant or solely to your Covered Dependents will be noted as such.

References to “we”, “us”, and “our” throughout refer to Health Options, Inc. We may also refer to ourselves as “HOI.”

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.

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.
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 **BlueCare 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 **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section.
What if I am covered under **BlueCare** and **another health plan?**	The **COORDINATION OF BENEFITS** section.
What happens when **my coverage ends?**	The **TERMINATION OF COVERAGE** section, along with the **CONTINUING COVERAGE** section.
What do the **terms used** throughout this Booklet **mean?**	The **DEFINITIONS** section.
Who do I call if I have **questions?**	Call our **customer service** department at **800-664-5295** (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 Booklet. All benefits for Covered Services are subject to: (1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, (2) the applicable Allowed Amount, (3) any limitations and exclusions, as well as any other provisions contained in this Booklet including any Endorsements that are part of your Booklet, and (4) our Medical Necessity guidelines and Coverage Access Rules then in effect (see the MEDICAL NECESSITY and COVERAGE ACCESS RULES sections).

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the WHAT IS NOT COVERED? section and in any Endorsements that are part of this Booklet. More than one limitation or exclusion may apply to a specific Service or a particular situation.

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

1. Provided, prescribed or ordered by an **In-Network Provider**;
2. Authorized in advance, if prior coverage authorization is required (see the COVERAGE ACCESS RULES section);
3. within the Covered Services Categories in this section;
4. actually rendered to you (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this Booklet and for which we receive an itemized statement or description of the procedure or Service which was rendered, including any applicable procedure code, diagnosis code and other information we require in order to process a claim for the Service;
5. Medically Necessary, as defined in this Booklet and determined by us or the Group in accordance with our Medical Necessity coverage criteria then in effect;
6. in accordance with the COVERAGE ACCESS RULES section;
7. rendered while your coverage is in force; and
8. not specifically or generally limited or excluded under this Booklet.

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

Covered Services Categories

Ambulance Services

Ground Ambulance

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

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

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

Air and Water Ambulance

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

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

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

Exclusion

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

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

b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment), or after being discharged from inpatient care; or

c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.

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

Ambulatory Surgical Center

Health Care Services provided 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

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, payment for Covered Services will include both the CRNA and the Physician's Services charges.

Exclusion

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

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Coverage Access Rules for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

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 Booklet; and
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician.
4. Residential Treatment Services, as defined in this Benefit Booklet.

Exclusion

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

Casts, Splints and Trusses

Casts, splints and trusses are covered when part of treatment in a facility, office or in a Hospital emergency room. This does not include the replacement of dental splints or trusses.

Child Cleft Lip and Cleft Palate Treatment

Health Care Services which are 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 are covered. In order to be covered, Services must be prescribed by a Provider who must certify in writing that the Services are Medically Necessary.

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 Booklet, 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 Booklet 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.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you in a Hospital or Ambulatory Surgical Center if:
    a. a Covered Dependent is under eight years of age and it is determined by a dentist and the Covered Dependent's Physician 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 for you 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 provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such Services could have been rendered within 62 days;
2. dental implants; and
3. Except as described above and in the Child Cleft Lip and Cleft Palate Treatment category, any 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, 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 are 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, such as insulin pump and tubing, to treat diabetes; and
4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Exclusion

Certain supplies used in the treatment of diabetes are covered under pharmacy benefits, such as blood glucose meters, lancets, test strips. If the Group provides pharmacy coverage under a BlueCare Rx Pharmacy Program, the diabetic supplies covered under that program will not be covered under this category. Refer to the PRESCRIPTION DRUG PROGRAM section for more information.

Diagnostic Services

Diagnostic Services are 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 provided at any location by a Provider licensed to perform dialysis, including a Dialysis Center.

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and

2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Coverage Access Rules for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

Durable Medical Equipment is 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.

Coverage Access Rules for Durable Medical Equipment

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

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

Exclusion

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

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services in or out of the Service Area for treatment of an Emergency Medical Condition are covered without the need for any prior authorization.

You must notify us as soon as possible, concerning the receipt of Emergency Services and/or any admission which results from an Emergency Medical Condition.

Special Payment Rules for Non-Grandfathered Plans

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

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 HOI In-Network Providers for the same Services;
2. the Allowed Amount as defined in this Booklet;
3. the usual and customary Provider charges for similar Services in the community where the Services were provided; or
4. what Medicare would have paid for the Services rendered.

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

Exclusion

Follow-up care must be rendered by an In-Network PCP or In-Network Specialist. If you are told you need follow-up care after your emergency room visit, be sure to contact your PCP or an In-Network Specialist first. Any follow-up care you receive that is provided by a Provider other than your PCP or an In-Network Specialist may not be covered.

Urgent Care Services

For non-critical but urgent care needs, you can 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 are covered when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

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

Eye Care

Coverage includes the following Services:

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

Exclusion

1. Health Care Services to diagnose or treat vision problems that are not a direct consequence of trauma or prior eye surgery;
2. vision examinations;
3. eye exercises or visual training;
4. eye glasses and contact lenses and their fitting; and
5. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.

Family Planning

Family planning Services are covered and include:

1. family planning counseling and Services, including 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 insertion and removal; and
4. surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services are covered under the Preventive Health Services category, please refer to that category for more information.

Exclusion

Contraceptive medications, devices and appliances, other than as noted above and reversal of surgical sterilization procedures are not covered. Elective abortions are also excluded.

Home Health Care

Home Health Care Services are 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 and we approve the treatment plan;
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 Booklet);
4. the Home Health Care Services are provided by or through a Home Health Agency within the Service Area; 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. other Medically Necessary Services; and
16. transplants as set forth in the Transplants Services category.

Exclusion

1. Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital:
    a. room and board provided during the admission;
    b. Physician visits provided while you were an inpatient;
    c. Occupational, Speech, Physical, and Cardiac Therapies; and
    d. other Services provided while you were an inpatient.
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.

Infertility Treatment

Infertility Services for a Covered Person who meets our criteria then in effect, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility, laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility.

Exclusion

Prescription Drugs, In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) and any Services associated with these procedures, or any Services associated with the donation or purchase of sperm.

Inpatient Rehabilitation

Inpatient Rehabilitation 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 Rehabilitative Therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five days a week and your Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Exclusion

All inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Behavioral Health Services category), Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

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

Mastectomy Services

Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas) and outpatient post-surgical follow-up care for Mastectomy Services are 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 normal 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, usually within about six weeks after the birth of the baby. This Copayment applies only to 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 including a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment, room and board and nursery. Your Cost Share for these Services is listed on your Schedule of Benefits under inpatient Hospital or Birth Center, depending on where Services are rendered. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply.

Exclusion

Maternity Services rendered outside the Service Area are not covered except in urgent situations when you did not and could not reasonably expect the need for Services before you left the Service Area.

Note: Under federal law, your Group Health Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, federal law generally

does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under federal law, your Group Health Plan can only require that a Provider obtain authorization for prescribing an inpatient Hospital stay that exceeds 48 hours (or 96 hours).

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.

Exclusion

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

Preventive Health Services

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

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

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. 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. respect to women, such additional preventive care and screenings not described in paragraph 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 Health 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 Health 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 Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

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

Exclusion

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

Prosthetic Devices

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

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

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

Exclusion

Expenses for cosmetic enhancements to artificial limbs.

Second Medical Opinion

You are entitled to a second medical opinion when:

1. you do not agree with the opinion of your treating Physician or us regarding the reasonableness or necessity of a surgical procedure or treatment of a serious injury or illness; or
2. you feel you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated.

You may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion, but will need to ask your PCP or an In-Network Specialist to get an authorization from us before you receive the Services. However, you should know that your Cost Share amount for Services rendered by an In-Network Provider (usually a set Copayment) for a second medical opinion will be lower than those rendered by an Out-of-Network Provider. When you use an Out-of-Network Provider for a second medical opinion your Cost Share will be a percentage of the Allowed Amount, which may be less than the Out-of-Network Provider charges for such Services. In this case, in addition to your

percentage of the Allowed Amount, you will also have to pay any charges billed by an Out-of-Network Provider in excess of the Allowed Amount.

All tests in connection with rendering the second medical opinion, including tests ordered by an Out-of-Network Physician, must be Medically Necessary and must be performed by In-Network Providers.

Coverage may be denied for a second medical opinion if you seek more than three second medical opinions in any Benefit Period and second medical opinion costs are deemed evidence that you are unreasonably over-utilizing the second medical opinion privileges. The decision, after review of documentation from the second medical opinion you obtained, will be controlling as to the Plan's obligation to pay for such treatment.

Self-Administered Prescription Drugs

Except as covered under the PRESCRIPTION DRUG PROGRAM section, only Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

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

1. room and board;
2. respiratory, pulmonary or inhalation therapy, 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 excluded.

Surgical Procedures

Surgical procedures performed by a Physician including surgical assistant Services rendered by a Physician 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; and
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. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Note: Gender reassignment surgery must be authorized, in advance, by us in order to be covered.

   Exclusions:

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

   a. reduction thyroid chondroplasty;
   b. liposuction;
   c. rhinoplasty;
   d. facial bone reconstruction;
   e. face lift;
   f. blepharoplasty;
   g. voice modification surgery ;
   h. hair removal/hairplasty; or
   i. breast augmentation.

   Payment Rules for Surgical Procedures

   1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure 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 authorized in advance and 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. The Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant ;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung transplant.

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

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized **before** they are provided.
4. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Plan.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

Virtual Visits between you and a Virtual Care Provider that is designated by us and under contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

PRESCRIPTION DRUG PROGRAM

BlueCare Rx Pharmacy Program

Coverage for Prescription Drugs and Supplies is provided through the BlueCare Rx Pharmacy Program described in this section. We have included this section in this Booklet for ease of reference, however it is important that you understand this BlueCare Rx Pharmacy Program is separate from the medical coverage described in other sections of this Booklet, and provisions which are specific to this Pharmacy Program are described in this section.

Coverage is provided to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this section, you must pay, at the time of purchase, your Cost Share amounts indicated on the BlueCare Rx Pharmacy Program Schedule of Benefits.

In the Medication Guide you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. You may be able to reduce your out-of-pocket expenses by: 1) 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 a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website 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 **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;
3. Medically Necessary, as defined in this Booklet 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, 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; and
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 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.

Coverage and Benefit Guidelines

The benefit guidelines set forth below apply to the benefits under the BlueCare Rx Pharmacy Program, as well as any other applicable payment rules specific to particular Covered Services listed in this Booklet.

Contraceptive Coverage

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

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

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

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

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

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

Exclusion

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants, such as Norplant and IUD, are excluded from coverage under this BlueCare Rx Pharmacy Program.

Covered Over-the-Counter (OTC) Drugs

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

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed 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.

Diabetic Coverage

All 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 BlueCare Rx Pharmacy Program: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and syringes and needles.

Exclusion

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

Mineral Supplements, Fluoride or Vitamins

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

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

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 excluded from coverage.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the cost share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

Preventive Medications

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

Specialty Pharmacy: Split Fill Option

Some types of medication may be difficult to tolerate for patients who are new to certain forms of treatment, such as oral oncology medication. To reduce waste and help avoid cost for medications that

will go unused, the Specialty Pharmacy may split the first fill for certain medications identified in the Medication Guide. The applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance would also be split between the two fills.

BlueCare Rx 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 Booklet.

1. The Plan will not cover more than the Maximum supply, as set forth in the BlueCare Rx Pharmacy Program 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 (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., 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 BlueCare Rx Pharmacy Program.
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 BlueCare Rx Pharmacy Program Schedule of Benefits;
    b. furnished to you without cost;
    c. Experimental or Investigational;
    d. indicated or used for the treatment of infertility;
    e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine or Renova;

f. prescribed by a Pharmacist except for vaccines;

g. used for smoking cessation, except as indicated as covered under the Preventive Health 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;

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 except when all active ingredients are FDA-approved Prescription Drugs with valid National Drug Codes.

14. Drugs and Supplies purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition 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. HOI and/or the Group, 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 HOI and/or the Group, 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 BlueCare Rx Pharmacy Program as indicated on the BlueCare Rx Pharmacy Program Schedule of Benefits.
18. Any benefit penalty reductions.
19. Drugs or Supplies you prescribe to yourself or 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 BlueCare Rx Pharmacy Program.

22. New Prescription Drugs.

Pharmacy Alternatives

For purposes of the section, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

Participating Pharmacies have agreed not to charge, or collect from, you, for each Covered Prescription Drug, Covered Prescription Supply more than the amount set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits.

To verify if a Pharmacy is a Participating Pharmacy, you may refer to the Pharmacy Program 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 present your ID Card to the Participating Pharmacy and the Pharmacy must be able to verify that you are, in fact, covered by us.

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

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

Specialty Pharmacy

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

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications.

The Specialty Pharmacies designated, solely by us, are the only Participating suppliers for Specialty Drugs. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Non-Participating for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueCare Rx 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.

Non-Participating Pharmacies

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from a Non-Participating Pharmacy is covered under this BlueCare Rx Pharmacy Program **only** if it is prescribed as a result of an Emergency Medical Condition or authorized in accordance with our criteria then in effect.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from a Non-Participating Pharmacy, as a result of an Emergency Medical Condition, or when authorized, you may be required 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 a Non-Participating 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 encourage the responsible use of Drugs and

Supplies.

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

Note: If coverage is not available, or is limited, this does not mean that you cannot obtain the Drug or Supply from the Pharmacy. It only means that the Plan 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

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

Prior to filling a Prescription, your Physician may contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

Responsible Quantity Program

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

Prior Coverage Authorization Program

You are required to obtain prior coverage authorization in accordance with our criteria then in effect, in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **If you do not obtain an authorization when one is required coverage and payment will be denied**. Prescription Drugs and Supplies and OTC Drugs that require prior coverage authorization are designated in the Medication Guide.

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

Information on our pharmacy utilization review programs is published in the Medication Guide 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.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued 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 Booklet. 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 or the Group in authorizing coverage are made only to determine whether coverage or benefits are available under this BlueCare Rx 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. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if the Plan has indicated that payment will not be made for such Prescription Drug, Supply or OTC Drug.

BlueCare Rx Pharmacy Program Definitions

Certain important terms applicable to the BlueCare Rx Pharmacy Program are set forth below. For additional applicable definitions, please refer to the DEFINITIONS section of this Booklet.

Biosimilar Prescription Drug is a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (known as 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.

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.

Coinsurance means, when applicable, the sharing of health care expenses for each Covered Prescription Drug and Supply and/or Covered OTC Drug between you and the Plan. After any applicable Pharmacy Deductible requirement is met, the Plan will pay a percentage of the Participating Pharmacy Allowance for each Covered Prescription Drug and Supply and/or Covered OTC Drug, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Copayment means, when applicable, the amount you must pay to a Participating Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits.

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

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under this BlueCare Rx 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:

1. Prescription diaphragms;

2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage;
3. syringes and needles prescribed with a Prescription Drug authorized for coverage;
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.

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

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

FDA means the United States Food and Drug Administration.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either 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 HOI, 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.

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

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

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

Medication Guide means the guide then in effect issued by us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Covered OTC 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. You may access the most current guide at www.floridablue.com or call the customer service phone number on your ID Card for current information.

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

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

New Prescription Drug(s) means An FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage

for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

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

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

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.

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

Participating Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies , Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

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

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, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

Pharmacy Deductible means, when applicable, the amount of charges up to the Participating Pharmacy Allowance, for Covered Prescription Drugs and Supplies and Covered OTC Drugs that you must actually pay per Benefit Period, in addition to any applicable Copayment or percentage of the Participating Pharmacy Allowance, to a Pharmacy who is recognized for payment under this BlueCare Rx Pharmacy Program, before the Plan's payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs begins.

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 coverage and benefits are provided, subject to the exclusions in this 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.

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

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

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.

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.

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of 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 an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

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

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

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 Booklet. **If you do not follow the Coverage Access Rules, any Services you receive will not be covered.** For further information, please refer to the COVERAGE ACCESS RULES section.

The Plan 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

Ambulance Services including but not limited to:

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

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

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.

Completion of any form and /or medical information.

Cost Share amounts you are required to pay even when the cost share amount is waived by a Provider.

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, breast augmentation.

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

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. 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).
    d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit;
    e. defined by, and covered under the PRESCRIPTION DRUG PROGRAM section.
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 drug which requires prior coverage authorization when prior coverage authorization is not obtained.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
    a. emergency stabilization;
    b. during a covered inpatient stay, or
    c. when proximately related to a surgical procedure.

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.

7. New Prescription Drug(s), as defined in the DEFINITIONS section.
8. Convenience Kits as defined in the DEFINITIONS section
9. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

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.

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 under the Plan, unless coverage is extended in accordance with the Extension of Benefits subsection in the CONTINUING COVERAGE section.
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 Booklet, 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 Booklet and determined by us in accordance with our criteria then in effect. 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.
9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Booklet.
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 rendered outside the Service Area, except Emergency Services for treatment of an Emergency Medical Condition, unless such Services are approved by us in advance.

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 category and Preventive Health Services categories of the WHAT IS COVERED? section.

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

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

Motor Vehicle Accidents 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.

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

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

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

1. beauty and barber services,
2. clothing, including support hose,
3. radio and television,
4. guest meals and accommodations,
5. telephone charges,
6. take-home supplies,
7. travel expenses (other than Medically Necessary Ambulance Services),
8. motel/hotel accommodations,
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting,
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs,
11. heating pads, hot water bottles, or ice packs,

12. physical fitness equipment,
13. hand rails and grab bars, and
14. Massage except as set forth in the WHAT IS COVERED? section.

Private Duty Nursing Care rendered at any location.

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCSBF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Smoking Cessation Programs, including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products, such as gum, transdermal patches, etc, (except as indicated as covered under the Preventive Health 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.

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.

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

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and does not have a contract with us to provide Virtual Visits under this Booklet.

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. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a. a licensed outdoor youth program, and/or
    b. a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Work Related Health Care Services to treat a work related Condition to the extent you are covered or required to be covered by Workers' Compensation law. Any Service or supply to diagnose or treat any Condition resulting from or in connection with your job or employment are excluded, except for Medically Necessary Services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

MEDICAL NECESSITY

In order for Health Care Services to be covered under this Booklet, the Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as determined by us and/or the Group and defined in this Booklet. **As a self-funded plan, Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; Suwannee County Board of Public Instruction has asked us to use our Medical Necessity criteria and guidelines currently in effect.**

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 Booklet and not for the purpose of recommending or providing medical care. Any Reviews conducted for Medical Necessity, may require review of 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 Booklet. 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. HOI and the Group are solely responsible for determining whether expenses incurred for that medical care are covered under this Booklet. In making coverage decisions, neither HOI nor the Group will 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 Booklet) or a Covered Service. You are free to obtain a Service even if coverage is denied 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 Shares explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Deductible

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by the Plan. Only those charges indicated on claims received for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount.

Family Deductible

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

Hospital Per Admission Deductible

The Hospital per admission Deductible, when applicable, must be satisfied by you for each Hospital admission before any payment will be made by the Plan for any claim for inpatient Services. The Hospital per admission Deductible applies regardless of the reason for the admission.

Copayments

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

Office Services Copayment

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

Inpatient Facility Services Copayment

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

to all inpatient admissions unless your Schedule of Benefits states otherwise. Additionally, you may be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment

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

Emergency Room Facility Services Copayment

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

Coinsurance

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

Special Calculation 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.

Out-of-Pocket Maximums

Individual Out-of-Pocket Maximum

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

Family Out-of-Pocket Maximum

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

Note: The Deductible, any applicable Copayments and Coinsurance will accumulate toward the out-of-pocket maximums. Any applicable Cost Share amounts you must pay under a prescription drug program, will not apply to the Deductible or the out-of-pocket maximums under this Booklet.

Prior Coverage Credit

You will be given credit for the satisfaction or partial satisfaction of any deductible and coinsurance maximums met by you under a prior group, blanket, or franchise insurance or group Health Maintenance Organization (HMO) policy maintained by Suwannee County Board of Public Instruction if this Plan replaces such a policy. This provision only applies if the prior group, blanket, or franchise insurance or HMO coverage was in effect immediately preceding the Effective Date of this Group Health Plan. This provision is only applicable for you during the initial Benefit Period of coverage under the Plan and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited by the Group's prior policy, toward your deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited toward your coinsurance maximum under the Group's prior policy, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to your out-of-pocket maximum under this Booklet.

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

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

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 641.54 of the Florida Statutes.

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 for Health Care Services which are non-Covered Services or excluded; and
4. any contribution amount required by Suwannee County Board of Public Instruction.

How Benefit Maximums are Credited

Except as described below, only the amounts actually paid by the Plan for Covered Services will be credited toward applicable benefit maximums. The amounts the Plan pays that are credited toward your Benefit Period maximums will be based on the Allowed Amount for the Covered Services provided. Also see the Special Calculation Rule for Capitated Providers subsection above for more information.

HEALTH CARE PROVIDER OPTIONS

Introduction

It is important that you understand how the Providers you choose to use for medical care will affect how much you have to pay for medical Services. Under this HMO plan, most Services must be rendered by In-Network Providers in order to be Covered Services. This is true even when the Services you receive are Medically Necessary (except in the case of an Emergency Services for an Emergency Medical Condition). This section explains some special rules for getting Covered Services with certain types of Providers under this Booklet

For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

You are responsible for making sure a Provider is In-Network prior to receiving Services. To find out if a Provider is in our network you can:

1. access the current BlueCare Provider directory on our website at www.floridablue.com; or
2. call the customer service phone number on your ID Card.

In-Network Providers

Primary Care Physician (PCP)

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP for each covered family member. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You do not need a referral to see your PCP.

Specialist Care

If you need to visit a Specialist, you and/or your PCP may choose any In-Network Specialist.

Your PCP may consult with us regarding coverage or benefits and with the Specialist in order to coordinate your care. This provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

You do not need a referral from your PCP to see an In-Network Specialist; however, some Services require an authorization from us before Services are rendered in order to be covered. In-Network Providers are responsible for obtaining authorization.

Below are some special rules for certain types of Providers:

Chiropractors and Podiatrists: Upon your request, a Doctor of Chiropractic or a Doctor of Podiatry who is an In-Network Provider may be assigned to you for the purpose of providing chiropractic Services and podiatric Services, respectively. You shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need for referrals from your PCP.

Certified Registered Nurse Anesthetist: You have access to anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if you request such Services, provided such Services are available, as determined by us and are Covered Services under the Plan.

Dermatologists: You may access an In-Network dermatologist for up to five visits each Benefit Period without an authorization. Some Services, such as surgical procedures will require an authorization before the Services are rendered and if you do not have an authorization; the Services will not be covered.

Obstetric and Gynecological Providers: You may access In-Network Providers who specialize in obstetrics or gynecology for obstetric or gynecological care without the need for authorization.

Osteopathic Hospitals: Inpatient and outpatient Services, similar to inpatient and outpatient Services by allopathic Hospitals may be covered at a Hospital accredited by the American Osteopathic Association when such Services are available in the Service Area even when such Hospital has not entered into a written agreement with us for such Services. The Hospital providing these Services may not charge more than their usual and customary rates less the average discount that we have with allopathic Hospitals within the Service Area. You must contact us to get the documents necessary to comply with this provision.

Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other Covered Services may be rendered by licensed Physician Assistants, nurse practitioners or other individuals who are not Physicians.

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.

You must use a Specialty Pharmacy to provide these Specialty Drugs. Please refer to the Medication Guide for a list of Specialty Pharmacies.

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.

Continuity of Coverage and Care Upon Termination of a Provider Contract

When a contract between us and an In-Network Provider (including a PCP) is terminated by us or the Provider without cause and, at the time of the In-network Provider's termination, you are actively receiving Services for a Condition, Services for that Condition shall continue even after the date of the In-Network Physician's contract termination. Services for that Condition will be covered with that Provider only until the earlier of:

1. treatment for that specific Condition is completed;
2. you select another In-Network Physician; or
3. the next open enrollment period.

This extension period will not exceed the maximum time period allowed under Florida law, and in no case will it be longer than six months after termination of the Provider's contract with us.

Maternity benefits will continue under this Plan, regardless of the trimester in which Services were initiated, until completion of your postpartum care, if you initiated your prenatal care prior to the termination of the In-Network Provider's contract.

The Group Health Plan is not required to cover or pay for any Services under this subsection for an individual whose coverage under the Plan is not in effect at the time Services are rendered. Further, this subsection does not apply if the In-Network Provider is terminated "for cause".

Services Not Available from In-Network Providers

Except as provided in the WHAT IS COVERED? section, if a Covered Service is not available through In-Network Providers, we may authorize coverage for such Services to be rendered by an Out-of-Network Provider. Covered Services provided by an Out-of-Network Provider must be authorized by us **before** the Services are rendered.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, the Group Health Plan 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 Booklet;
2. an assignment of the right to receive payments due under this Booklet; 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 Booklet, or any promise or obligation set forth in any contract, plan, or policy.

The Group Health Plan specifically reserves 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; 2) is a licensed Hospital or Physician and the benefits which have been assigned are for care provided per Florida Statutes; or 3) is an Ambulance Provider that provides transportation for care from a location where an Emergency Medical Condition, as defined per Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care per Florida Statutes. A written attestation of the assignment of benefits may be required.

BLUECARD® PROGRAM

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain Health Care Services outside of Florida, the claims for these Services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Only limited Services received outside of Florida are covered. As used in this section, "Out-of-Area Covered Services" only include Emergency Services for treatment of an Emergency Medical Condition obtained outside of Florida. Any other Services will not be covered even if processed through any Inter-Plan Arrangements.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard Program

Under the BlueCard Program, when you receive Out-of-Area Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the Out-of-Area Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Cost Share amounts.

Medical Emergency: If you experience a medical emergency while traveling outside of Florida, go to the nearest facility that can provide the type of Services needed.

When you receive Out-of-Area Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Services, if not a fixed dollar Copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in

expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside of Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, payment for such Covered Services will be based on the applicable Allowed Amount.

Blue Cross Blue Shield Global® Core Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Out-of-Area Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Out-of-Area Covered Services.

Outpatient Services

Physicians, Urgent Care Centers and other Providers of outpatient Services located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Out-of-Area Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Out-of-Area Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core

Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

COVERAGE ACCESS RULES

It is important that you become familiar with the rules for accessing health care coverage through this HMO plan. The following section explains our role and the Primary Care Physician's (PCP) role, how to access specialty care coverage, and what to do if Emergency Services are needed. It is also important for you to review all Service Area-specific Coverage Access Rules for particular types of Services and In-Network Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated Provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You are free to choose any PCP listed in our published list of PCPs whose practice is open to additional BlueCare patients. This choice should be made when you enroll. You are responsible for choosing a PCP for all minor Covered Dependents including a newborn child or an adopted newborn child. If you do not choose a PCP when enrolling, we will assign one to you and notify you of that assignment. The following important rules apply to your PCP relationship:

- 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 PCP allows the Physician to become knowledgeable about your health history.
- A PCP can help you determine the need to visit a Specialist and also help you find one based on his or her knowledge of you and your specific health care needs.
- A PCP may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with us as a Primary Care Physician.
- Care rendered by your PCP usually results in lower Cost Share for you.

The PCP you select maintains a Physician-patient relationship with you, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for helping to coordinate medical Services for you.

Both you and your PCP may request a change in the PCP assignment as discussed below:

1. You may request a transfer to another PCP whose practice is open to new BlueCare patients. The effective date of a transfer to the new PCP will depend upon when we receive your request. Requests may be made on our website at www.floridablue.com or by calling the number on the back of your ID card.
2. There are also times when a PCP, for good cause, may request that we assist you in choosing another PCP.
3. If your PCP terminates his or her contract with us or is unable to perform his or her duties or is on a leave of absence, we may help you choose another PCP or assign a new one for you.

Authorization Requirements

Many Services have to be authorized **before** the Services are rendered in order to be covered under this Booklet. **Since this is a self-funded plan, Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; Suwannee County Board of Public Instruction has asked us to use our authorization criteria and guidelines currently in effect.**

There may be times when Services are authorized, but only if received in a specific setting, such as an Ambulatory Surgical Center or Independent Diagnostic Testing Center. If the authorization includes a specific setting and you receive the Services in a different setting, such Services may be denied. For example, a procedure may be authorized only when performed in an Ambulatory Surgical Center. In this case, if you have the procedure done in a Hospital, the claim may be denied because the procedure was only authorized when performed in an Ambulatory Surgical Center.

In-Network Providers have agreed to obtain these authorizations for you; however, you should ask your Provider if an authorization has been obtained if one is required. Services that must be authorized by us in advance include, but are not limited to:

1. hospitalization, both inpatient and observation stays;
2. certain radiology Services, including advanced diagnostic imaging Services, such as CT scans, MRIs, MRAs and nuclear imaging;
3. Birth Center Services;
4. Services rendered in connection with Approved Clinical Trials;
5. Home Health Care;
6. certain Durable Medical Equipment;
7. Prosthetic Devices and Orthotic Devices;
8. Pain Management Services;
9. surgery (at all locations);
10. Services provided by Out-of-Network Providers;
11. all Services provided in a Skilled Nursing Facility;
12. certain injections and infusion therapy;
13. certain Provider-administered drugs (denoted with a special symbol in the Medication Guide);
14. Hospice Services; and
15. certain diagnostic Services.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

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 the 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, alternative benefits or payment for cost-effective Health Care Services may be offered to you. These alternative benefits or payments may be made available on a case-by-case basis when you meet the 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. Because your Group Health Plan is self-funded, Suwannee County Board of Public Instruction will be required to specifically agree to such treatment plan and the alternative benefits or payment.

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

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in this Group Health Plan, and who meets and continues to meet the Group's eligibility rules described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility rules are binding upon you and /or your eligible family members. No changes in the eligibility rules will be permitted except as approved by the Group. Acceptable documentation that an individual meets and continues to meet the eligibility requirements, such as a court order naming the Covered Plan Participant as the legal guardian or appropriate Adoption documentation may be required as described in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

Covered Plan Participant Eligibility

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

1. the employee must maintain his or her primary residence in the Service Area or be regularly employed in the Service Area;
2. be a bona fide employee;
3. the employee's job must fall within the job classifications designated by the Group;
4. complete any applicable Waiting Period established by the Group; and
5. meet any additional eligibility requirements required by the Group.

The Group's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Group; and
4. other individuals as determined by the Group.

The Group shall have sole discretion concerning the expansion of eligibility classifications.

Dependent Eligibility

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

1. The Covered Plan Participant's spouse under a legally valid existing marriage, who maintains his or her primary residence in the Service Area.
2. The Covered Plan Participant's natural, newborn, Adopted, Foster or step child (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan. A dependent child must maintain his or her primary residence in the Service Area only beginning with the Calendar Year following the year they reach age 26 to the end of the Calendar Year the dependent child reaches age 30
3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility as the Covered Plan Participant to establish that a child meets the eligibility rules. Eligibility will terminate at the end of the Calendar Year in which the child no longer meets the eligibility rules required to be an Eligible Dependent.

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:

1. otherwise eligible for coverage under the Group Health Plan;
2. incapable of self-sustaining employment by reason of intellectual or physical disability; and
3. chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 30th birthday..

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

Other Rules Regarding Eligibility

1. No individual whose coverage has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll in the Group Health Plan.
2. No person shall be refused enrollment or re-enrollment because of race, color, creed, marital status, gender, or age (except as provided in the Dependent Eligibility subsection).
3. The Covered Plan Participant must notify the Group 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 proper notification is not provided timely by the Covered Plan Participant, the Group shall have the right to retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met. Upon request, the Covered Plan Participant shall provide proof, which is acceptable to the Group, of a Covered Dependent's continuing eligibility for coverage.
4. If the Group offers an alternative health benefits plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for coverage under this Booklet.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage as described in this section. Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. Neither HOI nor the Group shall have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. You may apply for coverage by completing an Enrollment Form and submitting it to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during enrollment, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right the Group may have, the Group may terminate or Rescind your coverage.
3. The Group will not provide coverage or benefits to any person who would not have been eligible to enroll, had accurate and complete information been provided on a timely basis. In such cases, the Group may require you or a person legally responsible for you, to repay any payments made on your behalf.

How to Apply for Coverage

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

1. complete the Enrollment Form and submit it to the Group;
2. provide any other information the Group may need to determine eligibility, upon request;
3. agree to pay any contribution amounts required by the Group; and
4. to add Eligible Dependents or delete Covered Dependents, complete the Enrollment Form and submit it to the Group.

When applying for coverage, you must elect one of the types of coverage available under the Group Plan. Such types may include:

Coverage Type	**Provides Coverage for:**
Employee Only	the Eligible Employee only
Employee/Spouse	the Eligible Employee and his or her spouse
Employee/Child(ren)	the Eligible Employee and children only
Employee/Family	the Eligible Employee, spouse and children

There may be an additional contribution amounts for each Covered Dependent based on the coverage provided by the Group.

Enrollment Periods

There are only certain times during the year that you can enroll for coverage, these enrollment periods are as follows:

Initial Enrollment Period: this is the period of time when you are first eligible to enroll. It starts on the date you are first eligible and ends no less than 30 days later. This time can be when the Group first starts its Plan under this Booklet, or when an employee first becomes eligible for coverage under the Plan.

Annual Open Enrollment Period: this is the period of time (usually 30 days) when you have an opportunity to select coverage from the alternatives your Group offers in its health benefit program. This period takes place every year prior to the Anniversary Date. Suwannee County Board of Public Instruction will establish the dates and length of this period.

Special Enrollment Period: this is the 30-day period of time immediately following a special event such as getting a new dependent or losing other coverage. During this time you may apply for coverage because of the special event. Special events are described in the Special Enrollment Period subsection of this section.

Initial Enrollment Period

1. If you are an Eligible Employee when Suwannee County Board of Public Instruction first starts plan under this Booklet; you must enroll (yourself and any Eligible Dependents) during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. In this case, the Effective Date of coverage for you and the dependents you enroll will be the same as the Group.
2. If you become an Eligible Employee after Suwannee County Board of Public Instruction has this plan (for example, newly-hired employees) you must enroll (yourself and any Eligible Dependents) before or within the Initial Enrollment Period and your Effective Date of coverage will begin on the date specified in writing, by the Group.

Annual Open Enrollment Period

If you did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period you may apply for coverage by completing an Enrollment Form during an Annual Open Enrollment Period. Your Effective Date of coverage will be the date specified by the Group.

If you do not enroll or change your coverage selection during the Annual Open Enrollment Period, you must wait until the next Annual Open Enrollment Period to make any changes, unless a special event, as outlined in the Special Enrollment Period subsection of this section, occurs.

Special Enrollment Period

You may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, you must complete an Enrollment Form and submit it to the Group within the time periods noted below for each special enrollment event.

If you declined coverage when it was first offered under this Plan and you stated, in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment, you may apply for coverage if one of the following special enrollment events occurs and you complete an Enrollment Form and submit it to the Group within time periods indicated in the chart that follows.

Special Enrollment Event

Loss of Coverage under…	Caused by…	Enrollment Form due to Group within…
a group health plan or COBRA	• Exhaustion of COBRA • termination of employment • reduction in the number of hours you work • reaching or exceeding the lifetime maximum of all benefits under other health coverage • the employer stopped offering group health coverage • death of your spouse • divorce or legal separation • employer contributions toward such coverage are terminated	30 days of the date coverage was terminated
A Children's Health Insurance Program or Medicaid	• loss of eligibility for such coverage • becoming eligible for the optional state premium assistance program	60 days of the date coverage was terminated
***Adding Coverage...**	• your marriage • your getting a new dependent through birth, Adoption or placement in anticipation of Adoption	30 days of the date of the event

* The statement in the paragraph above this chart about declining coverage when it was first offered does not apply to these special enrollment events.

Your Effective Date of Coverage will be the date of the special enrollment event. If you do not enroll or change your coverage during the Special Enrollment Period you must wait until the next Annual Open Enrollment Period.

Note: Loss of coverage for failure to pay your required contribution on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

Dependent Enrollment

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

Newborn Children – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group. 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). The Group must be notified, in writing, when you are adding a newborn and the rules for Effective Date and contribution amounts charged for the newborn vary depending on when this written notification is received. The chart that follows indicates these differences:

Newborn Enrollment

If written notice is received within…	**The Effective Date of the newborn will be…**	**Contribution amounts for the newborn child…**
30 days after the date of birth	the date of birth	will **not** be charged **for the first 30 days**
31 to 60 days after the date of birth	the date of birth	will be charged from the date of birth
61 or more days* after the date birth	the date of birth	will be charged from the date of birth

*This applies only if the Group **has not had** an Annual Open Enrollment Period since the baby was born. If the written notice is received more than 60 days after the birth of the newborn child, and your Group **has had** an Annual Open Enrollment Period since the birth of the newborn, the child may not be added until the Group's next Annual Open Enrollment Period.

Additional Rules for Adopted Newborn Children

If an Adopted newborn's Effective Date of coverage is determined to be the date of birth (based on the above chart), a written agreement to Adopt such child must have been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents which we deemed necessary by us or the Group in order to administer this provision. 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 Covered Plan Participant to notify the Group within ten calendar days of the date that placement was to occur if the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Covered Plan Participant. If a child is born before the Effective Date of the Covered Plan Participant the newborn should be added during the Initial Enrollment Period.

Adopted/Foster Children – To enroll an Adopted child (other than a newborn child) or Foster Child, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days after the date of placement and the Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Covered Plan Participant pursuant to Florida law. If timely notice is given, no additional contribution amount will be charged for coverage of the Adopted or Foster Child for the duration of the notice period (the 30-day period before the child was placed in your home). You may need to

provide additional information and/or documents deemed necessary by us in order to properly administer this provision.

If timely notice is not given, the child will be added as of the date of placement so long as we receive the Enrollment Form within 60 days of the placement, and any applicable contribution amount is paid back to the date of placement. If notification is not received within 60 days of the date of placement, the Covered Plan Participant must make application during the Annual Open Enrollment Period or Special Enrollment Period in order for the Adopted or Foster Child to be covered.

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. It is your responsibility as the Covered Plan Participant to notify the Group if the Adoption does not take place. Upon receipt of this notification, such child's coverage will be terminated as of the Effective Date of the Adopted child.

Foster Children

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is your responsibility as the Covered Plan Participant to notify the Group in writing that the Foster Child is no longer in your care. Upon receipt of this notification, such child's coverage will be terminated on the date provided by the Group.

Marital Status – If the Covered Plan Participant marries after his or her Effective Date, he or she may add the spouse who is an Eligible Dependent due to a legally valid marriage. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the marriage and the Effective Date of coverage for the new spouse will be the date of the marriage.

Court Order – You, as the Covered Plan Participant may add an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided by you for a minor child under your plan. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the court order and the Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order will be the date required by the court order.

Other Provisions

Rehired Employees

If you are rehired as an employee of the Group; you are considered a newly-hired employee for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Policy, applicable to newly-hired employees and their Eligible Dependents if the employee does not qualify for the federal exemption, such as Effective Dates of coverage and Waiting Periods will apply to you.

TERMINATION OF COVERAGE

Covered Plan Participant

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

1. on the date the ASA between HOI and Suwannee County Board of Public Instruction terminates;
2. on the date the Covered Plan Participant becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the date the Covered Plan Participant no longer meets any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause; or
5. on the date specified by the Group.

Covered Dependent

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

1. on the date the Covered Plan Participant's coverage terminates for any reason;
2. on the date the Covered Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the last day of the Calendar Year that the Covered Dependent no longer meets the eligibility requirements;
4. on the date the Covered Dependent's coverage is terminated for cause;
5. on the date specified by the Group.

If you, as the Covered Plan Participant, wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group prior to the termination date requested.

If you wish to delete your spouse from coverage, in the case of divorce for example, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Termination for Cause

If any of the following events occur, the Group may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits;
2. you intentionally misrepresent, omit, or give false information on Enrollment Forms or other forms completed, by you or on your behalf;
3. fraudulent misuse of the ID Card;
4. you no longer live or work in the Service Area; or
5. a Covered Dependent reaches the limiting age.

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

Note: Only fraudulent misstatements on the Enrollment Form may be used by the Group to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

Rescission of Coverage

The Group and HOI reserve the right to Rescind coverage under this Booklet for any individual covered under this Booklet as permitted by law.

The Group and/or HOI may only Rescind your coverage if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

The Group and/or HOI will provide at least 45 days advance written notice to the Covered Plan Participant of the 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 COMPLAINT AND GRIEVANCE PROCESS section.

Notice of Termination

It is Suwannee County Board of Public Instruction's responsibility to immediately notify you of termination of the Group Health Plan for any reason.

Group Health Plan Responsibilities Upon Termination of Your Coverage

Upon termination of your coverage for any reason, HOI and the Group will have no further liability to you under the Group Health Plan, except as otherwise specifically described in this Booklet.

CONTINUING COVERAGE

Introduction

This section describes the ways coverage can be continued after your termination date. We have divided this section into three subsections: Federal and Florida Continuation Provisions, Conversion Privilege and Extension of Benefits.

Federal Continuation of Coverage Law

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

You must contact your Group to determine if you are entitled to COBRA continuation of coverage. Your Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify you of your rights under COBRA. If you do not meet your obligations under COBRA and this Plan, the Group shall not be liable for any claims incurred by you after your coverage terminates.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by the Group Health Plan; the duty to meet such obligations remains with Suwannee County Board of Public Instruction.

The following is a summary of what you may elect, if COBRA applies to Suwannee County Board of Public Instruction and you are eligible for such coverage:

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

   ***Note:** You are eligible for an 11 month extension of the 18 month COBRA continuation option above (up to a total of 29 months) if you are totally disabled, as defined by the Social Security Administration (SSA), at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. You must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependents may elect to continue their coverage for a period not to exceed 36 months in the case of:
   a. the Covered Plan Participant's entitlement to Medicare;
   b. divorce or legal separation from the Covered Plan Participant;
   c. death of the Covered Plan Participant;
   d. the employer files bankruptcy (subject to bankruptcy court approval); or
   e. a Covered Dependent child who ceases to be an Eligible Dependent under the terms of the Policy.

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

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

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

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Conversion Privilege

If your Group Health Plan has terminated you may apply for conversion to a non-group plan. HOI and the Group have no obligation to notify you of the conversion privilege. It is your sole responsibility to exercise this conversion privilege subject to the provisions set forth below.

Eligibility Criteria for Conversion

You are entitled to apply for a conversion contract for a non-group plan if:

1. you have been continuously covered under this Group Health Plan for at least three consecutive months; **or**
2. you were covered for at least three consecutive months under any other group policy providing similar benefits that this Group Health Plan immediately replaced; **and**
3. your coverage has been terminated for any reason, including discontinuance of this Group Health Plan in its entirety and termination of continued coverage under COBRA; **and**
4. you maintain your primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for Health Care Services. **We must receive the completed conversion application and the applicable premium payment within the 63-day period beginning on the date this Group Health Plan terminated.**

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

Conversion is not available if termination occurred for any of the following reasons:

1. you had not been continuously covered under the Group Health Plan for at least three months prior to termination;
2. failure by you to pay on a timely basis, any required contribution amounts required for coverage under the Group Health Plan;
3. replacement of coverage by similar group coverage occurs within 31 days of termination;
4. you commit fraud or intentional misrepresentation in applying for the Group Health Plan or for any Covered Services;
5. termination for cause as set forth in the TERMINATION OF COVERAGE subsection;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. you are eligible for, or covered under, Medicare.

Additionally, conversion is not available:

1. if you are eligible for similar benefits, whether or not you are actually covered under any arrangement of coverage for individuals in a group;
2. if you are covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical Service insured contract or medical practice or other prepayment plan, or by any other plan or program;
3. if similar benefits are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA); or
4. if the benefits provided or available to you, together with the benefits provided by us, would result in excess of coverage, as determined by us.

Conversion Coverage

The conversion contract issued to each individual who converts to non-group coverage shall include a level of benefits for "minimum Services" which is similar to the level of benefits for the Services included in this Booklet. For purposes of this section, the term "minimum Services" shall mean Services which include any of the following: emergency care, inpatient Hospital Services, Physician care, ambulatory diagnostic treatment, and preventive Health Care Services. Conversion coverage is not a continuation of the Group Health Plan. Benefits under such conversion coverage may differ from benefits under the Group Health Plan and any Endorsements attached thereto. Conversion coverage may continue in effect as long as you: (a) continue to meet all applicable eligibility requirements; (b) pay all applicable fees and charges; and (c) otherwise comply with all requirements under the conversion contract.

Effective Date of Conversion

The effective date of conversion coverage shall be the day following the termination under the Group Health Plan. However, until such time as coverage under the conversion contract becomes effective, you shall pay the Allowed Amount for any Covered Services rendered during the 63-day period immediately following termination of the Group Health Plan. In the event such conversion coverage becomes effective, you may request reimbursement from us for any payment for Covered Services. You must submit proof of payment to us in order to obtain reimbursement.

Extension of Benefits

If the Group Health Plan is terminated, coverage will end on the termination date. There will be no coverage or benefits for any Covered Service received on or after the termination date, except as listed below. The extension of benefits described below only applies when the Group Health Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Booklet.

Note: You must provide proof that you are entitled to an extension of benefits.

Extension of Benefits

1. If you are pregnant on the termination date of the Group Health Plan, a limited extension of the maternity benefits will be provided, as long as the pregnancy started while you were covered by the Group Health Plan. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate on the date the child is born.
2. If you are totally disabled on the termination date of the Group Health Plan because of a specific accident or illness that happened while you were covered under the Group Health Plan, a limited extension of benefits will be provided for you only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

   Note: For purposes of this subsection, you will be considered totally disabled only if, in our opinion, you are unable to work at a job for which you have the education, training, or experience, and you continue to require regular care from a Physician for the disability. This applies, even if you are not working (e.g., a student, non-working spouse, or children), if you are unable to perform the normal day-to-day activities which you would otherwise be able to perform.

Neither the Group nor HOI is required to provide an extension of benefits if you leave the Service Area with the intent to relocate or establish a new residence outside the Service Area; if you intentionally left out or provided false information on any Enrollment Form in order to obtain coverage or Covered Services; or if you were terminated for 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.

COORDINATION OF BENEFITS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided under this Booklet. It is designed to avoid duplication of payment for Covered Services and/or supplies. It is your responsibility to provide us information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you will be responsible for payment of any expenses related to denied claims.

Payment for Covered Services will be coordinated to the maximum extent allowed by law provided you follow the Coverage Access Rules set forth in the COVERAGE ACCESS RULES section. Plans 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 insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
4. Medicare, as described in the Medicare Secondary Payer Provisions subsection; and
5. To the extent permitted by law, any other government sponsored health insurance program.

The amount of payment, if any, is based on whether or not the Group Health Plan is the primary payer. When the Group Health Plan is primary, payment for Covered Services will be made without regard to your coverage under other plans. When the Group Health Plan is not primary, 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 that the primary payer's payment exceeds the maximum amount established by us, no payment will be made for such Services.** In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount obligated to the 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. the plan of the parent with custody is primary;

b. the plan of the re-married parent with custody is primary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; the step-parent's plan is secondary; and

c. the plan of the parent without custody pays last;

d. 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 an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:

   a. the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;

   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:

   a. first, the plan covering the person as an employee, or as the employee's dependent; and

   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.

7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary.

8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

Medicare Secondary Payer Provision

When you become covered under Medicare and are still eligible and covered under this Booklet, the Group Health Plan will be primary and Medicare benefits will be secondary, but only to the extent required by law. In all other instances, the Group Health Plan will be secondary to any Medicare benefits. When the Group Health Plan is the primary payer, claims for Covered Services should be filed with HOI first.

If you become covered under Medicare and are still eligible and covered under the Group Health Plan,

Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, the Group MAY NOT persuade you to decline or terminate your group health coverage and elect Medicare as the primary payer.

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

Individuals With End Stage Renal Disease

If you become entitled to Medicare coverage because of ESRD, your Group Health Plan is primary for 30 months beginning with the earlier of:

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

If Medicare was already primary before ESRD, Medicare will remain primary. Also, if your Group Health Plan coverage was primary before ESRD entitlement, the Group Health Plan will remain primary for the ESRD coordination period. If you are eligible for Medicare due to ESRD, your Group Health Plan coverage is primary for 30 months.

Disabled Active Individuals

The Group Health Plan coverage is primary, if:

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

Primary coverage under the Group Health Plan is pursuant to the following terms:

1. your Group Health Plan coverage is primary during any month in which you are entitled to Medicare coverage because of disability;
2. your entitlement to primary coverage under this subsection will terminate automatically when:
   a. you turn 65 years of age; or
   b. you no longer qualify for Medicare coverage because of disability; or
   c. you elect Medicare as the primary payer. Coverage will terminate as of the date of your election.

   Under Medicare, Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you or induce you to decline or terminate your group health coverage and elect Medicare as the primary payer.
3. Your entitlement to primary coverage under this subsection will terminate automatically if you no longer qualify under applicable Medicare regulations and instructions. The Group shall notify us, without delay, of any such change in status.

Miscellaneous

This section shall be changed, if necessary, to comply with federal statutory and regulatory Medicare Secondary Payer rules as they relate to Medicare beneficiaries who are covered under a Group Health Plan.

We will not be liable to Suwannee County Board of Public Instruction or anyone covered under the Group Health Plan due to any nonpayment of primary benefits that result from any failure of the Group's performance or obligations set forth in this section.

If primary payment is made for Covered Services rendered to you as described in this section in a period prior to receipt of the information required by the terms of this section, you may be required to reimburse the Group Health Plan for such payments.

Non-Duplication of Government Programs

The benefits provided under this Booklet 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.

CLAIMS PROCESSING

Introduction

This section is intended to:

1. help you understand what your treating Providers must do, under the terms of this Booklet, 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.

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

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

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

In-Network Providers have agreed to file Post-Service Claims for Covered Services they render to you. If you receive a bill from an In-Network Provider, you should forward it to us. If you require Emergency Services from an Out-of-Network Provider while inside or outside the Service Area or, if we refer you to an Out-of-Network Provider, the Group Health Plan will pay for Covered Services provided to you. If you receive a bill from an Out-of-Network Provider for Covered Services, you should forward it to us. We rely on the information you provide when processing a claim.

We must receive a Post-Service Claim within 90 days of the date the Covered Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if we do not receive it at the address indicated on your Identification Card within one year of the date the Covered 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 Covered Plan Participant's name and contract number as they appear on the Identification Card.

Note: Please refer to the PRESCRIPTION DRUGS PROGRAM section for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard Program (See the BLUECARD PROGRAM or AWAY FROM HOME CARE section).

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 Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more 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 portion(s) 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 process 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, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS 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.

Pre-Service Claims

How to file a Pre-Service Claim

This Booklet may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the COVERAGE ACCESS RULES section, the WHAT IS COVERED? section and other applicable sections of this Booklet. You may also call the customer service number on your Identification 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 Booklet 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, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Covered 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 Service(s); and
3. the reduction or termination of coverage or benefits by us was not due to an amendment to the Booklet or termination of your coverage as provided by this Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the COMPLAINT AND GRIEVANCE PROCESS described in this Booklet. 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 Covered Services.

Requests for Extension of Covered Services

Your Provider may request an extension of coverage or benefits for a Covered Service beyond the approved period of time or number of approved Covered 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 Covered 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 Covered Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Booklet.

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, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;

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

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 three 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. 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 nor Suwannee County Board of Public Instruction will have no liability for such claim.

Physical Examination

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. If you do not fully cooperate with such examination, we may deny the claim and we will have no liability for such claim.

Legal Actions

No legal action arising out of or in connection with coverage under this Booklet may be brought against HOI or Suwannee County Board of Public Instruction 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, in denial of the claim or cancellation or Rescission of your coverage.

Communication of Claims Decisions

All claims decisions, including denial and review decisions, will be communicated to you in writing. This written correspondence may indicate:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination.

3. A description of any additional information that would change the initial determination and why that information is necessary.
4. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures.
5. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational 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 Covered 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.

GENERAL PROVISIONS

Access to Information

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

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Booklet 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, the Group, 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 the Group Health Plan, specific medical information concerning you received by/from a Provider shall be kept confidential by HOI. 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, specifically including HOI's quality assurance and utilization review activities. Additionally, we may disclose such information to affiliated entities. 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 HOI 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 HOI and Suwannee County Board of Public Instruction, and must execute and submit such consents, releases, assignments, and other documents as may be requested in order to administer, and exercise any rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause as described in the TERMINATION OF COVERAGE section.

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Employer as Plan Administrator

Your employer, as the plan administrator, retains full, final, discretionary authority with respect to the administration of the coverage and benefits described in this Benefit Booklet, including, but not limited to, the authority to establish the benefits and scope of coverage to be provided hereunder; authority to make ultimate coverage and claims payment decisions; authority to determine the eligibility of individuals for coverage; and authority to construe and interpret the terms of coverage under this Benefit Booklet.

Evidence of Coverage

You have been provided with this Booklet and an Identification Card as evidence of coverage under Suwannee County Board of Public Instruction's Group Health Plan.

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 the Blue Cross and Blue Shield of Florida corporate website at www.floridablue.com.

Identification Cards

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

Modification of Provider Network

Our Provider network is subject to change at any time without prior notice to, or approval of, you or the Group. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, you or the Group. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered.

Non-Waiver of Defaults

Any failure by HOI or Suwannee County Board of Public Instruction 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 HOI's or the Group's right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law or this Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as 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 Identification Card.

If to you:

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

If to the Group:

To the address indicated by the Group.

Our Obligations Upon Termination

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

Relationships Between the Parties

HOI and Health Care Providers

Neither HOI nor any of its officers, directors or employees provides health care Services to you. By accepting 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. Neither HOI nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

HOI and the Group

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

You and In-Network Providers

The relationship between you and In-Network Providers shall be that of a health care Provider-patient relationship, in accordance with any applicable professional and ethical standards.

Right of Recovery

Whenever the Plan has made payments in excess of the maximum provided for under this Booklet, we or Suwannee County Board of Public Instruction 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 Booklet or an applicant for enrollment which we deem to be necessary.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan

including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of Suwannee County Board of Public Instruction and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Suwannee County Board of Public Instruction hereby specifically expresses its intent that Providers that have not entered into contracts with HOI to participate in our Provider networks shall not be third-party beneficiaries under the terms of the Suwannee County Board of Public Instruction's Group Health Plan or this Booklet.

COMPLAINT AND GRIEVANCE PROCESS

Introduction

We have established a process for reviewing your Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, your dissatisfaction with us, our administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent In-Network Provider. The Complaint and Grievance Process also permits you or your Physician, or a person acting on your behalf, to expedite our review of certain types of Grievances. The process described in this section must be followed if you have a Complaint or Grievance.

Informal Review

We encourage you to first attempt the informal resolution of any dissatisfaction by calling us. To advise us of a Complaint, you should first contact our customer service department, at the phone number is listed on your ID Card. A service associate, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to your satisfaction. You must provide all of the facts relevant to the Complaint to the service associate. If you do not provide all requested or relevant information, it may delay our review of the Complaint. Consequently, you must cooperate with us in our review of the matter.If you remain dissatisfied with our resolution of the Complaint, you may submit a Grievance in accordance with the Formal Review subsection below.

Formal Review

You, a Provider who has been directly involved in your treatment or diagnosis acting on your behalf, a state agency, or another person designated in writing by you, may submit a Grievance.

In order to begin the formal review process, you may fill out a pre-printed form, write a letter or meet with us in person to explain the facts and circumstances relating to the Grievance. You should provide as much detail as possible and attach copies of any relevant documentation. You are not required to use our form, however, we strongly urge you to use this form, as it was designed to help facilitate logging, identification, processing, and tracking of the Grievance through the review process. Written requests for formal review must be sent to the address listed in the Telephone Numbers and Addresses subsection.

If you need assistance in preparing your Grievance, you may contact us for assistance. If you are hearing impaired you may contact us via TTY/TDD.

Review of Grievances Involving Adverse Benefit Determination

A Grievance involving an Adverse Benefit Determination will be reviewed using the process described below. The Grievance must be submitted to us in writing for an internal Grievance 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 a Complaint or Grievance. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the Complaint or Grievance processed within the time frames set forth in this section.
2. We will offer to meet with you if you believe that such a meeting will help us resolve the Complaint or Grievance to your satisfaction, you may also initiate a request for such meeting by notifying us. You may elect to meet with us in person, by telephone conference call, or by video-conferencing (if facilities are available). We will not pay for your travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video

conferencing to be held at our administrative offices within the Service Area. We will make these telephone or video arrangements with no additional charge to you.

3. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The Expedited Review 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 review will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
4. 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.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date
6. 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 Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews the Adverse Benefit Determination on our behalf will be identified upon request.
10. 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. You may call our expedited phone line at the number listed at the end of this section.
11. 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.
12. If you wish to give someone else permission to file a Grievance for 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 Grievance. An Appointment of Representative form is not required if the Physician is requesting review of 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 customer service phone number on your ID Card.
13. The Internal Review Panel will review the Grievance 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.
14. We will advise you of all Grievance decisions in writing, as outlined in the Timing of Our Grievance Review on Adverse Benefit Determinations subsection.
15. We will provide written confirmation of our decision concerning a Claim Involving Urgent Care within two working days or three calendar days, whichever is less, after providing notification of that decision.
16. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain Grievances, as described in the External Review subsection below.

17. The Panel that reviews appeals is composed of individuals who did not participate in the previous decision, nor are they subordinates of such individual(s).
18. You have the right to an independent external review through an external review organization for certain Grievances, as provided in the Patient Protection and Affordable Care Act of 2010.

Timing of Our Grievance Review on Adverse Benefit Determinations

We will use our best efforts to review Grievances of Adverse Benefit Determinations and communicate the decision in accordance with the following time frames:

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

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.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements ("Deemed Exhaustion") and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Health Plan. If ERISA applies to the Group Health Plan, you are entitled, after exhaustion of the procedures described in this section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

External Review

If we have denied your request for payment of a claim and our decision involved 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 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. 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 HMO
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.

Telephone Numbers and Addresses

You may contact a Grievance Coordinator at the phone number listed on your ID Card or at the phone numbers and addresses listed below.

Florida Blue HMO
Attention: Grievance Department
Post Office Box 41609
Jacksonville, Florida 32230-1609
877-352-2583

877-842-9118 - Expedited Review for a Claim Involving Urgent Care

Dial 7-1-1 for Florida Relay Service assistance with TTY/TDD calls

IMPORTANT INFORMATION FOR YOU

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

Types of HMOs

Staff and Group Model HMOs

In a staff model HMO, the doctors and other Providers rendering care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract services with additional doctors and Providers. Unlike the staff or group model HMOs, the IPA model HMO does not provide Health Care Services itself. Instead, it pays independent, qualified Providers to render health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

Note: This description is not intended to be an exhaustive listing of all HMO organization models in use in the United States.

Health Options is an IPA Model HMO. **It is not a staff or group model HMO**. This means that the doctors and other Providers with whom we contract are independent contractors and not the employees or agents, actual or ostensible, of Health Options. Rather these independent doctors and Providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

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

- To be provided with information about our services and the associated Providers of Health Care Services.
- To receive medical care and treatment from In-Network Providers who have met our credentialing standards.

- To expect health care Providers who participate in our network to permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
- To expect to receive treatment and relevant information about your treatment from our In-Network Providers with courtesy, respect, and concern for your dignity and privacy.
- To appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in this Booklet.
- 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.
- To have access to your medical records, and to be assured that the confidentiality of your records is maintained, in accordance with applicable law and HOI's rules.

Responsibilities

- To seek all non-emergency care through your assigned PCP or another In-Network Provider and to cooperate with anyone providing your care and treatment.
- To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
- To be responsible for understanding and following instructions about your treatment and to ask questions if you do not understand or need an explanation.
- To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
- To pay your Cost Share amounts set forth on the Schedule of Benefits and to provide current information concerning your coverage status to any In-Network Provider.
- To follow the process for filing a grievance about medical or administrative decisions that you feel were made in error.
- To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
- To follow Coverage Access Rules established by us.

Disclosure of Continuing Care Facility Resident/Retirement Facility Resident Rights

If, at the time of enrollment you are a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, your PCP must refer you to that facility's skilled nursing unit or assisted living facility if:

1. you request it and the facility agrees;
2. your PCP finds that such care is Medically Necessary;
3. the facility agrees to be reimbursed at the same contracted rate as similar Providers for the same Covered Services and supplies; and
4. the facility meets all guidelines established by us related to quality of care, utilization, referral authorization, risk assumption, use of our Provider network, and other criteria applicable to Providers under contract with us for the same Services.

If your request to be referred to the skilled nursing unit or assisted living facility that is part of your place of residence is not honored, you have the right to initiate a Complaint or Grievance under the process described in this Booklet.

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, is a complex understanding. 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.

AWAY FROM HOME CARE®

Away From Home Care (AFHC) Guest Membership is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA). AFHC is available to you under the Group Health Plan through HOI, a participating Blue-sponsored HMO when the program's requirements are met. Guest Membership is defined as a courtesy membership for individuals who are temporarily residing outside of their Home HMO service area. Health Options, Inc. (HOI) is your Home HMO. For purposes of the Group Health Plan, you will be a guest member of the Host HMO and will be entitled to coverage and benefits under the terms of the Host HMO's benefit booklet.

Under AFHC, you receive a courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits, including routine and preventive Services. You will receive the benefits of the Host HMO plan while in that HMO Plan's service area. You remain a Covered Plan Participant under your Home HMO under the Group Health Plan and are entitled to payment for Covered Services not payable under your AFHC Guest Membership under the terms of this Booklet. Should your coverage with your Home HMO terminate, you will no longer be eligible for AFHC coverage, and if you are then in this program your AFHC coverage will also be terminated.

The Host HMO pays the Provider the lowest available rate on a fee-for-service basis and then bills the Home HMO for reimbursement. You pay any applicable Cost Share amounts to the Provider in the Host Plan's service area at the time of Service.

Guest Application

You must complete an AFHC Guest Application with the Home HMO, and then work with the Host HMO to locate a PCP in the Host Plan's service area. The AFHC Guest Application form is used to verify your eligibility and to provide the appropriate information for billing and reimbursement.

Guest Membership Types

The types of Guest Memberships are based on your eligibility and the length of time that you will be out of the Home HMO service area. The three types of Guest Memberships are as follows:

Long-Term Traveler

This Guest Membership is available to Covered Persons that are away from home for at least 90 consecutive days (three months) but not more than 180 days (six months).

This Guest Membership is typically used for long-term work assignments or for a retiree with a dual residence. Home HMOs may limit the number of Long-Term Traveler Guest Memberships to two per year.

Families Apart

The Families Apart Guest Membership is available to Covered Dependents that do not reside in the Home HMO service area for 90 or more consecutive days. A Covered Plan Participant is not eligible for this type of Guest Membership.

To qualify for a Families Apart Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

There is no administrative time limit on the length of a Families Apart Guest Membership.

Student

The Student Guest Membership is available to Covered Dependents that are out of the Home HMO Service Area for 90 or more consecutive days attending school.

To qualify for a Student Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

The Student Guest Membership is typically used for students while they are away at school. The student membership should terminate when the student returns to the Home HMO Service Area for the summer. There is no administrative time limit on the length of a Student Guest Membership.

Covered Dependents under a Student Guest Membership that seek care in a third HMO service area (out of the Home HMO area and out of the Host HMO area) should be referred back to HOI, the Home HMO.

Guest Membership Policies

Host HMOs need enough time to process and set up Guest Memberships before the desired effective date. A 15-day notification period is provided for Host HMOs to complete the processing and setup of the Guest Membership. Covered Persons can be under only one Guest Membership at a time.

Guest Membership Renewals

When your Guest Membership expires, you may apply for a separate, consecutive Guest Membership period to begin after your current one expires. The 15-day notification period applies to Guest Membership renewals, so it is important that you apply for renewal far enough in advance to avoid a lapse in Guest Membership.

Guest Membership renewals have the same requirements as initial Guest Memberships, including the 90-day out-of-area requirement. Renewals must be for a minimum of 90 or more consecutive days in length. A renewal requires that the Home HMO Guest Membership Coordinator re-verify eligibility, submit a new Guest Application form, obtain a new signature sticker and pay a new setup and renewal fee.

Renewals typically apply to Families Apart and Student Guest Memberships which commonly renew on an annual basis. A Long Term Traveler Guest Membership can also renew but you would need to re-qualify by being out of area for a minimum of 90 consecutive days from the date of the requested renewal, as well as meeting all other Home HMO eligibility requirements. You are not required to return to the Home HMO Service Area to qualify for a renewal.

DEFINITIONS

The following definitions will help you understand the terms that are used in this Booklet, including the Schedule of Benefits and any Endorsements attached to this Booklet. As you read through this Booklet you can refer to this section; we have identified defined terms in the Booklet, 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.

Administrative Services Agreement or **ASA** means an agreement between Suwannee County Board of Public Instruction and HOI. Under the Administrative Services Agreement, HOI provides claims processing and payment services, customer service, utilization review services, and access to HOI's network of independent contracting providers.

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.

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

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

Allergy Treatment means testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

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 the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and HOI.
2. In the case of Out-of-Network Providers located outside of the Service Area who participate in the BlueCard 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 in the Benefit Booklet for more details.
3. In the case of an Out-of-Network Provider that has not entered into an agreement with HOI 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 HOI 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 an HOI 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 HOI 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.

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

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with HOI 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.

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 date one year after the Effective Date stated in the ASA, and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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:

I. The Department of Veterans Affairs.

II. The Department of Defense.

III. 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.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;

2. Asperger's syndrome;

3. Pervasive developmental disorder not otherwise specified; and

4. Childhood Disintegrative Disorder.

B

Benefit Booklet or **Booklet** means the certificate of coverage, which is evidence of coverage under the Group Health Plan.

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

Birth Center means 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.

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.

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

C

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

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

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or 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 the Plan. After your Deductible is met, the Plan 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. Not all plans include coinsurance.

Complaint means an oral (non-written) expression of dissatisfaction, whether or not such dissatisfaction is made in person, by telephone, or by another person acting on your behalf.

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 COVERAGE ACCESS RULES section.

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

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

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

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

Cost Share means the dollar or percentage amount, 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.

Coverage Access Rules means the rules or procedures in this Benefit Booklet, your provider directory, or established by HOI, that you must follow in order for Health Care Services you receive to be covered. Failure to follow applicable Coverage Access Rules may result in the denial of coverage or benefits under this Booklet.

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

Covered Person means a Covered Plan Participant or Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who continues to meet all applicable eligibility requirements described in the ELIGIBILITY FOR COVERAGE section and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Dependent.

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

Custodial or **Custodial Care** means care that serves to assist 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

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider who is recognized for payment under this Booklet, before payment for Covered Services under the Group Health Plan begins. Not all plans include a deductible.

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.

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

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

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 for the Group means 12:01 a.m. on the date specified in the ASA; and for you means 12:01 a.m. on the date coverage will begin as specified in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

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

Eligible Employee means an employee who meets and continues to meet all of the eligibility requirements set forth in the ELIGIBILITY FOR COVERAGE section and is eligible to enroll as a Covered Plan Participant. An eligible employee is not a Covered Plan Participant until actually enrolled and accepted for coverage as a Covered Plan Participant by the Group.

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 Booklet. Endorsements may also be referred to as amendments.

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

Enrollment Forms means those forms, electronic or paper, which are used to maintain accurate enrollment files under the Group Health Plan.

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 or Suwannee County Board of Public Instruction:

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 or Suwannee County Board of Public Instruction):

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 or the Group 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.

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.

Gene Therapy means treating disease by replacing, manipulating, or supplementing nonfunctioning or malfunctioning genes.

Generally Accepted Standards of Medical Practice means standards that are based on reliable 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.

Grievance means a written expression of dissatisfaction.

Group means Suwannee County Board of Public Instruction, the employer, labor union, trust, association, partnership, or corporation, department or other organization or entity through which coverage and benefits described in this Booklet are made available to you, and through which you become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or **Plan** means the plan established and maintained by Suwannee County Board of Public Instruction for the provision of health care coverage and benefits to the individuals covered under this Booklet.

H

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.

HOI means Health Options, Inc., a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

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 Covered Plan Participants. 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, the Group Health Plan.

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 Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to provide Covered Services described in this Booklet.

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

Internal Review Panel means a panel established by us to review Grievances related to Adverse Benefit Determinations that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

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 Statues, or a similar applicable law of another state.

M

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 Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

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.

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

Medicare means the 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.

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

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

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, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

N

New Prescription Drug(s) means An FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

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

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

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to provide Covered Services described in this Booklet.

Outpatient Rehabilitation 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. Further, such an entity must meet our criteria for eligibility as an outpatient rehabilitation facility. The term outpatient rehabilitation facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III “specialty rehabilitation hospital” described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

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.

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

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or 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 electric format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

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".

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 Booklet condition payment for the Service (in whole or in part) on approval 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 Booklet 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 Health 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 the Physician who, at the time Covered Services are rendered, was under a primary care physician Provider contract with us. A primary care physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist may elect to contract with us as a primary care physician.

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

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 Booklet, a psychiatric facility is not a Hospital or a Substance Abuse Facility, as defined herein.

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

R

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.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of Rehabilitation Services to be provided to a person with rehabilitation potential. Such plan must have realistic goals which are attainable by the individual within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such Services are to be rendered. The rehabilitation plan must be renewed every 30 days.

Rehabilitation 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.

Rehabilitative Therapies means therapies with the primary purpose of restoring or improving a bodily or mental function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

Rescission or **Rescind** refers to HOI's or Suwannee County Board of Public Instruction's action to retroactively cancel or discontinue coverage under the Group Health Plan. 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.

S

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

Service Area means 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 the applicable service area is available at: https://www.floridablue.com/sites/floridablue.com/files/docs/county_landing_page.pdf.

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.

Specialist means a Physician who limits practice to specific Services or procedures such as surgery, radiology, pathology, certain age categories of patients such as pediatrics, geriatrics, certain body systems such as dermatology, orthopedics, cardiology, internal medicine or types of diseases such as allergy, psychiatry, infectious diseases, oncology. Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board.

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 an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. In-network specialty pharmacies are listed in the Medication Guide. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a specialty pharmacy.

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

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

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 Booklet a substance abuse facility is not a Hospital or a Psychiatric Facility, as defined herein.

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

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 Booklet, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

V

Virtual Care Provider is a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered. An Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications.

W

Waiting Period means the period of time specified by the Group, if any, which must be met by an individual before that individual is eligible to enroll for coverage under the Group Health Plan.

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.

Templates Included

Compliance/Notices/Meaningful Access Notice.jld
Compliance/Notices/Privacy Notice - Breast Reconstruction Notice.jld

78170-54--Schedule-Of-Benefits-1
78170-54--Rx-Schedule-Of-Benefits-1
78170-54--Benefit-Booklet-1

MATCHING CRITERIA

Record Number	471
Request Type	M
Health Product	BLUECARE
Small Group	N
Rx Product	BLUECARE RX
Rx Plan	5
Health Plan	54
IRX	N
Generic Choices	N
Generic Only	N/A
Closed Formulary	N
HSA	N
HSA-BRX	N
Standard	N
Basic	N
ACA	N
RX CoIns	N/A
ICC	N
CP-GF-BEN-IND	N
CP-GF-STATUS-IND	N
CP-GROUP-SUB	G
CP-GENERATION-IND	3
CP-EXCHANGE-IND	N
CP-RX-DED-IND	N

CP-RX-NGF-2012-HCR-IND	Y
CP-RX-GF-2012-HCR-IND	N
TAG-RX-SUFFIX	
AON	N/A
CP-ASO-IND	Y
Commerical	Y
CP-BCR-PEP-IND	N
Standard Or Basic	N
ROUTE	GROUP
EFF-YEAR	21
GRP-PKG-EFF-YEAR	21
GRP-NO	78170
DIV-NO	R10
PKG-NO	01
FEEDER1	0
FEEDER2	0
FEEDER3	0
FEEDER4	0
FEEDER5	0
FEEDER6	0
COE	,,,,,,,,,
DATE	6/5/21 10:53 AM

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

SUWANNEE CNTY BOARD OF PUBLIC
ATTN TERESA JONES
1740 OHIO AVE S
LIVE OAK FL 32064-4500

Thanks for choosing Florida Blue! See the enclosed **Welcome brochure** for everything you need to get the most value from your health plan. For plan info on the go, download the Florida Blue app or log in to your account at floridablue.com.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of
Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

This Master Contract is for SUWANNEE CNTY BOARD OF PUBLIC

Group Number 78170

Division(s)	Package	Division	Package

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc., d/b/a/ Florida Blue, Health Options, Inc., d/b/a Florida Blue HMO, and BeHealthy Florida, Inc., d/b/a Florida Blue Preferred HMO, collectively referred to as Florida Blue in this Notice) understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:
We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information, and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:
We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.
There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:
To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to

a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
- **Note:** If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Notice Regarding Coverage for Breast Reconstruction Surgery

If you have to have a mastectomy, your breast reconstruction surgery is covered under your health coverage. It can be done at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

BlueCare

Schedule of Benefits

Plan 122 with Integrated Prescription Drug Coverage – Single Coverage

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- Copayments listed in this Schedule of Benefits appear as a dollar amount, apply only after the Deductible is met and apply per visit.
- Your Cost Share will vary depending upon the medical Service you receive, the setting of the Services and the Provider you choose to see.
- References to Deductible are abbreviated as **"DED"** and references to Benefit Period are abbreviated as **"BP"**.

Your Benefit Period (BP).....01/01 – 12/31

DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET	YOU PAY
Deductible (DED) – Shared*	
Per person per BP	$5,000
Per family per BP	Not Applicable
Per Admission Deductible (PAD)	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	10%
Maximum Out-of-Pocket – Shared*	
Per person per BP	$6,550
Per family per BP	Not Applicable

*Refer to the YOUR SHARE OF HEALTH CARE EXPENSES section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Maximum Out-of-Pocket amounts are satisfied.

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

- Copayments
- Coinsurance (if applicable)
- DED
- PAD (if applicable)
- BlueCare Rx Cost Share

What **does not apply** to the maximum out-of-pocket?

- Charges for non-covered Services

OFFICE SERVICES	YOU PAY	
	PCP	Specialist
Office Visit Cost Share	DED + 10%	DED + 10%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 10%	DED + 10%
All other diagnostic Services (e.g., x-rays)	DED + 10%	DED + 10%
Allergy Injections	DED + 10%	DED + 10%
Allergy Testing	DED + 10%	DED + 10%
Maternity	DED + 10%	DED + 10%
Therapy and Spinal Manipulation (e.g., Physical, Speech, Cardiac or Occupational)	DED + 10%	DED + 10%

VIRTUAL HEALTH	YOU PAY
Virtual Visits	
General Medicine and Urgent Care rendered by a designated Virtual Care Provider	DED + 10%
Specialized Care rendered by a designated Virtual Care Provider	DED + 10%

Please visit http://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

MEDICAL PHARMACY	YOU PAY
Medication**	
Preferred Medications	DED + 10%
Non-Preferred Medications	DED + 10%
Maximum Out-of-Pocket per person per Month***	
Preferred Medications	$200
Non-Preferred Medications	$700

****Important** – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office visit Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy. Refer to the most current Medication Guide at www.floridablue.com to determine whether the medication is a Preferred or Non-Preferred medication.

*** The Preferred Medication Maximum Out-of-Pocket and the Non-Preferred Medication Maximum Out-of-Pocket are separate, and as such, accumulate separately. Therefore, amounts incurred for Preferred Medications shall be applied only to the Preferred Medication Maximum Out-of-Pocket and the Non-Preferred Medication amounts incurred shall be applied only to the Non-Preferred Maximum Out-of-Pocket.

PREVENTIVE HEALTH SERVICES	YOU PAY
Adult Wellness Services Physician's office and all other locations	$0
Adult Well Woman Services Physician's office and all other locations	$0
Child Health Supervision Services Physician's office and all other locations	$0
Colonoscopies (Routine)	$0
Mammograms	$0

OUTPATIENT DIAGNOSTIC SERVICES	YOU PAY
Independent Clinical Lab	DED + 10%
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 10%
All other diagnostic Services (e.g., x-rays)	DED + 10%
Outpatient Hospital Facility	See **Hospital Services**

EMERGENCY AND URGENT CARE SERVICES	YOU PAY
Ambulance Services	DED + 10%
Emergency Room Visits	See **Hospital Services**
Urgent Care Center	DED + 10%

OUTPATIENT SURGICAL SERVICES	YOU PAY
Ambulatory Surgical Center	
Facility	DED + 10%
PCP	DED + 10%
Radiologists, Anesthesiologists, and Pathologists	DED + 10%
Other health care professional Services rendered by all other Providers	DED + 10%
Outpatient Hospital Facility	See **Hospital Services**

HOSPITAL SERVICES	YOU PAY
Inpatient Facility	DED + 10%
Physician and other health care professional Services	DED + 10%
Outpatient Facility	DED + 10%
Physician and other health care professional Services	DED + 10%
Therapies and Spinal Manipulation	DED + 10%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 10%
All other diagnostic Services (e.g., x-rays)	DED + 10%
Emergency Room Visits In-Network Hospital Facility	DED + 10%
Out-of-Network Hospital Facility	DED + 10%
Physician and other health care professional Services	DED + 10%

SPECIAL SERVICES	YOU PAY
Birth Center	DED + 10%
Convenient Care Center	DED + 10%
Diabetic Equipment	DED + 10%
Dialysis Center	DED + 10%
Durable Medical Equipment	
Motorized wheelchairs	DED + 10%
All other Durable Medical Equipment	DED + 10%
Enteral Formula	DED + 10%
Home Health Care	DED + 10%
Home Health Care – Medical Pharmacy	
Preferred Prescription Drugs	DED + 10%
Non-Preferred Prescription Drugs	DED + 10%
Hospice Services	DED + 10%
Outpatient Rehabilitation Facility	DED + 10%
Physician Services (rendered at locations not otherwise noted in this schedule)	
PCP	DED + 10%
Specialist	DED + 10%
Prosthetic and Orthotic Devices	DED + 10%
Second Medical Opinion	
In-Network Provider	DED + 10%
Out-of-Network Provider	DED + 10%
Skilled Nursing Facility	DED + 10%

BEHAVIORAL HEALTH SERVICES	YOU PAY
Mental Health and Substance Dependency Treatment Services	
Outpatient Facility	
Emergency Room	DED + 10%
Hospital	DED + 10%
Physician Services at a Hospital and ER	
PCP	DED + 10%
Specialist	DED + 10%
Physician and other health care professionals licensed to perform such Services rendered at:	
PCP Office	DED + 10%
Specialist Office	DED + 10%
All other locations	
PCP	DED + 10%
Specialist	DED + 10%
Inpatient	
Facility	DED + 10%
Physician and other health care professional Services	DED + 10%

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Home Health Care visits.....60

Inpatient Rehabilitation days 30

Outpatient Therapies and Spinal Manipulation visits 30

Note: Spinal Manipulations are limited to 30 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum.

Skilled Nursing Facility days 45

BlueCare Rx Pharmacy Program

All Covered Drugs and Supplies purchased from a Pharmacy are subject to the **DED**, which must be satisfied by you before any payment will be made by us.

COVERED DRUGS AND SUPPLIES	YOU PAY
Generic Prescription Drugs and Covered OTC Drugs purchased from:	
Retail Pharmacy – For up to a One-Month Supply	DED + $10
Specialty Pharmacy - For up to a One-Month Supply	DED + $10
Mail Order Pharmacy – For up to a Three-Month Supply	DED + $25
Brand Name Prescription Drugs or Supplies purchased from:	
Retail Pharmacy – For up to a One-Month Supply	DED + $50
Specialty Pharmacy - For up to a One-Month Supply	DED + $50
Mail Order Pharmacy – For up to a Three-Month Supply	DED + $125

Important information affecting what you will pay for Covered Drugs and Supplies:

- In order to be covered under this BlueCare Rx Pharmacy Program, Brand Name Prescription Drugs **must** be included on the Formulary List. A formulary list is contained in the Closed Formulary Medication Guide, where you will find lists of Generic Prescription Drugs and Brand Name Prescription Drugs. YOu may be able to reduce your out-of-pocket expense by choosing Generic PRescription Drugs.
- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
    1. the Cost Share amount that applies to the Brand Name Prescription Drug you received as indicated in this Schedule of Benefits; **and**
    2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug is Medically Necessary.
- The Specialty Pharmacies designated, solely by us, are the only “participating” suppliers for Specialty Drugs.
- Some Specialty medications 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.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

BlueCare

Benefit Booklet for Covered Plan Participants of

Suwannee County Board of Public Instruction

Effective Date: May 1, 2021

A Self-Funded Group Health Benefit Plan Serviced by Health Options, Inc.

Group 78170
Plans 122, 123

Benefit Booklet

BlueCare

for Self-Funded Groups
Benefit Booklet

For Customer Service Assistance: 800-664-5295

Group 78170
Plans 122, 123

Benefit Booklet

TABLE OF CONTENTS

HOW TO USE YOUR BENEFIT BOOKLET

This is your Benefit Booklet ("Booklet"). It describes your coverage and benefits for Health Care Services, as well as the limitations and exclusions that apply, under the Group Health Plan ("Plan") established and maintained by Suwannee County Board of Public Instruction. Your Plan is self-funded; this means that benefits for Covered Services under the Plan will be paid either directly from the Group's general assets or a combination of its general assets and contributions made by Covered Plan Participants. The benefits provided under the Plan are not guaranteed or insured by an insurance company or by Health Options, Inc. ("HOI").

The sponsor of your Plan has contracted with us under an Administrative Services Agreement ("ASA"), to provide certain third party administrative services, including claims processing, customer service, and other services and access to our Health Maintenance Organization ("HMO") Provider network. HOI provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to you or claims submitted for processing under this Booklet for such Services. The payment of claims under the Plan depends exclusively upon the funding provided by Suwannee County Board of Public Instruction.

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

- your BlueCare benefits;
- what is covered;
- what is not covered;
- coverage and payment rules;
- how and when to file a claim and under what circumstances the Plan 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 benefits will be coordinated with other policies or plans; our subrogation rights of the Plan; and it's right of reimbursement.

If your benefits under this Plan are subject to the Employee Retirement Income Security Act of 1974 (ERISA), you should also read the Group's Summary Plan Description (SPD) for further important details concerning your rights and responsibilities under the Plan.

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

When reading your Booklet, please remember:

You should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered. Certain coverage information may be provided in the form of an Endorsement to this Booklet, if so, an Endorsement will either be inserted after the section that it modifies, or at the end of the Booklet. Be sure to always check for these additional documents before making benefit decisions.

The headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.

References to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Covered Plan Participant or solely to your Covered Dependents will be noted as such.

References to “we”, “us”, and “our” throughout refer to Health Options, Inc. We may also refer to ourselves as “HOI.”

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.

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.
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 **BlueCare 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 **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section.
What if I am covered under **BlueCare** and **another health plan?**	The **COORDINATION OF BENEFITS** section.
What happens when **my coverage ends?**	The **TERMINATION OF COVERAGE** section, along with the **CONTINUING COVERAGE** section.
What do the **terms used** throughout this Booklet **mean?**	The **DEFINITIONS** section.
Who do I call if I have **questions?**	Call our **customer service** department at **800-664-5295** (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 Booklet. All benefits for Covered Services are subject to: (1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, (2) the applicable Allowed Amount, (3) any limitations and exclusions, as well as any other provisions contained in this Booklet including any Endorsements that are part of your Booklet, and (4) our Medical Necessity guidelines and Coverage Access Rules then in effect (see the MEDICAL NECESSITY and COVERAGE ACCESS RULES sections).

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the WHAT IS NOT COVERED? section and in any Endorsements that are part of this Booklet. More than one limitation or exclusion may apply to a specific Service or a particular situation.

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

1. Provided, prescribed or ordered by an **In-Network Provider**;
2. Authorized in advance, if prior coverage authorization is required (see the COVERAGE ACCESS RULES section);
3. within the Covered Services Categories in this section;
4. actually rendered to you (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this Booklet and for which we receive an itemized statement or description of the procedure or Service which was rendered, including any applicable procedure code, diagnosis code and other information we require in order to process a claim for the Service;
5. Medically Necessary, as defined in this Booklet and determined by us or the Group in accordance with our Medical Necessity coverage criteria then in effect;
6. in accordance with the COVERAGE ACCESS RULES section;
7. rendered while your coverage is in force; and
8. not specifically or generally limited or excluded under this Booklet.

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

Covered Services Categories

Ambulance Services

Ground Ambulance

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

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

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

Air and Water Ambulance

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

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

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

Exclusion

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

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

b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment), or after being discharged from inpatient care; or

c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.

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

Ambulatory Surgical Center

Health Care Services provided 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

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, payment for Covered Services will include both the CRNA and the Physician's Services charges.

Exclusion

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

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Coverage Access Rules for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

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 Booklet; and
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician.
4. Residential Treatment Services, as defined in this Benefit Booklet.

Exclusion

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

Casts, Splints and Trusses

Casts, splints and trusses are covered when part of treatment in a facility, office or in a Hospital emergency room. This does not include the replacement of dental splints or trusses.

Child Cleft Lip and Cleft Palate Treatment

Health Care Services which are 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 are covered. In order to be covered, Services must be prescribed by a Provider who must certify in writing that the Services are Medically Necessary.

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 Booklet, 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 Booklet 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.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you in a Hospital or Ambulatory Surgical Center if:
    a. a Covered Dependent is under eight years of age and it is determined by a dentist and the Covered Dependent's Physician 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 for you 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 provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such Services could have been rendered within 62 days;
2. dental implants; and
3. Except as described above and in the Child Cleft Lip and Cleft Palate Treatment category, any 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, 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 are 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, such as insulin pump and tubing, to treat diabetes; and
4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Exclusion

Certain supplies used in the treatment of diabetes are covered under pharmacy benefits, such as blood glucose meters, lancets, test strips. If the Group provides pharmacy coverage under a BlueCare Rx Pharmacy Program, the diabetic supplies covered under that program will not be covered under this category. Refer to the PRESCRIPTION DRUG PROGRAM section for more information.

Diagnostic Services

Diagnostic Services are 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 provided at any location by a Provider licensed to perform dialysis, including a Dialysis Center.

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and

2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Coverage Access Rules for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

Durable Medical Equipment is 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.

Coverage Access Rules for Durable Medical Equipment

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

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

Exclusion

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

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services in or out of the Service Area for treatment of an Emergency Medical Condition are covered without the need for any prior authorization.

You must notify us as soon as possible, concerning the receipt of Emergency Services and/or any admission which results from an Emergency Medical Condition.

Special Payment Rules for Non-Grandfathered Plans

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

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 HOI In-Network Providers for the same Services;
2. the Allowed Amount as defined in this Booklet;
3. the usual and customary Provider charges for similar Services in the community where the Services were provided; or
4. what Medicare would have paid for the Services rendered.

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

Exclusion

Follow-up care must be rendered by an In-Network PCP or In-Network Specialist. If you are told you need follow-up care after your emergency room visit, be sure to contact your PCP or an In-Network Specialist first. Any follow-up care you receive that is provided by a Provider other than your PCP or an In-Network Specialist may not be covered.

Urgent Care Services

For non-critical but urgent care needs, you can 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 are covered when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

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

Eye Care

Coverage includes the following Services:

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

Exclusion

1. Health Care Services to diagnose or treat vision problems that are not a direct consequence of trauma or prior eye surgery;
2. vision examinations;
3. eye exercises or visual training;
4. eye glasses and contact lenses and their fitting; and
5. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.

Family Planning

Family planning Services are covered and include:

1. family planning counseling and Services, including 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 insertion and removal; and
4. surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services are covered under the Preventive Health Services category, please refer to that category for more information.

Exclusion

Contraceptive medications, devices and appliances, other than as noted above and reversal of surgical sterilization procedures are not covered. Elective abortions are also excluded.

Home Health Care

Home Health Care Services are 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 and we approve the treatment plan;
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 Booklet);

4. the Home Health Care Services are provided by or through a Home Health Agency within the Service Area; 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. other Medically Necessary Services; and
16. transplants as set forth in the Transplants Services category.

Exclusion

1. Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital:
    a. room and board provided during the admission;
    b. Physician visits provided while you were an inpatient;
    c. Occupational, Speech, Physical, and Cardiac Therapies; and
    d. other Services provided while you were an inpatient.
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.

Infertility Treatment

Infertility Services for a Covered Person who meets our criteria then in effect, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility, laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility.

Exclusion

Prescription Drugs, In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) and any Services associated with these procedures, or any Services associated with the donation or purchase of sperm.

Inpatient Rehabilitation

Inpatient Rehabilitation 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 Rehabilitative Therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five days a week and your Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Exclusion

All inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Behavioral Health Services category), Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

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

Mastectomy Services

Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas) and outpatient post-surgical follow-up care for Mastectomy Services are 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 normal 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, usually within about six weeks after the birth of the baby. This Copayment applies only to 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 including a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment, room and board and nursery. Your Cost Share for these Services is listed on your Schedule of Benefits under inpatient Hospital or Birth Center, depending on where Services are rendered. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply.

Exclusion

Maternity Services rendered outside the Service Area are not covered except in urgent situations when you did not and could not reasonably expect the need for Services before you left the Service Area.

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

Outpatient Therapies and Spinal Manipulation Services

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

   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.

   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.

   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.

   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).

   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; contrast baths are not covered.

   Coverage Access 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.

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

   Coverage Access Rules for Spinal Manipulation

   1. Coverage for spinal manipulation is limited to the number of spinal manipulations listed in your Schedule of Benefits each Benefit Period, 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.

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

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.

Exclusion

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

Preventive Health Services

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

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

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. 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. respect to women, such additional preventive care and screenings not described in paragraph 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 Health 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 Health 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 Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

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

Exclusion

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

Prosthetic Devices

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

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

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

Exclusion

Expenses for cosmetic enhancements to artificial limbs.

Second Medical Opinion

You are entitled to a second medical opinion when:

1. you do not agree with the opinion of your treating Physician or us regarding the reasonableness or necessity of a surgical procedure or treatment of a serious injury or illness; or
2. you feel you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated.

You may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion, but will need to ask your PCP or an In-Network Specialist to get an authorization from us before you receive the Services. However, you should know that your Cost Share amount for Services rendered by an In-Network Provider (usually a set Copayment) for a second medical opinion will be lower than those rendered by an Out-of-Network Provider. When you use an Out-of-Network Provider for a second medical opinion your Cost Share will be a percentage of the Allowed Amount, which may be less than the Out-of-Network Provider charges for such Services. In this case, in addition to your percentage of the Allowed Amount, you will also have to pay any charges billed by an Out-of-Network Provider in excess of the Allowed Amount.

All tests in connection with rendering the second medical opinion, including tests ordered by an Out-of-Network Physician, must be Medically Necessary and must be performed by In-Network Providers.

Coverage may be denied for a second medical opinion if you seek more than three second medical opinions in any Benefit Period and second medical opinion costs are deemed evidence that you are unreasonably over-utilizing the second medical opinion privileges. The decision, after review of documentation from the second medical opinion you obtained, will be controlling as to the Plan's obligation to pay for such treatment.

Self-Administered Prescription Drugs

Except as covered under the PRESCRIPTION DRUG PROGRAM section, only Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

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

1. room and board;
2. respiratory, pulmonary or inhalation therapy, 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 excluded.

Surgical Procedures

Surgical procedures performed by a Physician including surgical assistant Services rendered by a Physician 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; and
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. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Note: Gender reassignment surgery must be authorized, in advance, by us in order to be covered.

   Exclusions:

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

   a. reduction thyroid chondroplasty;
   b. liposuction;
   c. rhinoplasty;
   d. facial bone reconstruction;
   e. face lift;
   f. blepharoplasty;
   g. voice modification surgery ;
   h. hair removal/hairplasty; or
   i. breast augmentation.

   Payment Rules for Surgical Procedures

   1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure 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 authorized in advance and 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. The Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant ;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung transplant.

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

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized **before** they are provided.
4. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Plan.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.

7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

Virtual Visits between you and a Virtual Care Provider that is designated by us and under contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

PRESCRIPTION DRUG PROGRAM

BlueCare Rx Pharmacy Program

Coverage for Prescription Drugs and Supplies is provided through the BlueCare Rx Pharmacy Program described in this section.

Coverage is provided to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this section, you must pay, at the time of purchase, your Cost Share amounts indicated on the Schedule of Benefits.

A Formulary list is included in the Closed Formulary Medication Guide (referred to as "Medication Guide" hereafter), where you will find lists of Generic Prescription Drugs and Brand Name Prescription Drugs. Generic Prescription Drugs not included on the Formulary List are covered, unless specifically listed in the BlueCare Rx Pharmacy Program Limitations and Exclusions subsection. In order to be covered under this BlueCare Rx Pharmacy Program, Brand Name Prescription Drugs must be included on the Formulary List. You may be able to reduce your out-of-pocket expenses by using Participating Pharmacies and by choosing Generic Prescription Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website 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 **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;
3. Medically Necessary, as defined in this Booklet 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 Brand Name Prescription Drug, included on the Formulary List in the Medication Guide;
5. 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;
6. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide
7. a Prescription Drug contained in an anaphylactic kit;
8. authorized for coverage, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
9. not specifically or generally limited or excluded herein; and
10. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs;
11. reviewed by our Pharmacy and Therapeutics Committee; and
12. within the Coverage and Benefit Guidelines 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.

Coverage and Benefit Guidelines

The benefit guidelines set forth below apply to the benefits under the BlueCare Rx Pharmacy Program, as well as any other applicable payment rules specific to particular Covered Services listed in this Booklet.

Contraceptive Coverage

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

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

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

   Exceptions may be considered for Brand Name oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an "Exception Request Form" from your Physician.
   You can obtain an Exception Request Form on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

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

Exclusion

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants, such as Norplant and IUD, are excluded from coverage under this BlueCare Rx Pharmacy Program.

Covered Over-the-Counter (OTC) Drugs

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

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed 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.

Diabetic Coverage

All 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 BlueCare Rx Pharmacy Program: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and syringes and needles.

Exclusion

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

Mineral Supplements, Fluoride or Vitamins

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

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

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 excluded from coverage.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the cost share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

Preventive Medications

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

Specialty Pharmacy: Split Fill Option

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

Medication Guide. The applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance would also be split between the two fills.

BlueCare Rx 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 Booklet.

1. The Plan 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 (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., 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 BlueCare Rx Pharmacy Program.
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;

g. used for smoking cessation, except as indicated as covered under the Preventive Health 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. Brand Name Prescription Drugs, Supplies and OTC Drugs not listed in the Medication Guide;

8. Non-Formulary Drugs, unless approved through the exception process described below:

   Exception Process: Exceptions may be considered when designated Brand Name 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 number on your ID Card and one will be mailed to you upon request.

9. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines subsection.

10. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.

11. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs and Supplies subsection.

12. 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.

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

14. Drugs that are compounded except when all active ingredients are FDA-approved Prescription Drugs with valid National Drug Codes.

15. Drugs and Supplies purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized in advance by us.

16. 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. HOI and/or the Group, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.

17. 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 HOI and/or the Group, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.

18. Any amount you are required to pay under the BlueCare Rx Pharmacy Program as indicated on the Schedule of Benefits.

19. Any benefit penalty reductions.

20. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.

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

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

    a. the Drug is 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 BlueCare Rx Pharmacy Program.

23. New Prescription Drugs.

Pharmacy Alternatives

For purposes of the section, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

Participating Pharmacies have agreed not to charge, or collect from, you, for each Covered Prescription Drug, Covered Prescription Supply more than the amount set forth in the Schedule of Benefits.

To verify if a Pharmacy is a Participating Pharmacy, you may refer to the Pharmacy Program 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 present your ID Card to the Participating Pharmacy and the Pharmacy must be able to verify that you are, in fact, covered by us.

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

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

Specialty Pharmacy

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

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications.

The Specialty Pharmacies designated, solely by us, are the only Participating suppliers for Specialty Drugs. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Non-Participating for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueCare Rx 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.

Non-Participating Pharmacies

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from a Non-Participating Pharmacy is covered under this BlueCare Rx Pharmacy Program **only** if it is prescribed as a result of an Emergency Medical Condition or authorized in accordance with our criteria then in effect.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from a Non-Participating Pharmacy, as a result of an Emergency Medical Condition, or when authorized, you may be required 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 a Non-Participating 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 encourage the responsible use of Drugs and Supplies.

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

Note: If coverage is not available, or is limited, this does not mean that you cannot obtain the Drug or Supply from the Pharmacy. It only means that the Plan 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

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

Prior to filling a Prescription, your Physician may contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

Responsible Quantity Program

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

Prior Coverage Authorization Program

You are required to obtain prior coverage authorization in accordance with our criteria then in effect, in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **If you do not obtain an authorization when one is required coverage and payment will be denied**. Prescription Drugs and Supplies and OTC Drugs that require prior coverage authorization are designated in the Medication Guide.

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

Information on our pharmacy utilization review programs is published in the Medication Guide 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.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or

2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued 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 Booklet. 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 or the Group in authorizing coverage are made only to determine whether coverage or benefits are available under this BlueCare Rx 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. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if the Plan has indicated that payment will not be made for such Prescription Drug, Supply or OTC Drug.

BlueCare Rx Pharmacy Program Definitions

Certain important terms applicable to the BlueCare Rx Pharmacy Program are set forth below. For additional applicable definitions, please refer to the DEFINITIONS section of this Booklet.

Biosimilar Prescription Drug is a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (known as 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.

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. For purposes of this BlueCare RX Pharmacy Program, compound drugs are also considered a Brand Name Prescription Drug because the Brand Name Prescription Drug Cost Share also applies to compound drugs.

Closed Formulary Medication Guide (herein “Medication Guide”) means the guide then in effect issued by us that contains the Formulary List which designates the following categories of Prescription Drugs: Generic Prescription Drugs and Brand Name Prescription Drugs. **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 ID Card.

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

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under this BlueCare Rx 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:

1. Prescription diaphragms;
2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage;
3. syringes and needles prescribed with a Prescription Drug authorized for coverage;
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.

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

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

FDA means the United States Food and Drug Administration.

Formulary List means a list of Brand Name Prescription Drugs then in effect, for which coverage and benefits are provided, subject to the exclusions in this section. The Formulary List is contained within the Closed Formulary Medication Guide.

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 HOI, 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.

Mail Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug as set forth in the Schedule of Benefits. Please note, under this BlueCare Rx Pharmacy Program, you must meet the Deductible before the Mail Order Copayment, if applicable, will apply.

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

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

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 (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Non-Formulary Drug means a Brand Name Prescription Drug that is not included on the Formulary List then in effect.

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

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.

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

Participating Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies , Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

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

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, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

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

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

Program, emergency contraceptives and insulin are considered Prescription Drugs because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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.

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.

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of 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 an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

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

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

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 Booklet. **If you do not follow the Coverage Access Rules, any Services you receive will not be covered.** For further information, please refer to the COVERAGE ACCESS RULES section.

The Plan 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

Ambulance Services including but not limited to:

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

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

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.

Completion of any form and /or medical information.

Cost Share amounts you are required to pay even when the cost share amount is waived by a Provider.

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, breast augmentation.

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

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. 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).
    d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit;
    e. defined by, and covered under the PRESCRIPTION DRUG PROGRAM section.
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 drug which requires prior coverage authorization when prior coverage authorization is not obtained.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
    a. emergency stabilization;
    b. during a covered inpatient stay, or
    c. when proximately related to a surgical procedure.

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.

7. New Prescription Drug(s), as defined in the DEFINITIONS section.
8. Convenience Kits as defined in the DEFINITIONS section
9. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

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.

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 under the Plan, unless coverage is extended in accordance with the Extension of Benefits subsection in the CONTINUING COVERAGE section.
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 Booklet, 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 Booklet and determined by us in accordance with our criteria then in effect. 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.
9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Booklet.
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 rendered outside the Service Area, except Emergency Services for treatment of an Emergency Medical Condition, unless such Services are approved by us in advance.

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 category and Preventive Health Services categories of the WHAT IS COVERED? section.

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

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

Motor Vehicle Accidents 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.

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

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

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

1. beauty and barber services,
2. clothing, including support hose,
3. radio and television,
4. guest meals and accommodations,
5. telephone charges,
6. take-home supplies,
7. travel expenses (other than Medically Necessary Ambulance Services),
8. motel/hotel accommodations,
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting,
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs,
11. heating pads, hot water bottles, or ice packs,

12. physical fitness equipment,
13. hand rails and grab bars, and
14. Massage except as set forth in the WHAT IS COVERED? section.

Private Duty Nursing Care rendered at any location.

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCSBF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Smoking Cessation Programs, including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products, such as gum, transdermal patches, etc, (except as indicated as covered under the Preventive Health 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.

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.

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

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and does not have a contract with us to provide Virtual Visits under this Booklet.

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. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a. a licensed outdoor youth program, and/or
    b. a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Work Related Health Care Services to treat a work related Condition to the extent you are covered or required to be covered by Workers' Compensation law. Any Service or supply to diagnose or treat any Condition resulting from or in connection with your job or employment are excluded, except for Medically Necessary Services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

MEDICAL NECESSITY

In order for Health Care Services to be covered under this Booklet, the Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as determined by us and/or the Group and defined in this Booklet. **As a self-funded plan, Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; Suwannee County Board of Public Instruction has asked us to use our Medical Necessity criteria and guidelines currently in effect.**

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 Booklet and not for the purpose of recommending or providing medical care. Any Reviews conducted for Medical Necessity, may require review of 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 Booklet. 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. HOI and the Group are solely responsible for determining whether expenses incurred for that medical care are covered under this Booklet. In making coverage decisions, neither HOI nor the Group will 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 Booklet) or a Covered Service. You are free to obtain a Service even if coverage is denied 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 Shares explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Deductible

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by the Plan. Only those charges indicated on claims received for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount.

Family Deductible

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

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.

Hospital Per Admission Deductible

The Hospital per admission Deductible, when applicable, must be satisfied by you for each Hospital admission before any payment will be made by the Plan for any claim for inpatient Services. The Hospital per admission Deductible applies regardless of the reason for the admission.

Copayments

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

Office Services Copayment

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

Inpatient Facility Services Copayment

The Copayment for inpatient facility Services, if applicable to your plan, must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made by the Plan for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions unless your Schedule of Benefits states otherwise. Additionally, you may be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment

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

Emergency Room Facility Services Copayment

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

Coinsurance

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

Special Calculation 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.

Out-of-Pocket Maximums

Individual Out-of-Pocket Maximum

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

Family Out-of-Pocket Maximum

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

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 Benefit Period. 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 Benefit Period.

Note: The Deductible, any applicable Copayments and Coinsurance will accumulate toward the out-of-pocket maximums. Any applicable Cost Share amounts you must pay under a prescription drug program, will not apply to the Deductible or the out-of-pocket maximums under this Booklet.

Prior Coverage Credit

You will be given credit for the satisfaction or partial satisfaction of any deductible and coinsurance maximums met by you under a prior group, blanket, or franchise insurance or group Health Maintenance Organization (HMO) policy maintained by Suwannee County Board of Public Instruction if this Plan replaces such a policy. This provision only applies if the prior group, blanket, or franchise insurance or HMO coverage was in effect immediately preceding the Effective Date of this Group Health Plan. This provision is only applicable for you during the initial Benefit Period of coverage under the Plan and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited by the Group's prior policy, toward your deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited toward your coinsurance maximum under the Group's prior policy, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to your out-of-pocket maximum under this Booklet.

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

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

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 641.54 of the Florida Statutes.

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 for Health Care Services which are non-Covered Services or excluded; and
4. any contribution amount required by Suwannee County Board of Public Instruction.

How Benefit Maximums are Credited

Except as described below, only the amounts actually paid by the Plan for Covered Services will be credited toward applicable benefit maximums. The amounts the Plan pays that are credited toward your Benefit Period maximums will be based on the Allowed Amount for the Covered Services provided. Also see the Special Calculation Rule for Capitated Providers subsection above for more information.

HEALTH CARE PROVIDER OPTIONS

Introduction

It is important that you understand how the Providers you choose to use for medical care will affect how much you have to pay for medical Services. Under this HMO plan, most Services must be rendered by In-Network Providers in order to be Covered Services. This is true even when the Services you receive are Medically Necessary (except in the case of an Emergency Services for an Emergency Medical Condition). This section explains some special rules for getting Covered Services with certain types of Providers under this Booklet

For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

You are responsible for making sure a Provider is In-Network prior to receiving Services. To find out if a Provider is in our network you can:

1. access the current BlueCare Provider directory on our website at www.floridablue.com; or
2. call the customer service phone number on your ID Card.

In-Network Providers

Primary Care Physician (PCP)

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP for each covered family member. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You do not need a referral to see your PCP.

Specialist Care

If you need to visit a Specialist, you and/or your PCP may choose any In-Network Specialist.

Your PCP may consult with us regarding coverage or benefits and with the Specialist in order to coordinate your care. This provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

You do not need a referral from your PCP to see an In-Network Specialist; however, some Services require an authorization from us before Services are rendered in order to be covered. In-Network Providers are responsible for obtaining authorization.

Below are some special rules for certain types of Providers:

Chiropractors and Podiatrists: Upon your request, a Doctor of Chiropractic or a Doctor of Podiatry who is an In-Network Provider may be assigned to you for the purpose of providing chiropractic Services and podiatric Services, respectively. You shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need for referrals from your PCP.

Certified Registered Nurse Anesthetist: You have access to anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if you request such Services, provided such Services are available, as determined by us and are Covered Services under the Plan.

Dermatologists: You may access an In-Network dermatologist for up to five visits each Benefit Period without an authorization. Some Services, such as surgical procedures will require an authorization before the Services are rendered and if you do not have an authorization; the Services will not be covered.

Obstetric and Gynecological Providers: You may access In-Network Providers who specialize in obstetrics or gynecology for obstetric or gynecological care without the need for authorization.

Osteopathic Hospitals: Inpatient and outpatient Services, similar to inpatient and outpatient Services by allopathic Hospitals may be covered at a Hospital accredited by the American Osteopathic Association when such Services are available in the Service Area even when such Hospital has not entered into a written agreement with us for such Services. The Hospital providing these Services may not charge more than their usual and customary rates less the average discount that we have with allopathic Hospitals within the Service Area. You must contact us to get the documents necessary to comply with this provision.

Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other Covered Services may be rendered by licensed Physician Assistants, nurse practitioners or other individuals who are not Physicians.

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.

You must use a Specialty Pharmacy to provide these Specialty Drugs. Please refer to the Medication Guide for a list of Specialty Pharmacies.

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.

Continuity of Coverage and Care Upon Termination of a Provider Contract

When a contract between us and an In-Network Provider (including a PCP) is terminated by us or the Provider without cause and, at the time of the In-network Provider's termination, you are actively receiving Services for a Condition, Services for that Condition shall continue even after the date of the In-Network Physician's contract termination. Services for that Condition will be covered with that Provider only until the earlier of:

1. treatment for that specific Condition is completed;
2. you select another In-Network Physician; or
3. the next open enrollment period.

This extension period will not exceed the maximum time period allowed under Florida law, and in no case will it be longer than six months after termination of the Provider's contract with us.

Maternity benefits will continue under this Plan, regardless of the trimester in which Services were initiated, until completion of your postpartum care, if you initiated your prenatal care prior to the termination of the In-Network Provider's contract.

The Group Health Plan is not required to cover or pay for any Services under this subsection for an individual whose coverage under the Plan is not in effect at the time Services are rendered. Further, this subsection does not apply if the In-Network Provider is terminated "for cause".

Services Not Available from In-Network Providers

Except as provided in the WHAT IS COVERED? section, if a Covered Service is not available through In-Network Providers, we may authorize coverage for such Services to be rendered by an Out-of-Network Provider. Covered Services provided by an Out-of-Network Provider must be authorized by us **before** the Services are rendered.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, the Group Health Plan 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 Booklet;
2. an assignment of the right to receive payments due under this Booklet; 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 Booklet, or any promise or obligation set forth in any contract, plan, or policy.

The Group Health Plan specifically reserves 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; 2) is a licensed Hospital or Physician and the benefits which have been assigned are for care provided per Florida Statutes; or 3) is an Ambulance Provider that provides transportation for care from a location where an Emergency Medical Condition, as defined per Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care per Florida Statutes. A written attestation of the assignment of benefits may be required.

BLUECARD® PROGRAM

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain Health Care Services outside of Florida, the claims for these Services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Only limited Services received outside of Florida are covered. As used in this section, "Out-of-Area Covered Services" only include Emergency Services for treatment of an Emergency Medical Condition obtained outside of Florida. Any other Services will not be covered even if processed through any Inter-Plan Arrangements.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard Program

Under the BlueCard Program, when you receive Out-of-Area Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the Out-of-Area Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Cost Share amounts.

Medical Emergency: If you experience a medical emergency while traveling outside of Florida, go to the nearest facility that can provide the type of Services needed.

When you receive Out-of-Area Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Services, if not a fixed dollar Copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in

expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside of Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, payment for such Covered Services will be based on the applicable Allowed Amount.

Blue Cross Blue Shield Global® Core Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Out-of-Area Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Out-of-Area Covered Services.

Outpatient Services

Physicians, Urgent Care Centers and other Providers of outpatient Services located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Out-of-Area Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Out-of-Area Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core

Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

COVERAGE ACCESS RULES

It is important that you become familiar with the rules for accessing health care coverage through this HMO plan. The following section explains our role and the Primary Care Physician's (PCP) role, how to access specialty care coverage, and what to do if Emergency Services are needed. It is also important for you to review all Service Area-specific Coverage Access Rules for particular types of Services and In-Network Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated Provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You are free to choose any PCP listed in our published list of PCPs whose practice is open to additional BlueCare patients. This choice should be made when you enroll. You are responsible for choosing a PCP for all minor Covered Dependents including a newborn child or an adopted newborn child. If you do not choose a PCP when enrolling, we will assign one to you and notify you of that assignment. The following important rules apply to your PCP relationship:

- 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 PCP allows the Physician to become knowledgeable about your health history.
- A PCP can help you determine the need to visit a Specialist and also help you find one based on his or her knowledge of you and your specific health care needs.
- A PCP may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with us as a Primary Care Physician.
- Care rendered by your PCP usually results in lower Cost Share for you.

The PCP you select maintains a Physician-patient relationship with you, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for helping to coordinate medical Services for you.

Both you and your PCP may request a change in the PCP assignment as discussed below:

1. You may request a transfer to another PCP whose practice is open to new BlueCare patients. The effective date of a transfer to the new PCP will depend upon when we receive your request. Requests may be made on our website at www.floridablue.com or by calling the number on the back of your ID card.
2. There are also times when a PCP, for good cause, may request that we assist you in choosing another PCP.
3. If your PCP terminates his or her contract with us or is unable to perform his or her duties or is on a leave of absence, we may help you choose another PCP or assign a new one for you.

Authorization Requirements

Many Services have to be authorized **before** the Services are rendered in order to be covered under this Booklet. **Since this is a self-funded plan, Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; Suwannee County Board of Public Instruction has asked us to use our authorization criteria and guidelines currently in effect.**

There may be times when Services are authorized, but only if received in a specific setting, such as an Ambulatory Surgical Center or Independent Diagnostic Testing Center. If the authorization includes a specific setting and you receive the Services in a different setting, such Services may be denied. For example, a procedure may be authorized only when performed in an Ambulatory Surgical Center. In this case, if you have the procedure done in a Hospital, the claim may be denied because the procedure was only authorized when performed in an Ambulatory Surgical Center.

In-Network Providers have agreed to obtain these authorizations for you; however, you should ask your Provider if an authorization has been obtained if one is required. Services that must be authorized by us in advance include, but are not limited to:

1. hospitalization, both inpatient and observation stays;
2. certain radiology Services, including advanced diagnostic imaging Services, such as CT scans, MRIs, MRAs and nuclear imaging;
3. Birth Center Services;
4. Services rendered in connection with Approved Clinical Trials;
5. Home Health Care;
6. certain Durable Medical Equipment;
7. Prosthetic Devices and Orthotic Devices;
8. Pain Management Services;
9. surgery (at all locations);
10. Services provided by Out-of-Network Providers;
11. all Services provided in a Skilled Nursing Facility;
12. certain injections and infusion therapy;
13. certain Provider-administered drugs (denoted with a special symbol in the Medication Guide);
14. Hospice Services; and
15. certain diagnostic Services.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

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 the 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, alternative benefits or payment for cost-effective Health Care Services may be offered to you. These alternative benefits or payments may be made available on a case-by-case basis when you meet the 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. Because your Group Health Plan is self-funded, Suwannee County Board of Public Instruction will be required to specifically agree to such treatment plan and the alternative benefits or payment.

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

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in this Group Health Plan, and who meets and continues to meet the Group's eligibility rules described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility rules are binding upon you and /or your eligible family members. No changes in the eligibility rules will be permitted except as approved by the Group. Acceptable documentation that an individual meets and continues to meet the eligibility requirements, such as a court order naming the Covered Plan Participant as the legal guardian or appropriate Adoption documentation may be required as described in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

Covered Plan Participant Eligibility

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

1. the employee must maintain his or her primary residence in the Service Area or be regularly employed in the Service Area;
2. be a bona fide employee;
3. the employee's job must fall within the job classifications designated by the Group;
4. complete any applicable Waiting Period established by the Group; and
5. meet any additional eligibility requirements required by the Group.

The Group's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Group; and
4. other individuals as determined by the Group.

The Group shall have sole discretion concerning the expansion of eligibility classifications.

Dependent Eligibility

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

1. The Covered Plan Participant's spouse under a legally valid existing marriage, who maintains his or her primary residence in the Service Area.
2. The Covered Plan Participant's natural, newborn, Adopted, Foster or step child (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan. A dependent child must maintain his or her primary residence in the Service Area only beginning with the Calendar Year following the year they reach age 26 to the end of the Calendar Year the dependent child reaches age 30
3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility as the Covered Plan Participant to establish that a child meets the eligibility rules. Eligibility will terminate at the end of the Calendar Year in which the child no longer meets the eligibility rules required to be an Eligible Dependent.

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:

1. otherwise eligible for coverage under the Group Health Plan;
2. incapable of self-sustaining employment by reason of intellectual or physical disability; and
3. chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 30th birthday..

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

Other Rules Regarding Eligibility

1. No individual whose coverage has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll in the Group Health Plan.
2. No person shall be refused enrollment or re-enrollment because of race, color, creed, marital status, gender, or age (except as provided in the Dependent Eligibility subsection).
3. The Covered Plan Participant must notify the Group 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 proper notification is not provided timely by the Covered Plan Participant, the Group shall have the right to retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met. Upon request, the Covered Plan Participant shall provide proof, which is acceptable to the Group, of a Covered Dependent's continuing eligibility for coverage.
4. If the Group offers an alternative health benefits plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for coverage under this Booklet.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage as described in this section. Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. Neither HOI nor the Group shall have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. You may apply for coverage by completing an Enrollment Form and submitting it to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during enrollment, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right the Group may have, the Group may terminate or Rescind your coverage.
3. The Group will not provide coverage or benefits to any person who would not have been eligible to enroll, had accurate and complete information been provided on a timely basis. In such cases, the Group may require you or a person legally responsible for you, to repay any payments made on your behalf.

How to Apply for Coverage

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

1. complete the Enrollment Form and submit it to the Group;
2. provide any other information the Group may need to determine eligibility, upon request;
3. agree to pay any contribution amounts required by the Group; and
4. to add Eligible Dependents or delete Covered Dependents, complete the Enrollment Form and submit it to the Group.

When applying for coverage, you must elect one of the types of coverage available under the Group Plan. Such types may include:

Coverage Type	**Provides Coverage for:**
Employee Only	the Eligible Employee only
Employee/Spouse	the Eligible Employee and his or her spouse
Employee/Child(ren)	the Eligible Employee and children only
Employee/Family	the Eligible Employee, spouse and children

There may be an additional contribution amounts for each Covered Dependent based on the coverage provided by the Group.

Enrollment Periods

There are only certain times during the year that you can enroll for coverage, these enrollment periods are as follows:

Initial Enrollment Period: this is the period of time when you are first eligible to enroll. It starts on the date you are first eligible and ends no less than 30 days later. This time can be when the Group first starts its Plan under this Booklet, or when an employee first becomes eligible for coverage under the Plan.

Annual Open Enrollment Period: this is the period of time (usually 30 days) when you have an opportunity to select coverage from the alternatives your Group offers in its health benefit program. This period takes place every year prior to the Anniversary Date. Suwannee County Board of Public Instruction will establish the dates and length of this period.

Special Enrollment Period: this is the 30-day period of time immediately following a special event such as getting a new dependent or losing other coverage. During this time you may apply for coverage because of the special event. Special events are described in the Special Enrollment Period subsection of this section.

Initial Enrollment Period

1. If you are an Eligible Employee when Suwannee County Board of Public Instruction first starts plan under this Booklet; you must enroll (yourself and any Eligible Dependents) during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. In this case, the Effective Date of coverage for you and the dependents you enroll will be the same as the Group.
2. If you become an Eligible Employee after Suwannee County Board of Public Instruction has this plan (for example, newly-hired employees) you must enroll (yourself and any Eligible Dependents) before or within the Initial Enrollment Period and your Effective Date of coverage will begin on the date specified in writing, by the Group.

Annual Open Enrollment Period

If you did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period you may apply for coverage by completing an Enrollment Form during an Annual Open Enrollment Period. Your Effective Date of coverage will be the date specified by the Group.

If you do not enroll or change your coverage selection during the Annual Open Enrollment Period, you must wait until the next Annual Open Enrollment Period to make any changes, unless a special event, as outlined in the Special Enrollment Period subsection of this section, occurs.

Special Enrollment Period

You may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, you must complete an Enrollment Form and submit it to the Group within the time periods noted below for each special enrollment event.

If you declined coverage when it was first offered under this Plan and you stated, in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment, you may apply for coverage if one of the following special enrollment events occurs and you complete an Enrollment Form and submit it to the Group within time periods indicated in the chart that follows.

Special Enrollment Event

Loss of Coverage under…	Caused by…	Enrollment Form due to Group within…
a group health plan or COBRA	• Exhaustion of COBRA • termination of employment • reduction in the number of hours you work • reaching or exceeding the lifetime maximum of all benefits under other health coverage • the employer stopped offering group health coverage • death of your spouse • divorce or legal separation • employer contributions toward such coverage are terminated	30 days of the date coverage was terminated
A Children's Health Insurance Program or Medicaid	• loss of eligibility for such coverage • becoming eligible for the optional state premium assistance program	60 days of the date coverage was terminated
***Adding Coverage...**	• your marriage • your getting a new dependent through birth, Adoption or placement in anticipation of Adoption	30 days of the date of the event

* The statement in the paragraph above this chart about declining coverage when it was first offered does not apply to these special enrollment events.

Your Effective Date of Coverage will be the date of the special enrollment event. If you do not enroll or change your coverage during the Special Enrollment Period you must wait until the next Annual Open Enrollment Period.

Note: Loss of coverage for failure to pay your required contribution on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

Dependent Enrollment

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

Newborn Children – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group. 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). The Group must be notified, in writing, when you are adding a newborn and the rules for Effective Date and contribution amounts charged for the newborn vary depending on when this written notification is received. The chart that follows indicates these differences:

Newborn Enrollment

If written notice is received within…	**The Effective Date of the newborn will be…**	**Contribution amounts for the newborn child…**
30 days after the date of birth	the date of birth	will **not** be charged **for the first 30 days**
31 to 60 days after the date of birth	the date of birth	will be charged from the date of birth
61 or more days* after the date birth	the date of birth	will be charged from the date of birth

*This applies only if the Group **has not had** an Annual Open Enrollment Period since the baby was born. If the written notice is received more than 60 days after the birth of the newborn child, and your Group **has had** an Annual Open Enrollment Period since the birth of the newborn, the child may not be added until the Group's next Annual Open Enrollment Period.

Additional Rules for Adopted Newborn Children

If an Adopted newborn's Effective Date of coverage is determined to be the date of birth (based on the above chart), a written agreement to Adopt such child must have been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents which we deemed necessary by us or the Group in order to administer this provision. 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 Covered Plan Participant to notify the Group within ten calendar days of the date that placement was to occur if the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Covered Plan Participant. If a child is born before the Effective Date of the Covered Plan Participant the newborn should be added during the Initial Enrollment Period.

Adopted/Foster Children – To enroll an Adopted child (other than a newborn child) or Foster Child, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days after the date of placement and the Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Covered Plan Participant pursuant to Florida law. If timely notice is given, no additional contribution amount will be charged for coverage of the Adopted or Foster Child for the duration of the notice period (the 30-day period before the child was placed in your home). You may need to

provide additional information and/or documents deemed necessary by us in order to properly administer this provision.

If timely notice is not given, the child will be added as of the date of placement so long as we receive the Enrollment Form within 60 days of the placement, and any applicable contribution amount is paid back to the date of placement. If notification is not received within 60 days of the date of placement, the Covered Plan Participant must make application during the Annual Open Enrollment Period or Special Enrollment Period in order for the Adopted or Foster Child to be covered.

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. It is your responsibility as the Covered Plan Participant to notify the Group if the Adoption does not take place. Upon receipt of this notification, such child's coverage will be terminated as of the Effective Date of the Adopted child.

Foster Children

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is your responsibility as the Covered Plan Participant to notify the Group in writing that the Foster Child is no longer in your care. Upon receipt of this notification, such child's coverage will be terminated on the date provided by the Group.

Marital Status – If the Covered Plan Participant marries after his or her Effective Date, he or she may add the spouse who is an Eligible Dependent due to a legally valid marriage. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the marriage and the Effective Date of coverage for the new spouse will be the date of the marriage.

Court Order – You, as the Covered Plan Participant may add an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided by you for a minor child under your plan. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the court order and the Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order will be the date required by the court order.

Other Provisions

Rehired Employees

If you are rehired as an employee of the Group; you are considered a newly-hired employee for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Policy, applicable to newly-hired employees and their Eligible Dependents if the employee does not qualify for the federal exemption, such as Effective Dates of coverage and Waiting Periods will apply to you.

TERMINATION OF COVERAGE

Covered Plan Participant

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

1. on the date the ASA between HOI and Suwannee County Board of Public Instruction terminates;
2. on the date the Covered Plan Participant becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the date the Covered Plan Participant no longer meets any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause; or
5. on the date specified by the Group.

Covered Dependent

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

1. on the date the Covered Plan Participant's coverage terminates for any reason;
2. on the date the Covered Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the last day of the Calendar Year that the Covered Dependent no longer meets the eligibility requirements;
4. on the date the Covered Dependent's coverage is terminated for cause;
5. on the date specified by the Group.

If you, as the Covered Plan Participant, wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group prior to the termination date requested.

If you wish to delete your spouse from coverage, in the case of divorce for example, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Termination for Cause

If any of the following events occur, the Group may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits;
2. you intentionally misrepresent, omit, or give false information on Enrollment Forms or other forms completed, by you or on your behalf;
3. fraudulent misuse of the ID Card;
4. you no longer live or work in the Service Area; or
5. a Covered Dependent reaches the limiting age.

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

Note: Only fraudulent misstatements on the Enrollment Form may be used by the Group to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

Rescission of Coverage

The Group and HOI reserve the right to Rescind coverage under this Booklet for any individual covered under this Booklet as permitted by law.

The Group and/or HOI may only Rescind your coverage if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

The Group and/or HOI will provide at least 45 days advance written notice to the Covered Plan Participant of the 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 COMPLAINT AND GRIEVANCE PROCESS section.

Notice of Termination

It is Suwannee County Board of Public Instruction's responsibility to immediately notify you of termination of the Group Health Plan for any reason.

Group Health Plan Responsibilities Upon Termination of Your Coverage

Upon termination of your coverage for any reason, HOI and the Group will have no further liability to you under the Group Health Plan, except as otherwise specifically described in this Booklet.

CONTINUING COVERAGE

Introduction

This section describes the ways coverage can be continued after your termination date. We have divided this section into three subsections: Federal and Florida Continuation Provisions, Conversion Privilege and Extension of Benefits.

Federal Continuation of Coverage Law

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

You must contact your Group to determine if you are entitled to COBRA continuation of coverage. Your Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify you of your rights under COBRA. If you do not meet your obligations under COBRA and this Plan, the Group shall not be liable for any claims incurred by you after your coverage terminates.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by the Group Health Plan; the duty to meet such obligations remains with Suwannee County Board of Public Instruction.

The following is a summary of what you may elect, if COBRA applies to Suwannee County Board of Public Instruction and you are eligible for such coverage:

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

   ***Note:** You are eligible for an 11 month extension of the 18 month COBRA continuation option above (up to a total of 29 months) if you are totally disabled, as defined by the Social Security Administration (SSA), at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. You must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependents may elect to continue their coverage for a period not to exceed 36 months in the case of:
   a. the Covered Plan Participant's entitlement to Medicare;
   b. divorce or legal separation from the Covered Plan Participant;
   c. death of the Covered Plan Participant;
   d. the employer files bankruptcy (subject to bankruptcy court approval); or
   e. a Covered Dependent child who ceases to be an Eligible Dependent under the terms of the Policy.

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

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

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

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Conversion Privilege

If your Group Health Plan has terminated you may apply for conversion to a non-group plan. HOI and the Group have no obligation to notify you of the conversion privilege. It is your sole responsibility to exercise this conversion privilege subject to the provisions set forth below.

Eligibility Criteria for Conversion

You are entitled to apply for a conversion contract for a non-group plan if:

1. you have been continuously covered under this Group Health Plan for at least three consecutive months; **or**
2. you were covered for at least three consecutive months under any other group policy providing similar benefits that this Group Health Plan immediately replaced; **and**
3. your coverage has been terminated for any reason, including discontinuance of this Group Health Plan in its entirety and termination of continued coverage under COBRA; **and**
4. you maintain your primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for Health Care Services. **We must receive the completed conversion application and the applicable premium payment within the 63-day period beginning on the date this Group Health Plan terminated.**

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

Conversion is not available if termination occurred for any of the following reasons:

1. you had not been continuously covered under the Group Health Plan for at least three months prior to termination;
2. failure by you to pay on a timely basis, any required contribution amounts required for coverage under the Group Health Plan;
3. replacement of coverage by similar group coverage occurs within 31 days of termination;
4. you commit fraud or intentional misrepresentation in applying for the Group Health Plan or for any Covered Services;
5. termination for cause as set forth in the TERMINATION OF COVERAGE subsection;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. you are eligible for, or covered under, Medicare.

Additionally, conversion is not available:

1. if you are eligible for similar benefits, whether or not you are actually covered under any arrangement of coverage for individuals in a group;
2. if you are covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical Service insured contract or medical practice or other prepayment plan, or by any other plan or program;
3. if similar benefits are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA); or
4. if the benefits provided or available to you, together with the benefits provided by us, would result in excess of coverage, as determined by us.

Conversion Coverage

The conversion contract issued to each individual who converts to non-group coverage shall include a level of benefits for "minimum Services" which is similar to the level of benefits for the Services included in this Booklet. For purposes of this section, the term "minimum Services" shall mean Services which include any of the following: emergency care, inpatient Hospital Services, Physician care, ambulatory diagnostic treatment, and preventive Health Care Services. Conversion coverage is not a continuation of the Group Health Plan. Benefits under such conversion coverage may differ from benefits under the Group Health Plan and any Endorsements attached thereto. Conversion coverage may continue in effect as long as you: (a) continue to meet all applicable eligibility requirements; (b) pay all applicable fees and charges; and (c) otherwise comply with all requirements under the conversion contract.

Effective Date of Conversion

The effective date of conversion coverage shall be the day following the termination under the Group Health Plan. However, until such time as coverage under the conversion contract becomes effective, you shall pay the Allowed Amount for any Covered Services rendered during the 63-day period immediately following termination of the Group Health Plan. In the event such conversion coverage becomes effective, you may request reimbursement from us for any payment for Covered Services. You must submit proof of payment to us in order to obtain reimbursement.

Extension of Benefits

If the Group Health Plan is terminated, coverage will end on the termination date. There will be no coverage or benefits for any Covered Service received on or after the termination date, except as listed below. The extension of benefits described below only applies when the Group Health Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Booklet.

Note: You must provide proof that you are entitled to an extension of benefits.

Extension of Benefits

1. If you are pregnant on the termination date of the Group Health Plan, a limited extension of the maternity benefits will be provided, as long as the pregnancy started while you were covered by the Group Health Plan. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate on the date the child is born.
2. If you are totally disabled on the termination date of the Group Health Plan because of a specific accident or illness that happened while you were covered under the Group Health Plan, a limited extension of benefits will be provided for you only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

   Note: For purposes of this subsection, you will be considered totally disabled only if, in our opinion, you are unable to work at a job for which you have the education, training, or experience, and you continue to require regular care from a Physician for the disability. This applies, even if you are not working (e.g., a student, non-working spouse, or children), if you are unable to perform the normal day-to-day activities which you would otherwise be able to perform.

Neither the Group nor HOI is required to provide an extension of benefits if you leave the Service Area with the intent to relocate or establish a new residence outside the Service Area; if you intentionally left out or provided false information on any Enrollment Form in order to obtain coverage or Covered Services; or if you were terminated for 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.

COORDINATION OF BENEFITS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided under this Booklet. It is designed to avoid duplication of payment for Covered Services and/or supplies. It is your responsibility to provide us information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you will be responsible for payment of any expenses related to denied claims.

Payment for Covered Services will be coordinated to the maximum extent allowed by law provided you follow the Coverage Access Rules set forth in the COVERAGE ACCESS RULES section. Plans 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 insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
4. Medicare, as described in the Medicare Secondary Payer Provisions subsection; and
5. To the extent permitted by law, any other government sponsored health insurance program.

The amount of payment, if any, is based on whether or not the Group Health Plan is the primary payer. When the Group Health Plan is primary, payment for Covered Services will be made without regard to your coverage under other plans. When the Group Health Plan is not primary, 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 that the primary payer's payment exceeds the maximum amount established by us, no payment will be made for such Services.** In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount obligated to the 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. the plan of the parent with custody is primary;

b. the plan of the re-married parent with custody is primary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; the step-parent's plan is secondary; and

c. the plan of the parent without custody pays last;

d. 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 an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:

   a. the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;

   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:

   a. first, the plan covering the person as an employee, or as the employee's dependent; and

   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.

7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary.

8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

Medicare Secondary Payer Provision

When you become covered under Medicare and are still eligible and covered under this Booklet, the Group Health Plan will be primary and Medicare benefits will be secondary, but only to the extent required by law. In all other instances, the Group Health Plan will be secondary to any Medicare benefits. When the Group Health Plan is the primary payer, claims for Covered Services should be filed with HOI first.

If you become covered under Medicare and are still eligible and covered under the Group Health Plan,

Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, the Group MAY NOT persuade you to decline or terminate your group health coverage and elect Medicare as the primary payer.

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

Individuals With End Stage Renal Disease

If you become entitled to Medicare coverage because of ESRD, your Group Health Plan is primary for 30 months beginning with the earlier of:

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

If Medicare was already primary before ESRD, Medicare will remain primary. Also, if your Group Health Plan coverage was primary before ESRD entitlement, the Group Health Plan will remain primary for the ESRD coordination period. If you are eligible for Medicare due to ESRD, your Group Health Plan coverage is primary for 30 months.

Disabled Active Individuals

The Group Health Plan coverage is primary, if:

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

Primary coverage under the Group Health Plan is pursuant to the following terms:

1. your Group Health Plan coverage is primary during any month in which you are entitled to Medicare coverage because of disability;
2. your entitlement to primary coverage under this subsection will terminate automatically when:
   a. you turn 65 years of age; or
   b. you no longer qualify for Medicare coverage because of disability; or
   c. you elect Medicare as the primary payer. Coverage will terminate as of the date of your election.

   Under Medicare, Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you or induce you to decline or terminate your group health coverage and elect Medicare as the primary payer.
3. Your entitlement to primary coverage under this subsection will terminate automatically if you no longer qualify under applicable Medicare regulations and instructions. The Group shall notify us, without delay, of any such change in status.

Miscellaneous

This section shall be changed, if necessary, to comply with federal statutory and regulatory Medicare Secondary Payer rules as they relate to Medicare beneficiaries who are covered under a Group Health Plan.

We will not be liable to Suwannee County Board of Public Instruction or anyone covered under the Group Health Plan due to any nonpayment of primary benefits that result from any failure of the Group's performance or obligations set forth in this section.

If primary payment is made for Covered Services rendered to you as described in this section in a period prior to receipt of the information required by the terms of this section, you may be required to reimburse the Group Health Plan for such payments.

Non-Duplication of Government Programs

The benefits provided under this Booklet 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.

CLAIMS PROCESSING

Introduction

This section is intended to:

1. help you understand what your treating Providers must do, under the terms of this Booklet, 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.

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

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

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

In-Network Providers have agreed to file Post-Service Claims for Covered Services they render to you. If you receive a bill from an In-Network Provider, you should forward it to us. If you require Emergency Services from an Out-of-Network Provider while inside or outside the Service Area or, if we refer you to an Out-of-Network Provider, the Group Health Plan will pay for Covered Services provided to you. If you receive a bill from an Out-of-Network Provider for Covered Services, you should forward it to us. We rely on the information you provide when processing a claim.

We must receive a Post-Service Claim within 90 days of the date the Covered Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if we do not receive it at the address indicated on your Identification Card within one year of the date the Covered 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 Covered Plan Participant's name and contract number as they appear on the Identification Card.

Note: Please refer to the PRESCRIPTION DRUGS PROGRAM section for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard Program (See the BLUECARD PROGRAM or AWAY FROM HOME CARE section).

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 Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more 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 portion(s) 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 process 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, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS 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.

Pre-Service Claims

How to file a Pre-Service Claim

This Booklet may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the COVERAGE ACCESS RULES section, the WHAT IS COVERED? section and other applicable sections of this Booklet. You may also call the customer service number on your Identification 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 Booklet 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, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Covered 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 Service(s); and
3. the reduction or termination of coverage or benefits by us was not due to an amendment to the Booklet or termination of your coverage as provided by this Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the COMPLAINT AND GRIEVANCE PROCESS described in this Booklet. 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 Covered Services.

Requests for Extension of Covered Services

Your Provider may request an extension of coverage or benefits for a Covered Service beyond the approved period of time or number of approved Covered 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 Covered 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 Covered Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Booklet.

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, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;

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

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 three 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. 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 nor Suwannee County Board of Public Instruction will have no liability for such claim.

Physical Examination

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. If you do not fully cooperate with such examination, we may deny the claim and we will have no liability for such claim.

Legal Actions

No legal action arising out of or in connection with coverage under this Booklet may be brought against HOI or Suwannee County Board of Public Instruction 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, in denial of the claim or cancellation or Rescission of your coverage.

Communication of Claims Decisions

All claims decisions, including denial and review decisions, will be communicated to you in writing. This written correspondence may indicate:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination.

3. A description of any additional information that would change the initial determination and why that information is necessary.
4. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures.
5. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational 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 Covered 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.

GENERAL PROVISIONS

Access to Information

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

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Booklet 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, the Group, 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 the Group Health Plan, specific medical information concerning you received by/from a Provider shall be kept confidential by HOI. 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, specifically including HOI's quality assurance and utilization review activities. Additionally, we may disclose such information to affiliated entities. 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 HOI 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 HOI and Suwannee County Board of Public Instruction, and must execute and submit such consents, releases, assignments, and other documents as may be requested in order to administer, and exercise any rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause as described in the TERMINATION OF COVERAGE section.

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Employer as Plan Administrator

Your employer, as the plan administrator, retains full, final, discretionary authority with respect to the administration of the coverage and benefits described in this Benefit Booklet, including, but not limited to, the authority to establish the benefits and scope of coverage to be provided hereunder; authority to make ultimate coverage and claims payment decisions; authority to determine the eligibility of individuals for coverage; and authority to construe and interpret the terms of coverage under this Benefit Booklet.

Evidence of Coverage

You have been provided with this Booklet and an Identification Card as evidence of coverage under Suwannee County Board of Public Instruction's Group Health Plan.

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 the Blue Cross and Blue Shield of Florida corporate website at www.floridablue.com.

Identification Cards

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

Modification of Provider Network

Our Provider network is subject to change at any time without prior notice to, or approval of, you or the Group. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, you or the Group. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered.

Non-Waiver of Defaults

Any failure by HOI or Suwannee County Board of Public Instruction 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 HOI's or the Group's right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law or this Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as 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 Identification Card.

If to you:

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

If to the Group:

To the address indicated by the Group.

Our Obligations Upon Termination

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

Relationships Between the Parties

HOI and Health Care Providers

Neither HOI nor any of its officers, directors or employees provides health care Services to you. By accepting 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. Neither HOI nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

HOI and the Group

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

You and In-Network Providers

The relationship between you and In-Network Providers shall be that of a health care Provider-patient relationship, in accordance with any applicable professional and ethical standards.

Right of Recovery

Whenever the Plan has made payments in excess of the maximum provided for under this Booklet, we or Suwannee County Board of Public Instruction 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 Booklet or an applicant for enrollment which we deem to be necessary.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan

including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of Suwannee County Board of Public Instruction and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Suwannee County Board of Public Instruction hereby specifically expresses its intent that Providers that have not entered into contracts with HOI to participate in our Provider networks shall not be third-party beneficiaries under the terms of the Suwannee County Board of Public Instruction's Group Health Plan or this Booklet.

COMPLAINT AND GRIEVANCE PROCESS

Introduction

We have established a process for reviewing your Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, your dissatisfaction with us, our administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent In-Network Provider. The Complaint and Grievance Process also permits you or your Physician, or a person acting on your behalf, to expedite our review of certain types of Grievances. The process described in this section must be followed if you have a Complaint or Grievance.

Informal Review

We encourage you to first attempt the informal resolution of any dissatisfaction by calling us. To advise us of a Complaint, you should first contact our customer service department, at the phone number is listed on your ID Card. A service associate, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to your satisfaction. You must provide all of the facts relevant to the Complaint to the service associate. If you do not provide all requested or relevant information, it may delay our review of the Complaint. Consequently, you must cooperate with us in our review of the matter.If you remain dissatisfied with our resolution of the Complaint, you may submit a Grievance in accordance with the Formal Review subsection below.

Formal Review

You, a Provider who has been directly involved in your treatment or diagnosis acting on your behalf, a state agency, or another person designated in writing by you, may submit a Grievance.

In order to begin the formal review process, you may fill out a pre-printed form, write a letter or meet with us in person to explain the facts and circumstances relating to the Grievance. You should provide as much detail as possible and attach copies of any relevant documentation. You are not required to use our form, however, we strongly urge you to use this form, as it was designed to help facilitate logging, identification, processing, and tracking of the Grievance through the review process. Written requests for formal review must be sent to the address listed in the Telephone Numbers and Addresses subsection.

If you need assistance in preparing your Grievance, you may contact us for assistance. If you are hearing impaired you may contact us via TTY/TDD.

Review of Grievances Involving Adverse Benefit Determination

A Grievance involving an Adverse Benefit Determination will be reviewed using the process described below. The Grievance must be submitted to us in writing for an internal Grievance 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 a Complaint or Grievance. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the Complaint or Grievance processed within the time frames set forth in this section.
2. We will offer to meet with you if you believe that such a meeting will help us resolve the Complaint or Grievance to your satisfaction, you may also initiate a request for such meeting by notifying us. You may elect to meet with us in person, by telephone conference call, or by video-conferencing (if facilities are available). We will not pay for your travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video

conferencing to be held at our administrative offices within the Service Area. We will make these telephone or video arrangements with no additional charge to you.

3. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The Expedited Review 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 review will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
4. 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.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date
6. 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 Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews the Adverse Benefit Determination on our behalf will be identified upon request.
10. 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. You may call our expedited phone line at the number listed at the end of this section.
11. 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.
12. If you wish to give someone else permission to file a Grievance for 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 Grievance. An Appointment of Representative form is not required if the Physician is requesting review of 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 customer service phone number on your ID Card.
13. The Internal Review Panel will review the Grievance 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.
14. We will advise you of all Grievance decisions in writing, as outlined in the Timing of Our Grievance Review on Adverse Benefit Determinations subsection.
15. We will provide written confirmation of our decision concerning a Claim Involving Urgent Care within two working days or three calendar days, whichever is less, after providing notification of that decision.
16. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain Grievances, as described in the External Review subsection below.

17. The Panel that reviews appeals is composed of individuals who did not participate in the previous decision, nor are they subordinates of such individual(s).
18. You have the right to an independent external review through an external review organization for certain Grievances, as provided in the Patient Protection and Affordable Care Act of 2010.

Timing of Our Grievance Review on Adverse Benefit Determinations

We will use our best efforts to review Grievances of Adverse Benefit Determinations and communicate the decision in accordance with the following time frames:

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

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.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements ("Deemed Exhaustion") and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Health Plan. If ERISA applies to the Group Health Plan, you are entitled, after exhaustion of the procedures described in this section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

External Review

If we have denied your request for payment of a claim and our decision involved 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 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. 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 HMO
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.

Telephone Numbers and Addresses

You may contact a Grievance Coordinator at the phone number listed on your ID Card or at the phone numbers and addresses listed below.

Florida Blue HMO
Attention: Grievance Department
Post Office Box 41609
Jacksonville, Florida 32230-1609
877-352-2583

877-842-9118 - Expedited Review for a Claim Involving Urgent Care

Dial 7-1-1 for Florida Relay Service assistance with TTY/TDD calls

IMPORTANT INFORMATION FOR YOU

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

Types of HMOs

Staff and Group Model HMOs

In a staff model HMO, the doctors and other Providers rendering care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract services with additional doctors and Providers. Unlike the staff or group model HMOs, the IPA model HMO does not provide Health Care Services itself. Instead, it pays independent, qualified Providers to render health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

Note: This description is not intended to be an exhaustive listing of all HMO organization models in use in the United States.

Health Options is an IPA Model HMO. **It is not a staff or group model HMO**. This means that the doctors and other Providers with whom we contract are independent contractors and not the employees or agents, actual or ostensible, of Health Options. Rather these independent doctors and Providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

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

- To be provided with information about our services and the associated Providers of Health Care Services.
- To receive medical care and treatment from In-Network Providers who have met our credentialing standards.

- To expect health care Providers who participate in our network to permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
- To expect to receive treatment and relevant information about your treatment from our In-Network Providers with courtesy, respect, and concern for your dignity and privacy.
- To appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in this Booklet.
- 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.
- To have access to your medical records, and to be assured that the confidentiality of your records is maintained, in accordance with applicable law and HOI's rules.

Responsibilities

- To seek all non-emergency care through your assigned PCP or another In-Network Provider and to cooperate with anyone providing your care and treatment.
- To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
- To be responsible for understanding and following instructions about your treatment and to ask questions if you do not understand or need an explanation.
- To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
- To pay your Cost Share amounts set forth on the Schedule of Benefits and to provide current information concerning your coverage status to any In-Network Provider.
- To follow the process for filing a grievance about medical or administrative decisions that you feel were made in error.
- To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
- To follow Coverage Access Rules established by us.

Disclosure of Continuing Care Facility Resident/Retirement Facility Resident Rights

If, at the time of enrollment you are a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, your PCP must refer you to that facility's skilled nursing unit or assisted living facility if:

1. you request it and the facility agrees;
2. your PCP finds that such care is Medically Necessary;
3. the facility agrees to be reimbursed at the same contracted rate as similar Providers for the same Covered Services and supplies; and
4. the facility meets all guidelines established by us related to quality of care, utilization, referral authorization, risk assumption, use of our Provider network, and other criteria applicable to Providers under contract with us for the same Services.

If your request to be referred to the skilled nursing unit or assisted living facility that is part of your place of residence is not honored, you have the right to initiate a Complaint or Grievance under the process described in this Booklet.

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, is a complex understanding. 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.

AWAY FROM HOME CARE®

Away From Home Care (AFHC) Guest Membership is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA). AFHC is available to you under the Group Health Plan through HOI, a participating Blue-sponsored HMO when the program's requirements are met. Guest Membership is defined as a courtesy membership for individuals who are temporarily residing outside of their Home HMO service area. Health Options, Inc. (HOI) is your Home HMO. For purposes of the Group Health Plan, you will be a guest member of the Host HMO and will be entitled to coverage and benefits under the terms of the Host HMO's benefit booklet.

Under AFHC, you receive a courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits, including routine and preventive Services. You will receive the benefits of the Host HMO plan while in that HMO Plan's service area. You remain a Covered Plan Participant under your Home HMO under the Group Health Plan and are entitled to payment for Covered Services not payable under your AFHC Guest Membership under the terms of this Booklet. Should your coverage with your Home HMO terminate, you will no longer be eligible for AFHC coverage, and if you are then in this program your AFHC coverage will also be terminated.

The Host HMO pays the Provider the lowest available rate on a fee-for-service basis and then bills the Home HMO for reimbursement. You pay any applicable Cost Share amounts to the Provider in the Host Plan's service area at the time of Service.

Guest Application

You must complete an AFHC Guest Application with the Home HMO, and then work with the Host HMO to locate a PCP in the Host Plan's service area. The AFHC Guest Application form is used to verify your eligibility and to provide the appropriate information for billing and reimbursement.

Guest Membership Types

The types of Guest Memberships are based on your eligibility and the length of time that you will be out of the Home HMO service area. The three types of Guest Memberships are as follows:

Long-Term Traveler

This Guest Membership is available to Covered Persons that are away from home for at least 90 consecutive days (three months) but not more than 180 days (six months).

This Guest Membership is typically used for long-term work assignments or for a retiree with a dual residence. Home HMOs may limit the number of Long-Term Traveler Guest Memberships to two per year.

Families Apart

The Families Apart Guest Membership is available to Covered Dependents that do not reside in the Home HMO service area for 90 or more consecutive days. A Covered Plan Participant is not eligible for this type of Guest Membership.

To qualify for a Families Apart Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

There is no administrative time limit on the length of a Families Apart Guest Membership.

Student

The Student Guest Membership is available to Covered Dependents that are out of the Home HMO Service Area for 90 or more consecutive days attending school.

To qualify for a Student Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

The Student Guest Membership is typically used for students while they are away at school. The student membership should terminate when the student returns to the Home HMO Service Area for the summer. There is no administrative time limit on the length of a Student Guest Membership.

Covered Dependents under a Student Guest Membership that seek care in a third HMO service area (out of the Home HMO area and out of the Host HMO area) should be referred back to HOI, the Home HMO.

Guest Membership Policies

Host HMOs need enough time to process and set up Guest Memberships before the desired effective date. A 15-day notification period is provided for Host HMOs to complete the processing and setup of the Guest Membership. Covered Persons can be under only one Guest Membership at a time.

Guest Membership Renewals

When your Guest Membership expires, you may apply for a separate, consecutive Guest Membership period to begin after your current one expires. The 15-day notification period applies to Guest Membership renewals, so it is important that you apply for renewal far enough in advance to avoid a lapse in Guest Membership.

Guest Membership renewals have the same requirements as initial Guest Memberships, including the 90-day out-of-area requirement. Renewals must be for a minimum of 90 or more consecutive days in length. A renewal requires that the Home HMO Guest Membership Coordinator re-verify eligibility, submit a new Guest Application form, obtain a new signature sticker and pay a new setup and renewal fee.

Renewals typically apply to Families Apart and Student Guest Memberships which commonly renew on an annual basis. A Long Term Traveler Guest Membership can also renew but you would need to re-qualify by being out of area for a minimum of 90 consecutive days from the date of the requested renewal, as well as meeting all other Home HMO eligibility requirements. You are not required to return to the Home HMO Service Area to qualify for a renewal.

DEFINITIONS

The following definitions will help you understand the terms that are used in this Booklet, including the Schedule of Benefits and any Endorsements attached to this Booklet. As you read through this Booklet you can refer to this section; we have identified defined terms in the Booklet, 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.

Administrative Services Agreement or **ASA** means an agreement between Suwannee County Board of Public Instruction and HOI. Under the Administrative Services Agreement, HOI provides claims processing and payment services, customer service, utilization review services, and access to HOI's network of independent contracting providers.

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.

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

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

Allergy Treatment means testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

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 the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and HOI.
2. In the case of Out-of-Network Providers located outside of the Service Area who participate in the BlueCard 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 in the Benefit Booklet for more details.
3. In the case of an Out-of-Network Provider that has not entered into an agreement with HOI 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 HOI 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 an HOI 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 HOI 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.

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

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with HOI 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.

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 date one year after the Effective Date stated in the ASA, and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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:

I. The Department of Veterans Affairs.

II. The Department of Defense.

III. 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.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;

2. Asperger's syndrome;

3. Pervasive developmental disorder not otherwise specified; and

4. Childhood Disintegrative Disorder.

B

Benefit Booklet or **Booklet** means the certificate of coverage, which is evidence of coverage under the Group Health Plan.

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

Birth Center means 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.

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.

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

C

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

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

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

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or 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 the Plan. After your Deductible is met, the Plan 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. Not all plans include coinsurance.

Complaint means an oral (non-written) expression of dissatisfaction, whether or not such dissatisfaction is made in person, by telephone, or by another person acting on your behalf.

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 COVERAGE ACCESS RULES section.

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

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

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

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

Cost Share means the dollar or percentage amount, 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.

Coverage Access Rules means the rules or procedures in this Benefit Booklet, your provider directory, or established by HOI, that you must follow in order for Health Care Services you receive to be covered. Failure to follow applicable Coverage Access Rules may result in the denial of coverage or benefits under this Booklet.

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

Covered Person means a Covered Plan Participant or Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who continues to meet all applicable eligibility requirements described in the ELIGIBILITY FOR COVERAGE section and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Dependent.

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

Custodial or **Custodial Care** means care that serves to assist 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

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider who is recognized for payment under this Booklet, before payment for Covered Services under the Group Health Plan begins. Not all plans include a deductible.

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.

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent;
5. the Covered Plan Participant has submitted acceptable proof of evidence of common residence and joint financial responsibility to the Group.

6. the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

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 for the Group means 12:01 a.m. on the date specified in the ASA; and for you means 12:01 a.m. on the date coverage will begin as specified in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

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

Eligible Employee means an employee who meets and continues to meet all of the eligibility requirements set forth in the ELIGIBILITY FOR COVERAGE section and is eligible to enroll as a Covered Plan Participant. An eligible employee is not a Covered Plan Participant until actually enrolled and accepted for coverage as a Covered Plan Participant by the Group.

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 Booklet. Endorsements may also be referred to as amendments.

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

Enrollment Forms means those forms, electronic or paper, which are used to maintain accurate enrollment files under the Group Health Plan.

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 or Suwannee County Board of Public Instruction:

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 or Suwannee County Board of Public Instruction):

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 or the Group 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.

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.

Gene Therapy means treating disease by replacing, manipulating, or supplementing nonfunctioning or malfunctioning genes.

Generally Accepted Standards of Medical Practice means standards that are based on reliable 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.

Grievance means a written expression of dissatisfaction.

Group means Suwannee County Board of Public Instruction, the employer, labor union, trust, association, partnership, or corporation, department or other organization or entity through which coverage and benefits described in this Booklet are made available to you, and through which you become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or **Plan** means the plan established and maintained by Suwannee County Board of Public Instruction for the provision of health care coverage and benefits to the individuals covered under this Booklet.

H

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.

HOI means Health Options, Inc., a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

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 Covered Plan Participants. 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, the Group Health Plan.

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 Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to provide Covered Services described in this Booklet.

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

Internal Review Panel means a panel established by us to review Grievances related to Adverse Benefit Determinations that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

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 Statues, or a similar applicable law of another state.

M

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 Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

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.

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

Medicare means the 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.

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

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

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, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

N

New Prescription Drug(s) means An FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

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

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

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to provide Covered Services described in this Booklet.

Outpatient Rehabilitation 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. Further, such an entity must meet our criteria for eligibility as an outpatient rehabilitation facility. The term outpatient rehabilitation facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III “specialty rehabilitation hospital” described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

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.

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

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or 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 electric format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

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".

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 Booklet condition payment for the Service (in whole or in part) on approval 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 Booklet 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 Health 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 the Physician who, at the time Covered Services are rendered, was under a primary care physician Provider contract with us. A primary care physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist may elect to contract with us as a primary care physician.

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

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 Booklet, a psychiatric facility is not a Hospital or a Substance Abuse Facility, as defined herein.

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

R

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.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of Rehabilitation Services to be provided to a person with rehabilitation potential. Such plan must have realistic goals which are attainable by the individual within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such Services are to be rendered. The rehabilitation plan must be renewed every 30 days.

Rehabilitation 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.

Rehabilitative Therapies means therapies with the primary purpose of restoring or improving a bodily or mental function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

Rescission or **Rescind** refers to HOI's or Suwannee County Board of Public Instruction's action to retroactively cancel or discontinue coverage under the Group Health Plan. 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.

S

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

Service Area means 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 the applicable service area is available at: https://www.floridablue.com/sites/floridablue.com/files/docs/county_landing_page.pdf.

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.

Specialist means a Physician who limits practice to specific Services or procedures such as surgery, radiology, pathology, certain age categories of patients such as pediatrics, geriatrics, certain body systems such as dermatology, orthopedics, cardiology, internal medicine or types of diseases such as allergy, psychiatry, infectious diseases, oncology. Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board.

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 an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. In-network specialty pharmacies are listed in the Medication Guide. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a specialty pharmacy.

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

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

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 Booklet a substance abuse facility is not a Hospital or a Psychiatric Facility, as defined herein.

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

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 Booklet, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

V

Virtual Care Provider is a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered. An Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications.

W

Waiting Period means the period of time specified by the Group, if any, which must be met by an individual before that individual is eligible to enroll for coverage under the Group Health Plan.

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.

Templates Included

Compliance/Notices/Meaningful Access Notice.jld
Compliance/Notices/Privacy Notice - Breast Reconstruction Notice.jld

78170-122--Schedule-Of-Benefits-1
78170-122--Benefit-Booklet-1

MATCHING CRITERIA

Record Number	468
Request Type	M
Health Product	BLUECARE
Small Group	N
Rx Product	BLUECARE RX
Rx Plan	49
Health Plan	122
IRX	Y
Generic Choices	N
Generic Only	N/A
Closed Formulary	N
HSA	Y
HSA-BRX	N
Standard	N
Basic	N
ACA	N
RX Coins	N/A
ICC	N
CP-GF-BEN-IND	N
CP-GF-STATUS-IND	N
CP-GROUP-SUB	G
CP-GENERATION-IND	3
CP-EXCHANGE-IND	N
CP-RX-DED-IND	N

CP-RX-NGF-2012-HCR-IND	Y
CP-RX-GF-2012-HCR-IND	N
TAG-RX-SUFFIX	
AON	N/A
CP-ASO-IND	Y
Commerical	Y
CP-BCR-PEP-IND	N
Standard Or Basic	N
ROUTE	GROUP
EFF-YEAR	21
GRP-PKG-EFF-YEAR	21
GRP-NO	78170
DIV-NO	C11
PKG-NO	01
FEEDER1	0
FEEDER2	0
FEEDER3	0
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Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

SUWANNEE CNTY BOARD OF PUBLIC
ATTN TERESA JONES
1740 OHIO AVE S
LIVE OAK FL 32064-4500

Thanks for choosing Florida Blue! See the enclosed **Welcome brochure** for everything you need to get the most value from your health plan. For plan info on the go, download the Florida Blue app or log in to your account at floridablue.com.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of
Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

This Master Contract is for SUWANNEE CNTY BOARD OF PUBLIC

Group Number 78170

Division(s)	Package	Division	Package

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

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Blue Cross and Blue Shield Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc., d/b/a/ Florida Blue, Health Options, Inc., d/b/a Florida Blue HMO, and BeHealthy Florida, Inc., d/b/a Florida Blue Preferred HMO, collectively referred to as Florida Blue in this Notice) understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:
We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information, and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:
We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.
There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:
To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to

a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
- **Note:** If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Florida Blue

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Blue Cross and Blue Shield Association

Notice Regarding Coverage for Breast Reconstruction Surgery

If you have to have a mastectomy, your breast reconstruction surgery is covered under your health coverage. It can be done at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

BlueCare

Schedule of Benefits

Plan 123 with Integrated Prescription Drug Coverage – Family Coverage

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- Copayments listed in this Schedule of Benefits appear as a dollar amount, apply only after the Deductible is met and apply per visit.
- Your Cost Share will vary depending upon the medical Service you receive, the setting of the Services and the Provider you choose to see.
- References to Deductible are abbreviated as **"DED"** and references to Benefit Period are abbreviated as **"BP"**.

Your Benefit Period (BP).....01/01 – 12/31

DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET	YOU PAY
Deductible (DED) – Embedded*	
Per person per BP	$5,000
Per family per BP	$10,000
Per Admission Deductible (PAD)	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	10%
Maximum Out-of-Pocket – Embedded*	
Per person per BP	$6,850
Per family per BP	$13,100

*Refer to the YOUR SHARE OF HEALTH CARE EXPENSES section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Maximum Out-of-Pocket amounts are satisfied.

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

- Copayments
- Coinsurance (if applicable)
- DED
- PAD (if applicable)
- BlueCare Rx Cost Share

What **does not apply** to the maximum out-of-pocket?

- Charges for non-covered Services

OFFICE SERVICES	YOU PAY	
	PCP	Specialist
Office Visit Cost Share	DED + 10%	DED + 10%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 10%	DED + 10%
All other diagnostic Services (e.g., x-rays)	DED + 10%	DED + 10%
Allergy Injections	DED + 10%	DED + 10%
Allergy Testing	DED + 10%	DED + 10%
Maternity	DED + 10%	DED + 10%
Therapy and Spinal Manipulation (e.g., Physical, Speech, Cardiac or Occupational)	DED + 10%	DED + 10%

VIRTUAL HEALTH	YOU PAY
Virtual Visits General Medicine and Urgent Care rendered by a designated Virtual Care Provider	DED + 10%
Specialized Care rendered by a designated Virtual Care Provider	DED + 10%

Please visit http://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

MEDICAL PHARMACY	YOU PAY
Medication**	
Preferred Medications	DED + 10%
Non-Preferred Medications	DED + 10%
Maximum Out-of-Pocket per person per Month***	
Preferred Medications	$200
Non-Preferred Medications	$700

****Important** – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office visit Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy. Refer to the most current Medication Guide at www.floridablue.com to determine whether the medication is a Preferred or Non-Preferred medication.

*** The Preferred Medication Maximum Out-of-Pocket and the Non-Preferred Medication Maximum Out-of-Pocket are separate, and as such, accumulate separately. Therefore, amounts incurred for Preferred Medications shall be applied only to the Preferred Medication Maximum Out-of-Pocket and the Non-Preferred Medication amounts incurred shall be applied only to the Non-Preferred Maximum Out-of-Pocket.

PREVENTIVE HEALTH SERVICES	YOU PAY
Adult Wellness Services Physician's office and all other locations	$0
Adult Well Woman Services Physician's office and all other locations	$0
Child Health Supervision Services Physician's office and all other locations	$0
Colonoscopies (Routine)	$0
Mammograms	$0

OUTPATIENT DIAGNOSTIC SERVICES	YOU PAY
Independent Clinical Lab	DED + 10%
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 10%
All other diagnostic Services (e.g., x-rays)	DED + 10%
Outpatient Hospital Facility	See **Hospital Services**

EMERGENCY AND URGENT CARE SERVICES	YOU PAY
Ambulance Services	DED + 10%
Emergency Room Visits	See **Hospital Services**
Urgent Care Center	DED + 10%

OUTPATIENT SURGICAL SERVICES	YOU PAY
Ambulatory Surgical Center	
Facility	DED + 10%
PCP	DED + 10%
Radiologists, Anesthesiologists, and Pathologists	DED + 10%
Other health care professional Services rendered by all other Providers	DED + 10%
Outpatient Hospital Facility	See **Hospital Services**

HOSPITAL SERVICES	YOU PAY
Inpatient Facility	DED + 10%
Physician and other health care professional Services	DED + 10%
Outpatient Facility	DED + 10%
Physician and other health care professional Services	DED + 10%
Therapies and Spinal Manipulation	DED + 10%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 10%
All other diagnostic Services (e.g., x-rays)	DED + 10%
Emergency Room Visits In-Network Hospital Facility	DED + 10%
Out-of-Network Hospital Facility	DED + 10%
Physician and other health care professional Services	DED + 10%

SPECIAL SERVICES	YOU PAY
Birth Center	DED + 10%
Convenient Care Center	DED + 10%
Diabetic Equipment	DED + 10%
Dialysis Center	DED + 10%
Durable Medical Equipment	
Motorized wheelchairs	DED + 10%
All other Durable Medical Equipment	DED + 10%
Enteral Formula	DED + 10%
Home Health Care	DED + 10%
Home Health Care – Medical Pharmacy	
Preferred Prescription Drugs	DED + 10%
Non-Preferred Prescription Drugs	DED + 10%
Hospice Services	DED + 10%
Outpatient Rehabilitation Facility	DED + 10%
Physician Services (rendered at locations not otherwise noted in this schedule)	
PCP	DED + 10%
Specialist	DED + 10%
Prosthetic and Orthotic Devices	DED + 10%
Second Medical Opinion	
In-Network Provider	DED + 10%
Out-of-Network Provider	DED + 10%
Skilled Nursing Facility	DED + 10%

BEHAVIORAL HEALTH SERVICES	YOU PAY
Mental Health and Substance Dependency Treatment Services	
Outpatient Facility	
Emergency Room	DED + 10%
Hospital	DED + 10%
Physician Services at a Hospital and ER	
PCP	DED + 10%
Specialist	DED + 10%
Physician and other health care professionals licensed to perform such Services rendered at:	
PCP Office	DED + 10%
Specialist Office	DED + 10%
All other locations	
PCP	DED + 10%
Specialist	DED + 10%
Inpatient	
Facility	DED + 10%
Physician and other health care professional Services	DED + 10%

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Home Health Care visits.....60

Inpatient Rehabilitation days 30

Outpatient Therapies and Spinal Manipulation visits 30

Note: Spinal Manipulations are limited to 30 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum.

Skilled Nursing Facility days 45

BlueCare Rx Pharmacy Program

All Covered Drugs and Supplies purchased from a Pharmacy are subject to the **DED**, which must be satisfied by you before any payment will be made by us.

COVERED DRUGS AND SUPPLIES	YOU PAY
Generic Prescription Drugs and Covered OTC Drugs purchased from:	
Retail Pharmacy – For up to a One-Month Supply	DED + $10
Specialty Pharmacy - For up to a One-Month Supply	DED + $10
Mail Order Pharmacy – For up to a Three-Month Supply	DED + $25
Brand Name Prescription Drugs or Supplies purchased from:	
Retail Pharmacy – For up to a One-Month Supply	DED + $50
Specialty Pharmacy - For up to a One-Month Supply	DED + $50
Mail Order Pharmacy – For up to a Three-Month Supply	DED + $125

Important information affecting what you will pay for Covered Drugs and Supplies:

- In order to be covered under this BlueCare Rx Pharmacy Program, Brand Name Prescription Drugs **must** be included on the Formulary List. A formulary list is contained in the Closed Formulary Medication Guide, where you will find lists of Generic Prescription Drugs and Brand Name Prescription Drugs. YOu may be able to reduce your out-of-pocket expense by choosing Generic PRescription Drugs.
- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
    1. the Cost Share amount that applies to the Brand Name Prescription Drug you received as indicated in this Schedule of Benefits; **and**
    2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug is Medically Necessary.
- The Specialty Pharmacies designated, solely by us, are the only “participating” suppliers for Specialty Drugs.
- Some Specialty medications 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.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

BlueCare

Benefit Booklet for Covered Plan Participants of

Suwannee County Board of Public Instruction

Effective Date: May 1, 2021

A Self-Funded Group Health Benefit Plan Serviced by Health Options, Inc.

Group 78170
Plans 122, 123

Benefit Booklet

BlueCare

for Self-Funded Groups
Benefit Booklet

For Customer Service Assistance: 800-664-5295

Group 78170
Plans 122, 123

Benefit Booklet

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HOW TO USE YOUR BENEFIT BOOKLET

This is your Benefit Booklet ("Booklet"). It describes your coverage and benefits for Health Care Services, as well as the limitations and exclusions that apply, under the Group Health Plan ("Plan") established and maintained by Suwannee County Board of Public Instruction. Your Plan is self-funded; this means that benefits for Covered Services under the Plan will be paid either directly from the Group's general assets or a combination of its general assets and contributions made by Covered Plan Participants. The benefits provided under the Plan are not guaranteed or insured by an insurance company or by Health Options, Inc. ("HOI").

The sponsor of your Plan has contracted with us under an Administrative Services Agreement ("ASA"), to provide certain third party administrative services, including claims processing, customer service, and other services and access to our Health Maintenance Organization ("HMO") Provider network. HOI provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to you or claims submitted for processing under this Booklet for such Services. The payment of claims under the Plan depends exclusively upon the funding provided by Suwannee County Board of Public Instruction.

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

- your BlueCare benefits;
- what is covered;
- what is not covered;
- coverage and payment rules;
- how and when to file a claim and under what circumstances the Plan 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 benefits will be coordinated with other policies or plans; our subrogation rights of the Plan; and it's right of reimbursement.

If your benefits under this Plan are subject to the Employee Retirement Income Security Act of 1974 (ERISA), you should also read the Group's Summary Plan Description (SPD) for further important details concerning your rights and responsibilities under the Plan.

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

When reading your Booklet, please remember:

You should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered. Certain coverage information may be provided in the form of an Endorsement to this Booklet, if so, an Endorsement will either be inserted after the section that it modifies, or at the end of the Booklet. Be sure to always check for these additional documents before making benefit decisions.

The headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.

References to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Covered Plan Participant or solely to your Covered Dependents will be noted as such.

References to “we”, “us”, and “our” throughout refer to Health Options, Inc. We may also refer to ourselves as “HOI.”

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.

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.
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 **BlueCare 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 **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section.
What if I am covered under **BlueCare** and **another health plan?**	The **COORDINATION OF BENEFITS** section.
What happens when **my coverage ends?**	The **TERMINATION OF COVERAGE** section, along with the **CONTINUING COVERAGE** section.
What do the **terms used** throughout this Booklet **mean?**	The **DEFINITIONS** section.
Who do I call if I have **questions?**	Call our **customer service** department at **800-664-5295** (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 Booklet. All benefits for Covered Services are subject to: (1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, (2) the applicable Allowed Amount, (3) any limitations and exclusions, as well as any other provisions contained in this Booklet including any Endorsements that are part of your Booklet, and (4) our Medical Necessity guidelines and Coverage Access Rules then in effect (see the MEDICAL NECESSITY and COVERAGE ACCESS RULES sections).

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the WHAT IS NOT COVERED? section and in any Endorsements that are part of this Booklet. More than one limitation or exclusion may apply to a specific Service or a particular situation.

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

1. Provided, prescribed or ordered by an **In-Network Provider**;
2. Authorized in advance, if prior coverage authorization is required (see the COVERAGE ACCESS RULES section);
3. within the Covered Services Categories in this section;
4. actually rendered to you (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this Booklet and for which we receive an itemized statement or description of the procedure or Service which was rendered, including any applicable procedure code, diagnosis code and other information we require in order to process a claim for the Service;
5. Medically Necessary, as defined in this Booklet and determined by us or the Group in accordance with our Medical Necessity coverage criteria then in effect;
6. in accordance with the COVERAGE ACCESS RULES section;
7. rendered while your coverage is in force; and
8. not specifically or generally limited or excluded under this Booklet.

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

Covered Services Categories

Ambulance Services

Ground Ambulance

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

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

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

Air and Water Ambulance

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

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

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

Exclusion

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

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

b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment), or after being discharged from inpatient care; or

c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.

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

Ambulatory Surgical Center

Health Care Services provided 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

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, payment for Covered Services will include both the CRNA and the Physician's Services charges.

Exclusion

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

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Coverage Access Rules for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

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 Booklet; and
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician.
4. Residential Treatment Services, as defined in this Benefit Booklet.

Exclusion

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

Casts, Splints and Trusses

Casts, splints and trusses are covered when part of treatment in a facility, office or in a Hospital emergency room. This does not include the replacement of dental splints or trusses.

Child Cleft Lip and Cleft Palate Treatment

Health Care Services which are 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 are covered. In order to be covered, Services must be prescribed by a Provider who must certify in writing that the Services are Medically Necessary.

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 Booklet, 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 Booklet 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.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you in a Hospital or Ambulatory Surgical Center if:
    a. a Covered Dependent is under eight years of age and it is determined by a dentist and the Covered Dependent's Physician 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 for you 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 provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such Services could have been rendered within 62 days;
2. dental implants; and
3. Except as described above and in the Child Cleft Lip and Cleft Palate Treatment category, any 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, 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 are 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, such as insulin pump and tubing, to treat diabetes; and
4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Exclusion

Certain supplies used in the treatment of diabetes are covered under pharmacy benefits, such as blood glucose meters, lancets, test strips. If the Group provides pharmacy coverage under a BlueCare Rx Pharmacy Program, the diabetic supplies covered under that program will not be covered under this category. Refer to the PRESCRIPTION DRUG PROGRAM section for more information.

Diagnostic Services

Diagnostic Services are 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 provided at any location by a Provider licensed to perform dialysis, including a Dialysis Center.

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and

2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Coverage Access Rules for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

Durable Medical Equipment is 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.

Coverage Access Rules for Durable Medical Equipment

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

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

Exclusion

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

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services in or out of the Service Area for treatment of an Emergency Medical Condition are covered without the need for any prior authorization.

You must notify us as soon as possible, concerning the receipt of Emergency Services and/or any admission which results from an Emergency Medical Condition.

Special Payment Rules for Non-Grandfathered Plans

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

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 HOI In-Network Providers for the same Services;
2. the Allowed Amount as defined in this Booklet;
3. the usual and customary Provider charges for similar Services in the community where the Services were provided; or
4. what Medicare would have paid for the Services rendered.

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

Exclusion

Follow-up care must be rendered by an In-Network PCP or In-Network Specialist. If you are told you need follow-up care after your emergency room visit, be sure to contact your PCP or an In-Network Specialist first. Any follow-up care you receive that is provided by a Provider other than your PCP or an In-Network Specialist may not be covered.

Urgent Care Services

For non-critical but urgent care needs, you can 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 are covered when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

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

Eye Care

Coverage includes the following Services:

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

Exclusion

1. Health Care Services to diagnose or treat vision problems that are not a direct consequence of trauma or prior eye surgery;
2. vision examinations;
3. eye exercises or visual training;
4. eye glasses and contact lenses and their fitting; and
5. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.

Family Planning

Family planning Services are covered and include:

1. family planning counseling and Services, including 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 insertion and removal; and
4. surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services are covered under the Preventive Health Services category, please refer to that category for more information.

Exclusion

Contraceptive medications, devices and appliances, other than as noted above and reversal of surgical sterilization procedures are not covered. Elective abortions are also excluded.

Home Health Care

Home Health Care Services are 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 and we approve the treatment plan;
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 Booklet);

4. the Home Health Care Services are provided by or through a Home Health Agency within the Service Area; 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. other Medically Necessary Services; and
16. transplants as set forth in the Transplants Services category.

Exclusion

1. Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital:
    a. room and board provided during the admission;
    b. Physician visits provided while you were an inpatient;
    c. Occupational, Speech, Physical, and Cardiac Therapies; and
    d. other Services provided while you were an inpatient.
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.

Infertility Treatment

Infertility Services for a Covered Person who meets our criteria then in effect, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility, laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility.

Exclusion

Prescription Drugs, In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) and any Services associated with these procedures, or any Services associated with the donation or purchase of sperm.

Inpatient Rehabilitation

Inpatient Rehabilitation 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 Rehabilitative Therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five days a week and your Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Exclusion

All inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Behavioral Health Services category), Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

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

Mastectomy Services

Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas) and outpatient post-surgical follow-up care for Mastectomy Services are 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 normal 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, usually within about six weeks after the birth of the baby. This Copayment applies only to 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 including a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment, room and board and nursery. Your Cost Share for these Services is listed on your Schedule of Benefits under inpatient Hospital or Birth Center, depending on where Services are rendered. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply.

Exclusion

Maternity Services rendered outside the Service Area are not covered except in urgent situations when you did not and could not reasonably expect the need for Services before you left the Service Area.

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

Outpatient Therapies and Spinal Manipulation Services

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

   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.

   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.

   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.

   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).

   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; contrast baths are not covered.

   Coverage Access 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.

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

   Coverage Access Rules for Spinal Manipulation

   1. Coverage for spinal manipulation is limited to the number of spinal manipulations listed in your Schedule of Benefits each Benefit Period, 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.

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

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.

Exclusion

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

Preventive Health Services

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

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

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. 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. respect to women, such additional preventive care and screenings not described in paragraph 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 Health 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 Health 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 Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

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

Exclusion

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

Prosthetic Devices

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

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

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

Exclusion

Expenses for cosmetic enhancements to artificial limbs.

Second Medical Opinion

You are entitled to a second medical opinion when:

1. you do not agree with the opinion of your treating Physician or us regarding the reasonableness or necessity of a surgical procedure or treatment of a serious injury or illness; or
2. you feel you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated.

You may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion, but will need to ask your PCP or an In-Network Specialist to get an authorization from us before you receive the Services. However, you should know that your Cost Share amount for Services rendered by an In-Network Provider (usually a set Copayment) for a second medical opinion will be lower than those rendered by an Out-of-Network Provider. When you use an Out-of-Network Provider for a second medical opinion your Cost Share will be a percentage of the Allowed Amount, which may be less than the Out-of-Network Provider charges for such Services. In this case, in addition to your percentage of the Allowed Amount, you will also have to pay any charges billed by an Out-of-Network Provider in excess of the Allowed Amount.

All tests in connection with rendering the second medical opinion, including tests ordered by an Out-of-Network Physician, must be Medically Necessary and must be performed by In-Network Providers.

Coverage may be denied for a second medical opinion if you seek more than three second medical opinions in any Benefit Period and second medical opinion costs are deemed evidence that you are unreasonably over-utilizing the second medical opinion privileges. The decision, after review of documentation from the second medical opinion you obtained, will be controlling as to the Plan's obligation to pay for such treatment.

Self-Administered Prescription Drugs

Except as covered under the PRESCRIPTION DRUG PROGRAM section, only Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

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

1. room and board;
2. respiratory, pulmonary or inhalation therapy, 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 excluded.

Surgical Procedures

Surgical procedures performed by a Physician including surgical assistant Services rendered by a Physician 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; and
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. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Note: Gender reassignment surgery must be authorized, in advance, by us in order to be covered.

   Exclusions:

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

   a. reduction thyroid chondroplasty;
   b. liposuction;
   c. rhinoplasty;
   d. facial bone reconstruction;
   e. face lift;
   f. blepharoplasty;
   g. voice modification surgery ;
   h. hair removal/hairplasty; or
   i. breast augmentation.

   Payment Rules for Surgical Procedures

   1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure 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 authorized in advance and 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. The Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant ;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung transplant.

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

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized **before** they are provided.
4. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Plan.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.

7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

Virtual Visits between you and a Virtual Care Provider that is designated by us and under contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

PRESCRIPTION DRUG PROGRAM

BlueCare Rx Pharmacy Program

Coverage for Prescription Drugs and Supplies is provided through the BlueCare Rx Pharmacy Program described in this section.

Coverage is provided to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this section, you must pay, at the time of purchase, your Cost Share amounts indicated on the Schedule of Benefits.

A Formulary list is included in the Closed Formulary Medication Guide (referred to as "Medication Guide" hereafter), where you will find lists of Generic Prescription Drugs and Brand Name Prescription Drugs. Generic Prescription Drugs not included on the Formulary List are covered, unless specifically listed in the BlueCare Rx Pharmacy Program Limitations and Exclusions subsection. In order to be covered under this BlueCare Rx Pharmacy Program, Brand Name Prescription Drugs must be included on the Formulary List. You may be able to reduce your out-of-pocket expenses by using Participating Pharmacies and by choosing Generic Prescription Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website 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 **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;
3. Medically Necessary, as defined in this Booklet 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 Brand Name Prescription Drug, included on the Formulary List in the Medication Guide;
5. 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;
6. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide
7. a Prescription Drug contained in an anaphylactic kit;
8. authorized for coverage, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
9. not specifically or generally limited or excluded herein; and
10. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs;
11. reviewed by our Pharmacy and Therapeutics Committee; and
12. within the Coverage and Benefit Guidelines 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.

Coverage and Benefit Guidelines

The benefit guidelines set forth below apply to the benefits under the BlueCare Rx Pharmacy Program, as well as any other applicable payment rules specific to particular Covered Services listed in this Booklet.

Contraceptive Coverage

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

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

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

   Exceptions may be considered for Brand Name oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an "Exception Request Form" from your Physician.
   You can obtain an Exception Request Form on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

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

Exclusion

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants, such as Norplant and IUD, are excluded from coverage under this BlueCare Rx Pharmacy Program.

Covered Over-the-Counter (OTC) Drugs

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

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed 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.

Diabetic Coverage

All 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 BlueCare Rx Pharmacy Program: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and syringes and needles.

Exclusion

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

Mineral Supplements, Fluoride or Vitamins

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

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

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 excluded from coverage.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the cost share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

Preventive Medications

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

Specialty Pharmacy: Split Fill Option

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

Medication Guide. The applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance would also be split between the two fills.

BlueCare Rx 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 Booklet.

1. The Plan 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 (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., 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 BlueCare Rx Pharmacy Program.
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;

g. used for smoking cessation, except as indicated as covered under the Preventive Health 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. Brand Name Prescription Drugs, Supplies and OTC Drugs not listed in the Medication Guide;

8. Non-Formulary Drugs, unless approved through the exception process described below:

   Exception Process: Exceptions may be considered when designated Brand Name 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 number on your ID Card and one will be mailed to you upon request.

9. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines subsection.

10. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.

11. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs and Supplies subsection.

12. 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.

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

14. Drugs that are compounded except when all active ingredients are FDA-approved Prescription Drugs with valid National Drug Codes.

15. Drugs and Supplies purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized in advance by us.

16. 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. HOI and/or the Group, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.

17. 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 HOI and/or the Group, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.

18. Any amount you are required to pay under the BlueCare Rx Pharmacy Program as indicated on the Schedule of Benefits.

19. Any benefit penalty reductions.

20. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.

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

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

    a. the Drug is 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 BlueCare Rx Pharmacy Program.

23. New Prescription Drugs.

Pharmacy Alternatives

For purposes of the section, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

Participating Pharmacies have agreed not to charge, or collect from, you, for each Covered Prescription Drug, Covered Prescription Supply more than the amount set forth in the Schedule of Benefits.

To verify if a Pharmacy is a Participating Pharmacy, you may refer to the Pharmacy Program 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 present your ID Card to the Participating Pharmacy and the Pharmacy must be able to verify that you are, in fact, covered by us.

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

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

Specialty Pharmacy

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

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications.

The Specialty Pharmacies designated, solely by us, are the only Participating suppliers for Specialty Drugs. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Non-Participating for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueCare Rx 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.

Non-Participating Pharmacies

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from a Non-Participating Pharmacy is covered under this BlueCare Rx Pharmacy Program **only** if it is prescribed as a result of an Emergency Medical Condition or authorized in accordance with our criteria then in effect.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from a Non-Participating Pharmacy, as a result of an Emergency Medical Condition, or when authorized, you may be required 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 a Non-Participating 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 encourage the responsible use of Drugs and Supplies.

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

Note: If coverage is not available, or is limited, this does not mean that you cannot obtain the Drug or Supply from the Pharmacy. It only means that the Plan 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

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

Prior to filling a Prescription, your Physician may contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

Responsible Quantity Program

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

Prior Coverage Authorization Program

You are required to obtain prior coverage authorization in accordance with our criteria then in effect, in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **If you do not obtain an authorization when one is required coverage and payment will be denied**. Prescription Drugs and Supplies and OTC Drugs that require prior coverage authorization are designated in the Medication Guide.

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

Information on our pharmacy utilization review programs is published in the Medication Guide 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.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or

2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued 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 Booklet. 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 or the Group in authorizing coverage are made only to determine whether coverage or benefits are available under this BlueCare Rx 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. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if the Plan has indicated that payment will not be made for such Prescription Drug, Supply or OTC Drug.

BlueCare Rx Pharmacy Program Definitions

Certain important terms applicable to the BlueCare Rx Pharmacy Program are set forth below. For additional applicable definitions, please refer to the DEFINITIONS section of this Booklet.

Biosimilar Prescription Drug is a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (known as 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.

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. For purposes of this BlueCare RX Pharmacy Program, compound drugs are also considered a Brand Name Prescription Drug because the Brand Name Prescription Drug Cost Share also applies to compound drugs.

Closed Formulary Medication Guide (herein “Medication Guide”) means the guide then in effect issued by us that contains the Formulary List which designates the following categories of Prescription Drugs: Generic Prescription Drugs and Brand Name Prescription Drugs. **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 ID Card.

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

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under this BlueCare Rx 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:

1. Prescription diaphragms;
2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage;
3. syringes and needles prescribed with a Prescription Drug authorized for coverage;
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.

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

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

FDA means the United States Food and Drug Administration.

Formulary List means a list of Brand Name Prescription Drugs then in effect, for which coverage and benefits are provided, subject to the exclusions in this section. The Formulary List is contained within the Closed Formulary Medication Guide.

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 HOI, 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.

Mail Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug as set forth in the Schedule of Benefits. Please note, under this BlueCare Rx Pharmacy Program, you must meet the Deductible before the Mail Order Copayment, if applicable, will apply.

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

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

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 (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Non-Formulary Drug means a Brand Name Prescription Drug that is not included on the Formulary List then in effect.

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

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.

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

Participating Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies , Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

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

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, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

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

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

Program, emergency contraceptives and insulin are considered Prescription Drugs because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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.

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.

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of 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 an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

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

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

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 Booklet. **If you do not follow the Coverage Access Rules, any Services you receive will not be covered.** For further information, please refer to the COVERAGE ACCESS RULES section.

The Plan 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

Ambulance Services including but not limited to:

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

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

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.

Completion of any form and /or medical information.

Cost Share amounts you are required to pay even when the cost share amount is waived by a Provider.

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, breast augmentation.

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

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. 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).
    d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit;
    e. defined by, and covered under the PRESCRIPTION DRUG PROGRAM section.
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 drug which requires prior coverage authorization when prior coverage authorization is not obtained.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
    a. emergency stabilization;
    b. during a covered inpatient stay, or
    c. when proximately related to a surgical procedure.

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.

7. New Prescription Drug(s), as defined in the DEFINITIONS section.
8. Convenience Kits as defined in the DEFINITIONS section
9. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

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.

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 under the Plan, unless coverage is extended in accordance with the Extension of Benefits subsection in the CONTINUING COVERAGE section.
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 Booklet, 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 Booklet and determined by us in accordance with our criteria then in effect. 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.
9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Booklet.
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 rendered outside the Service Area, except Emergency Services for treatment of an Emergency Medical Condition, unless such Services are approved by us in advance.

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 category and Preventive Health Services categories of the WHAT IS COVERED? section.

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

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

Motor Vehicle Accidents 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.

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

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

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

1. beauty and barber services,
2. clothing, including support hose,
3. radio and television,
4. guest meals and accommodations,
5. telephone charges,
6. take-home supplies,
7. travel expenses (other than Medically Necessary Ambulance Services),
8. motel/hotel accommodations,
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting,
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs,
11. heating pads, hot water bottles, or ice packs,

12. physical fitness equipment,
13. hand rails and grab bars, and
14. Massage except as set forth in the WHAT IS COVERED? section.

Private Duty Nursing Care rendered at any location.

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCSBF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Smoking Cessation Programs, including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products, such as gum, transdermal patches, etc, (except as indicated as covered under the Preventive Health 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.

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.

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

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and does not have a contract with us to provide Virtual Visits under this Booklet.

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. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a. a licensed outdoor youth program, and/or
    b. a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Work Related Health Care Services to treat a work related Condition to the extent you are covered or required to be covered by Workers' Compensation law. Any Service or supply to diagnose or treat any Condition resulting from or in connection with your job or employment are excluded, except for Medically Necessary Services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

MEDICAL NECESSITY

In order for Health Care Services to be covered under this Booklet, the Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as determined by us and/or the Group and defined in this Booklet. **As a self-funded plan, Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; Suwannee County Board of Public Instruction has asked us to use our Medical Necessity criteria and guidelines currently in effect.**

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 Booklet and not for the purpose of recommending or providing medical care. Any Reviews conducted for Medical Necessity, may require review of 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 Booklet. 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. HOI and the Group are solely responsible for determining whether expenses incurred for that medical care are covered under this Booklet. In making coverage decisions, neither HOI nor the Group will 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 Booklet) or a Covered Service. You are free to obtain a Service even if coverage is denied 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 Shares explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Deductible

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by the Plan. Only those charges indicated on claims received for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount.

Family Deductible

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

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.

Hospital Per Admission Deductible

The Hospital per admission Deductible, when applicable, must be satisfied by you for each Hospital admission before any payment will be made by the Plan for any claim for inpatient Services. The Hospital per admission Deductible applies regardless of the reason for the admission.

Copayments

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

Office Services Copayment

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

Inpatient Facility Services Copayment

The Copayment for inpatient facility Services, if applicable to your plan, must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made by the Plan for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions unless your Schedule of Benefits states otherwise. Additionally, you may be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment

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

Emergency Room Facility Services Copayment

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

Coinsurance

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

Special Calculation 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.

Out-of-Pocket Maximums

Individual Out-of-Pocket Maximum

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

Family Out-of-Pocket Maximum

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

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 Benefit Period. 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 Benefit Period.

Note: The Deductible, any applicable Copayments and Coinsurance will accumulate toward the out-of-pocket maximums. Any applicable Cost Share amounts you must pay under a prescription drug program, will not apply to the Deductible or the out-of-pocket maximums under this Booklet.

Prior Coverage Credit

You will be given credit for the satisfaction or partial satisfaction of any deductible and coinsurance maximums met by you under a prior group, blanket, or franchise insurance or group Health Maintenance Organization (HMO) policy maintained by Suwannee County Board of Public Instruction if this Plan replaces such a policy. This provision only applies if the prior group, blanket, or franchise insurance or HMO coverage was in effect immediately preceding the Effective Date of this Group Health Plan. This provision is only applicable for you during the initial Benefit Period of coverage under the Plan and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited by the Group's prior policy, toward your deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited toward your coinsurance maximum under the Group's prior policy, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to your out-of-pocket maximum under this Booklet.

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

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

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 641.54 of the Florida Statutes.

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 for Health Care Services which are non-Covered Services or excluded; and
4. any contribution amount required by Suwannee County Board of Public Instruction.

How Benefit Maximums are Credited

Except as described below, only the amounts actually paid by the Plan for Covered Services will be credited toward applicable benefit maximums. The amounts the Plan pays that are credited toward your Benefit Period maximums will be based on the Allowed Amount for the Covered Services provided. Also see the Special Calculation Rule for Capitated Providers subsection above for more information.

HEALTH CARE PROVIDER OPTIONS

Introduction

It is important that you understand how the Providers you choose to use for medical care will affect how much you have to pay for medical Services. Under this HMO plan, most Services must be rendered by In-Network Providers in order to be Covered Services. This is true even when the Services you receive are Medically Necessary (except in the case of an Emergency Services for an Emergency Medical Condition). This section explains some special rules for getting Covered Services with certain types of Providers under this Booklet

For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

You are responsible for making sure a Provider is In-Network prior to receiving Services. To find out if a Provider is in our network you can:

1. access the current BlueCare Provider directory on our website at www.floridablue.com; or
2. call the customer service phone number on your ID Card.

In-Network Providers

Primary Care Physician (PCP)

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP for each covered family member. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You do not need a referral to see your PCP.

Specialist Care

If you need to visit a Specialist, you and/or your PCP may choose any In-Network Specialist.

Your PCP may consult with us regarding coverage or benefits and with the Specialist in order to coordinate your care. This provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

You do not need a referral from your PCP to see an In-Network Specialist; however, some Services require an authorization from us before Services are rendered in order to be covered. In-Network Providers are responsible for obtaining authorization.

Below are some special rules for certain types of Providers:

Chiropractors and Podiatrists: Upon your request, a Doctor of Chiropractic or a Doctor of Podiatry who is an In-Network Provider may be assigned to you for the purpose of providing chiropractic Services and podiatric Services, respectively. You shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need for referrals from your PCP.

Certified Registered Nurse Anesthetist: You have access to anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if you request such Services, provided such Services are available, as determined by us and are Covered Services under the Plan.

Dermatologists: You may access an In-Network dermatologist for up to five visits each Benefit Period without an authorization. Some Services, such as surgical procedures will require an authorization before the Services are rendered and if you do not have an authorization; the Services will not be covered.

Obstetric and Gynecological Providers: You may access In-Network Providers who specialize in obstetrics or gynecology for obstetric or gynecological care without the need for authorization.

Osteopathic Hospitals: Inpatient and outpatient Services, similar to inpatient and outpatient Services by allopathic Hospitals may be covered at a Hospital accredited by the American Osteopathic Association when such Services are available in the Service Area even when such Hospital has not entered into a written agreement with us for such Services. The Hospital providing these Services may not charge more than their usual and customary rates less the average discount that we have with allopathic Hospitals within the Service Area. You must contact us to get the documents necessary to comply with this provision.

Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other Covered Services may be rendered by licensed Physician Assistants, nurse practitioners or other individuals who are not Physicians.

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.

You must use a Specialty Pharmacy to provide these Specialty Drugs. Please refer to the Medication Guide for a list of Specialty Pharmacies.

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.

Continuity of Coverage and Care Upon Termination of a Provider Contract

When a contract between us and an In-Network Provider (including a PCP) is terminated by us or the Provider without cause and, at the time of the In-network Provider's termination, you are actively receiving Services for a Condition, Services for that Condition shall continue even after the date of the In-Network Physician's contract termination. Services for that Condition will be covered with that Provider only until the earlier of:

1. treatment for that specific Condition is completed;
2. you select another In-Network Physician; or
3. the next open enrollment period.

This extension period will not exceed the maximum time period allowed under Florida law, and in no case will it be longer than six months after termination of the Provider's contract with us.

Maternity benefits will continue under this Plan, regardless of the trimester in which Services were initiated, until completion of your postpartum care, if you initiated your prenatal care prior to the termination of the In-Network Provider's contract.

The Group Health Plan is not required to cover or pay for any Services under this subsection for an individual whose coverage under the Plan is not in effect at the time Services are rendered. Further, this subsection does not apply if the In-Network Provider is terminated "for cause".

Services Not Available from In-Network Providers

Except as provided in the WHAT IS COVERED? section, if a Covered Service is not available through In-Network Providers, we may authorize coverage for such Services to be rendered by an Out-of-Network Provider. Covered Services provided by an Out-of-Network Provider must be authorized by us **before** the Services are rendered.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, the Group Health Plan 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 Booklet;
2. an assignment of the right to receive payments due under this Booklet; 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 Booklet, or any promise or obligation set forth in any contract, plan, or policy.

The Group Health Plan specifically reserves 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; 2) is a licensed Hospital or Physician and the benefits which have been assigned are for care provided per Florida Statutes; or 3) is an Ambulance Provider that provides transportation for care from a location where an Emergency Medical Condition, as defined per Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care per Florida Statutes. A written attestation of the assignment of benefits may be required.

BLUECARD® PROGRAM

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain Health Care Services outside of Florida, the claims for these Services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Only limited Services received outside of Florida are covered. As used in this section, "Out-of-Area Covered Services" only include Emergency Services for treatment of an Emergency Medical Condition obtained outside of Florida. Any other Services will not be covered even if processed through any Inter-Plan Arrangements.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard Program

Under the BlueCard Program, when you receive Out-of-Area Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the Out-of-Area Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Cost Share amounts.

Medical Emergency: If you experience a medical emergency while traveling outside of Florida, go to the nearest facility that can provide the type of Services needed.

When you receive Out-of-Area Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Services, if not a fixed dollar Copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in

expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside of Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, payment for such Covered Services will be based on the applicable Allowed Amount.

Blue Cross Blue Shield Global® Core Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Out-of-Area Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Out-of-Area Covered Services.

Outpatient Services

Physicians, Urgent Care Centers and other Providers of outpatient Services located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Out-of-Area Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Out-of-Area Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core

Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

COVERAGE ACCESS RULES

It is important that you become familiar with the rules for accessing health care coverage through this HMO plan. The following section explains our role and the Primary Care Physician's (PCP) role, how to access specialty care coverage, and what to do if Emergency Services are needed. It is also important for you to review all Service Area-specific Coverage Access Rules for particular types of Services and In-Network Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated Provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You are free to choose any PCP listed in our published list of PCPs whose practice is open to additional BlueCare patients. This choice should be made when you enroll. You are responsible for choosing a PCP for all minor Covered Dependents including a newborn child or an adopted newborn child. If you do not choose a PCP when enrolling, we will assign one to you and notify you of that assignment. The following important rules apply to your PCP relationship:

- 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 PCP allows the Physician to become knowledgeable about your health history.
- A PCP can help you determine the need to visit a Specialist and also help you find one based on his or her knowledge of you and your specific health care needs.
- A PCP may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with us as a Primary Care Physician.
- Care rendered by your PCP usually results in lower Cost Share for you.

The PCP you select maintains a Physician-patient relationship with you, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for helping to coordinate medical Services for you.

Both you and your PCP may request a change in the PCP assignment as discussed below:

1. You may request a transfer to another PCP whose practice is open to new BlueCare patients. The effective date of a transfer to the new PCP will depend upon when we receive your request. Requests may be made on our website at www.floridablue.com or by calling the number on the back of your ID card.
2. There are also times when a PCP, for good cause, may request that we assist you in choosing another PCP.
3. If your PCP terminates his or her contract with us or is unable to perform his or her duties or is on a leave of absence, we may help you choose another PCP or assign a new one for you.

Authorization Requirements

Many Services have to be authorized **before** the Services are rendered in order to be covered under this Booklet. **Since this is a self-funded plan, Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; Suwannee County Board of Public Instruction has asked us to use our authorization criteria and guidelines currently in effect.**

There may be times when Services are authorized, but only if received in a specific setting, such as an Ambulatory Surgical Center or Independent Diagnostic Testing Center. If the authorization includes a specific setting and you receive the Services in a different setting, such Services may be denied. For example, a procedure may be authorized only when performed in an Ambulatory Surgical Center. In this case, if you have the procedure done in a Hospital, the claim may be denied because the procedure was only authorized when performed in an Ambulatory Surgical Center.

In-Network Providers have agreed to obtain these authorizations for you; however, you should ask your Provider if an authorization has been obtained if one is required. Services that must be authorized by us in advance include, but are not limited to:

1. hospitalization, both inpatient and observation stays;
2. certain radiology Services, including advanced diagnostic imaging Services, such as CT scans, MRIs, MRAs and nuclear imaging;
3. Birth Center Services;
4. Services rendered in connection with Approved Clinical Trials;
5. Home Health Care;
6. certain Durable Medical Equipment;
7. Prosthetic Devices and Orthotic Devices;
8. Pain Management Services;
9. surgery (at all locations);
10. Services provided by Out-of-Network Providers;
11. all Services provided in a Skilled Nursing Facility;
12. certain injections and infusion therapy;
13. certain Provider-administered drugs (denoted with a special symbol in the Medication Guide);
14. Hospice Services; and
15. certain diagnostic Services.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

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 the 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, alternative benefits or payment for cost-effective Health Care Services may be offered to you. These alternative benefits or payments may be made available on a case-by-case basis when you meet the 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. Because your Group Health Plan is self-funded, Suwannee County Board of Public Instruction will be required to specifically agree to such treatment plan and the alternative benefits or payment.

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

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in this Group Health Plan, and who meets and continues to meet the Group's eligibility rules described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility rules are binding upon you and /or your eligible family members. No changes in the eligibility rules will be permitted except as approved by the Group. Acceptable documentation that an individual meets and continues to meet the eligibility requirements, such as a court order naming the Covered Plan Participant as the legal guardian or appropriate Adoption documentation may be required as described in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

Covered Plan Participant Eligibility

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

1. the employee must maintain his or her primary residence in the Service Area or be regularly employed in the Service Area;
2. be a bona fide employee;
3. the employee's job must fall within the job classifications designated by the Group;
4. complete any applicable Waiting Period established by the Group; and
5. meet any additional eligibility requirements required by the Group.

The Group's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Group; and
4. other individuals as determined by the Group.

The Group shall have sole discretion concerning the expansion of eligibility classifications.

Dependent Eligibility

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

1. The Covered Plan Participant's spouse under a legally valid existing marriage, who maintains his or her primary residence in the Service Area.
2. The Covered Plan Participant's natural, newborn, Adopted, Foster or step child (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan. A dependent child must maintain his or her primary residence in the Service Area only beginning with the Calendar Year following the year they reach age 26 to the end of the Calendar Year the dependent child reaches age 30
3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility as the Covered Plan Participant to establish that a child meets the eligibility rules. Eligibility will terminate at the end of the Calendar Year in which the child no longer meets the eligibility rules required to be an Eligible Dependent.

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:

1. otherwise eligible for coverage under the Group Health Plan;
2. incapable of self-sustaining employment by reason of intellectual or physical disability; and
3. chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 30th birthday..

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

Other Rules Regarding Eligibility

1. No individual whose coverage has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll in the Group Health Plan.
2. No person shall be refused enrollment or re-enrollment because of race, color, creed, marital status, gender, or age (except as provided in the Dependent Eligibility subsection).
3. The Covered Plan Participant must notify the Group 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 proper notification is not provided timely by the Covered Plan Participant, the Group shall have the right to retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met. Upon request, the Covered Plan Participant shall provide proof, which is acceptable to the Group, of a Covered Dependent's continuing eligibility for coverage.
4. If the Group offers an alternative health benefits plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for coverage under this Booklet.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage as described in this section. Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. Neither HOI nor the Group shall have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. You may apply for coverage by completing an Enrollment Form and submitting it to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during enrollment, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right the Group may have, the Group may terminate or Rescind your coverage.
3. The Group will not provide coverage or benefits to any person who would not have been eligible to enroll, had accurate and complete information been provided on a timely basis. In such cases, the Group may require you or a person legally responsible for you, to repay any payments made on your behalf.

How to Apply for Coverage

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

1. complete the Enrollment Form and submit it to the Group;
2. provide any other information the Group may need to determine eligibility, upon request;
3. agree to pay any contribution amounts required by the Group; and
4. to add Eligible Dependents or delete Covered Dependents, complete the Enrollment Form and submit it to the Group.

When applying for coverage, you must elect one of the types of coverage available under the Group Plan. Such types may include:

Coverage Type	**Provides Coverage for:**
Employee Only	the Eligible Employee only
Employee/Spouse	the Eligible Employee and his or her spouse
Employee/Child(ren)	the Eligible Employee and children only
Employee/Family	the Eligible Employee, spouse and children

There may be an additional contribution amounts for each Covered Dependent based on the coverage provided by the Group.

Enrollment Periods

There are only certain times during the year that you can enroll for coverage, these enrollment periods are as follows:

Initial Enrollment Period: this is the period of time when you are first eligible to enroll. It starts on the date you are first eligible and ends no less than 30 days later. This time can be when the Group first starts its Plan under this Booklet, or when an employee first becomes eligible for coverage under the Plan.

Annual Open Enrollment Period: this is the period of time (usually 30 days) when you have an opportunity to select coverage from the alternatives your Group offers in its health benefit program. This period takes place every year prior to the Anniversary Date. Suwannee County Board of Public Instruction will establish the dates and length of this period.

Special Enrollment Period: this is the 30-day period of time immediately following a special event such as getting a new dependent or losing other coverage. During this time you may apply for coverage because of the special event. Special events are described in the Special Enrollment Period subsection of this section.

Initial Enrollment Period

1. If you are an Eligible Employee when Suwannee County Board of Public Instruction first starts plan under this Booklet; you must enroll (yourself and any Eligible Dependents) during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. In this case, the Effective Date of coverage for you and the dependents you enroll will be the same as the Group.
2. If you become an Eligible Employee after Suwannee County Board of Public Instruction has this plan (for example, newly-hired employees) you must enroll (yourself and any Eligible Dependents) before or within the Initial Enrollment Period and your Effective Date of coverage will begin on the date specified in writing, by the Group.

Annual Open Enrollment Period

If you did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period you may apply for coverage by completing an Enrollment Form during an Annual Open Enrollment Period. Your Effective Date of coverage will be the date specified by the Group.

If you do not enroll or change your coverage selection during the Annual Open Enrollment Period, you must wait until the next Annual Open Enrollment Period to make any changes, unless a special event, as outlined in the Special Enrollment Period subsection of this section, occurs.

Special Enrollment Period

You may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, you must complete an Enrollment Form and submit it to the Group within the time periods noted below for each special enrollment event.

If you declined coverage when it was first offered under this Plan and you stated, in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment, you may apply for coverage if one of the following special enrollment events occurs and you complete an Enrollment Form and submit it to the Group within time periods indicated in the chart that follows.

Special Enrollment Event

Loss of Coverage under…	Caused by…	Enrollment Form due to Group within…
a group health plan or COBRA	• Exhaustion of COBRA • termination of employment • reduction in the number of hours you work • reaching or exceeding the lifetime maximum of all benefits under other health coverage • the employer stopped offering group health coverage • death of your spouse • divorce or legal separation • employer contributions toward such coverage are terminated	30 days of the date coverage was terminated
A Children's Health Insurance Program or Medicaid	• loss of eligibility for such coverage • becoming eligible for the optional state premium assistance program	60 days of the date coverage was terminated
***Adding Coverage...**	• your marriage • your getting a new dependent through birth, Adoption or placement in anticipation of Adoption	30 days of the date of the event

* The statement in the paragraph above this chart about declining coverage when it was first offered does not apply to these special enrollment events.

Your Effective Date of Coverage will be the date of the special enrollment event. If you do not enroll or change your coverage during the Special Enrollment Period you must wait until the next Annual Open Enrollment Period.

Note: Loss of coverage for failure to pay your required contribution on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

Dependent Enrollment

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

Newborn Children – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group. 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). The Group must be notified, in writing, when you are adding a newborn and the rules for Effective Date and contribution amounts charged for the newborn vary depending on when this written notification is received. The chart that follows indicates these differences:

Newborn Enrollment

If written notice is received within…	**The Effective Date of the newborn will be…**	**Contribution amounts for the newborn child…**
30 days after the date of birth	the date of birth	will **not** be charged **for the first 30 days**
31 to 60 days after the date of birth	the date of birth	will be charged from the date of birth
61 or more days* after the date birth	the date of birth	will be charged from the date of birth

*This applies only if the Group **has not had** an Annual Open Enrollment Period since the baby was born. If the written notice is received more than 60 days after the birth of the newborn child, and your Group **has had** an Annual Open Enrollment Period since the birth of the newborn, the child may not be added until the Group's next Annual Open Enrollment Period.

Additional Rules for Adopted Newborn Children

If an Adopted newborn's Effective Date of coverage is determined to be the date of birth (based on the above chart), a written agreement to Adopt such child must have been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents which we deemed necessary by us or the Group in order to administer this provision. 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 Covered Plan Participant to notify the Group within ten calendar days of the date that placement was to occur if the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Covered Plan Participant. If a child is born before the Effective Date of the Covered Plan Participant the newborn should be added during the Initial Enrollment Period.

Adopted/Foster Children – To enroll an Adopted child (other than a newborn child) or Foster Child, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days after the date of placement and the Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Covered Plan Participant pursuant to Florida law. If timely notice is given, no additional contribution amount will be charged for coverage of the Adopted or Foster Child for the duration of the notice period (the 30-day period before the child was placed in your home). You may need to

provide additional information and/or documents deemed necessary by us in order to properly administer this provision.

If timely notice is not given, the child will be added as of the date of placement so long as we receive the Enrollment Form within 60 days of the placement, and any applicable contribution amount is paid back to the date of placement. If notification is not received within 60 days of the date of placement, the Covered Plan Participant must make application during the Annual Open Enrollment Period or Special Enrollment Period in order for the Adopted or Foster Child to be covered.

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. It is your responsibility as the Covered Plan Participant to notify the Group if the Adoption does not take place. Upon receipt of this notification, such child's coverage will be terminated as of the Effective Date of the Adopted child.

Foster Children

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is your responsibility as the Covered Plan Participant to notify the Group in writing that the Foster Child is no longer in your care. Upon receipt of this notification, such child's coverage will be terminated on the date provided by the Group.

Marital Status – If the Covered Plan Participant marries after his or her Effective Date, he or she may add the spouse who is an Eligible Dependent due to a legally valid marriage. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the marriage and the Effective Date of coverage for the new spouse will be the date of the marriage.

Court Order – You, as the Covered Plan Participant may add an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided by you for a minor child under your plan. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the court order and the Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order will be the date required by the court order.

Other Provisions

Rehired Employees

If you are rehired as an employee of the Group; you are considered a newly-hired employee for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Policy, applicable to newly-hired employees and their Eligible Dependents if the employee does not qualify for the federal exemption, such as Effective Dates of coverage and Waiting Periods will apply to you.

TERMINATION OF COVERAGE

Covered Plan Participant

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

1. on the date the ASA between HOI and Suwannee County Board of Public Instruction terminates;
2. on the date the Covered Plan Participant becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the date the Covered Plan Participant no longer meets any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause; or
5. on the date specified by the Group.

Covered Dependent

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

1. on the date the Covered Plan Participant's coverage terminates for any reason;
2. on the date the Covered Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the last day of the Calendar Year that the Covered Dependent no longer meets the eligibility requirements;
4. on the date the Covered Dependent's coverage is terminated for cause;
5. on the date specified by the Group.

If you, as the Covered Plan Participant, wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group prior to the termination date requested.

If you wish to delete your spouse from coverage, in the case of divorce for example, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Termination for Cause

If any of the following events occur, the Group may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits;
2. you intentionally misrepresent, omit, or give false information on Enrollment Forms or other forms completed, by you or on your behalf;
3. fraudulent misuse of the ID Card;
4. you no longer live or work in the Service Area; or
5. a Covered Dependent reaches the limiting age.

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

Note: Only fraudulent misstatements on the Enrollment Form may be used by the Group to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

Rescission of Coverage

The Group and HOI reserve the right to Rescind coverage under this Booklet for any individual covered under this Booklet as permitted by law.

The Group and/or HOI may only Rescind your coverage if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

The Group and/or HOI will provide at least 45 days advance written notice to the Covered Plan Participant of the 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 COMPLAINT AND GRIEVANCE PROCESS section.

Notice of Termination

It is Suwannee County Board of Public Instruction's responsibility to immediately notify you of termination of the Group Health Plan for any reason.

Group Health Plan Responsibilities Upon Termination of Your Coverage

Upon termination of your coverage for any reason, HOI and the Group will have no further liability to you under the Group Health Plan, except as otherwise specifically described in this Booklet.

CONTINUING COVERAGE

Introduction

This section describes the ways coverage can be continued after your termination date. We have divided this section into three subsections: Federal and Florida Continuation Provisions, Conversion Privilege and Extension of Benefits.

Federal Continuation of Coverage Law

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

You must contact your Group to determine if you are entitled to COBRA continuation of coverage. Your Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify you of your rights under COBRA. If you do not meet your obligations under COBRA and this Plan, the Group shall not be liable for any claims incurred by you after your coverage terminates.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by the Group Health Plan; the duty to meet such obligations remains with Suwannee County Board of Public Instruction.

The following is a summary of what you may elect, if COBRA applies to Suwannee County Board of Public Instruction and you are eligible for such coverage:

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

   ***Note:** You are eligible for an 11 month extension of the 18 month COBRA continuation option above (up to a total of 29 months) if you are totally disabled, as defined by the Social Security Administration (SSA), at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. You must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependents may elect to continue their coverage for a period not to exceed 36 months in the case of:
   a. the Covered Plan Participant's entitlement to Medicare;
   b. divorce or legal separation from the Covered Plan Participant;
   c. death of the Covered Plan Participant;
   d. the employer files bankruptcy (subject to bankruptcy court approval); or
   e. a Covered Dependent child who ceases to be an Eligible Dependent under the terms of the Policy.

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

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

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

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Conversion Privilege

If your Group Health Plan has terminated you may apply for conversion to a non-group plan. HOI and the Group have no obligation to notify you of the conversion privilege. It is your sole responsibility to exercise this conversion privilege subject to the provisions set forth below.

Eligibility Criteria for Conversion

You are entitled to apply for a conversion contract for a non-group plan if:

1. you have been continuously covered under this Group Health Plan for at least three consecutive months; **or**
2. you were covered for at least three consecutive months under any other group policy providing similar benefits that this Group Health Plan immediately replaced; **and**
3. your coverage has been terminated for any reason, including discontinuance of this Group Health Plan in its entirety and termination of continued coverage under COBRA; **and**
4. you maintain your primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for Health Care Services. **We must receive the completed conversion application and the applicable premium payment within the 63-day period beginning on the date this Group Health Plan terminated.**

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

Conversion is not available if termination occurred for any of the following reasons:

1. you had not been continuously covered under the Group Health Plan for at least three months prior to termination;
2. failure by you to pay on a timely basis, any required contribution amounts required for coverage under the Group Health Plan;
3. replacement of coverage by similar group coverage occurs within 31 days of termination;
4. you commit fraud or intentional misrepresentation in applying for the Group Health Plan or for any Covered Services;
5. termination for cause as set forth in the TERMINATION OF COVERAGE subsection;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. you are eligible for, or covered under, Medicare.

Additionally, conversion is not available:

1. if you are eligible for similar benefits, whether or not you are actually covered under any arrangement of coverage for individuals in a group;
2. if you are covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical Service insured contract or medical practice or other prepayment plan, or by any other plan or program;
3. if similar benefits are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA); or
4. if the benefits provided or available to you, together with the benefits provided by us, would result in excess of coverage, as determined by us.

Conversion Coverage

The conversion contract issued to each individual who converts to non-group coverage shall include a level of benefits for "minimum Services" which is similar to the level of benefits for the Services included in this Booklet. For purposes of this section, the term "minimum Services" shall mean Services which include any of the following: emergency care, inpatient Hospital Services, Physician care, ambulatory diagnostic treatment, and preventive Health Care Services. Conversion coverage is not a continuation of the Group Health Plan. Benefits under such conversion coverage may differ from benefits under the Group Health Plan and any Endorsements attached thereto. Conversion coverage may continue in effect as long as you: (a) continue to meet all applicable eligibility requirements; (b) pay all applicable fees and charges; and (c) otherwise comply with all requirements under the conversion contract.

Effective Date of Conversion

The effective date of conversion coverage shall be the day following the termination under the Group Health Plan. However, until such time as coverage under the conversion contract becomes effective, you shall pay the Allowed Amount for any Covered Services rendered during the 63-day period immediately following termination of the Group Health Plan. In the event such conversion coverage becomes effective, you may request reimbursement from us for any payment for Covered Services. You must submit proof of payment to us in order to obtain reimbursement.

Extension of Benefits

If the Group Health Plan is terminated, coverage will end on the termination date. There will be no coverage or benefits for any Covered Service received on or after the termination date, except as listed below. The extension of benefits described below only applies when the Group Health Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Booklet.

Note: You must provide proof that you are entitled to an extension of benefits.

Extension of Benefits

1. If you are pregnant on the termination date of the Group Health Plan, a limited extension of the maternity benefits will be provided, as long as the pregnancy started while you were covered by the Group Health Plan. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate on the date the child is born.
2. If you are totally disabled on the termination date of the Group Health Plan because of a specific accident or illness that happened while you were covered under the Group Health Plan, a limited extension of benefits will be provided for you only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

   Note: For purposes of this subsection, you will be considered totally disabled only if, in our opinion, you are unable to work at a job for which you have the education, training, or experience, and you continue to require regular care from a Physician for the disability. This applies, even if you are not working (e.g., a student, non-working spouse, or children), if you are unable to perform the normal day-to-day activities which you would otherwise be able to perform.

Neither the Group nor HOI is required to provide an extension of benefits if you leave the Service Area with the intent to relocate or establish a new residence outside the Service Area; if you intentionally left out or provided false information on any Enrollment Form in order to obtain coverage or Covered Services; or if you were terminated for 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.

COORDINATION OF BENEFITS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided under this Booklet. It is designed to avoid duplication of payment for Covered Services and/or supplies. It is your responsibility to provide us information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you will be responsible for payment of any expenses related to denied claims.

Payment for Covered Services will be coordinated to the maximum extent allowed by law provided you follow the Coverage Access Rules set forth in the COVERAGE ACCESS RULES section. Plans 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 insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
4. Medicare, as described in the Medicare Secondary Payer Provisions subsection; and
5. To the extent permitted by law, any other government sponsored health insurance program.

The amount of payment, if any, is based on whether or not the Group Health Plan is the primary payer. When the Group Health Plan is primary, payment for Covered Services will be made without regard to your coverage under other plans. When the Group Health Plan is not primary, 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 that the primary payer's payment exceeds the maximum amount established by us, no payment will be made for such Services.** In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount obligated to the 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. the plan of the parent with custody is primary;

b. the plan of the re-married parent with custody is primary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; the step-parent's plan is secondary; and

c. the plan of the parent without custody pays last;

d. 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 an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:

   a. the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;

   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:

   a. first, the plan covering the person as an employee, or as the employee's dependent; and

   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.

7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary.

8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

Medicare Secondary Payer Provision

When you become covered under Medicare and are still eligible and covered under this Booklet, the Group Health Plan will be primary and Medicare benefits will be secondary, but only to the extent required by law. In all other instances, the Group Health Plan will be secondary to any Medicare benefits. When the Group Health Plan is the primary payer, claims for Covered Services should be filed with HOI first.

If you become covered under Medicare and are still eligible and covered under the Group Health Plan,

Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, the Group MAY NOT persuade you to decline or terminate your group health coverage and elect Medicare as the primary payer.

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

Individuals With End Stage Renal Disease

If you become entitled to Medicare coverage because of ESRD, your Group Health Plan is primary for 30 months beginning with the earlier of:

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

If Medicare was already primary before ESRD, Medicare will remain primary. Also, if your Group Health Plan coverage was primary before ESRD entitlement, the Group Health Plan will remain primary for the ESRD coordination period. If you are eligible for Medicare due to ESRD, your Group Health Plan coverage is primary for 30 months.

Disabled Active Individuals

The Group Health Plan coverage is primary, if:

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

Primary coverage under the Group Health Plan is pursuant to the following terms:

1. your Group Health Plan coverage is primary during any month in which you are entitled to Medicare coverage because of disability;
2. your entitlement to primary coverage under this subsection will terminate automatically when:
   a. you turn 65 years of age; or
   b. you no longer qualify for Medicare coverage because of disability; or
   c. you elect Medicare as the primary payer. Coverage will terminate as of the date of your election.

   Under Medicare, Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you or induce you to decline or terminate your group health coverage and elect Medicare as the primary payer.
3. Your entitlement to primary coverage under this subsection will terminate automatically if you no longer qualify under applicable Medicare regulations and instructions. The Group shall notify us, without delay, of any such change in status.

Miscellaneous

This section shall be changed, if necessary, to comply with federal statutory and regulatory Medicare Secondary Payer rules as they relate to Medicare beneficiaries who are covered under a Group Health Plan.

We will not be liable to Suwannee County Board of Public Instruction or anyone covered under the Group Health Plan due to any nonpayment of primary benefits that result from any failure of the Group's performance or obligations set forth in this section.

If primary payment is made for Covered Services rendered to you as described in this section in a period prior to receipt of the information required by the terms of this section, you may be required to reimburse the Group Health Plan for such payments.

Non-Duplication of Government Programs

The benefits provided under this Booklet 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.

CLAIMS PROCESSING

Introduction

This section is intended to:

1. help you understand what your treating Providers must do, under the terms of this Booklet, 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.

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

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

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

In-Network Providers have agreed to file Post-Service Claims for Covered Services they render to you. If you receive a bill from an In-Network Provider, you should forward it to us. If you require Emergency Services from an Out-of-Network Provider while inside or outside the Service Area or, if we refer you to an Out-of-Network Provider, the Group Health Plan will pay for Covered Services provided to you. If you receive a bill from an Out-of-Network Provider for Covered Services, you should forward it to us. We rely on the information you provide when processing a claim.

We must receive a Post-Service Claim within 90 days of the date the Covered Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if we do not receive it at the address indicated on your Identification Card within one year of the date the Covered 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 Covered Plan Participant's name and contract number as they appear on the Identification Card.

Note: Please refer to the PRESCRIPTION DRUGS PROGRAM section for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard Program (See the BLUECARD PROGRAM or AWAY FROM HOME CARE section).

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 Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more 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 portion(s) 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 process 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, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS 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.

Pre-Service Claims

How to file a Pre-Service Claim

This Booklet may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the COVERAGE ACCESS RULES section, the WHAT IS COVERED? section and other applicable sections of this Booklet. You may also call the customer service number on your Identification 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 Booklet 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, and the appeal procedures described in the COMPLAINT AND GRIEVANCE PROCESS section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Covered 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 Service(s); and
3. the reduction or termination of coverage or benefits by us was not due to an amendment to the Booklet or termination of your coverage as provided by this Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the COMPLAINT AND GRIEVANCE PROCESS described in this Booklet. 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 Covered Services.

Requests for Extension of Covered Services

Your Provider may request an extension of coverage or benefits for a Covered Service beyond the approved period of time or number of approved Covered 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 Covered 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 Covered Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Booklet.

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, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;

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

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 three 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. 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 nor Suwannee County Board of Public Instruction will have no liability for such claim.

Physical Examination

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. If you do not fully cooperate with such examination, we may deny the claim and we will have no liability for such claim.

Legal Actions

No legal action arising out of or in connection with coverage under this Booklet may be brought against HOI or Suwannee County Board of Public Instruction 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, in denial of the claim or cancellation or Rescission of your coverage.

Communication of Claims Decisions

All claims decisions, including denial and review decisions, will be communicated to you in writing. This written correspondence may indicate:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination.

3. A description of any additional information that would change the initial determination and why that information is necessary.
4. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures.
5. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational 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 Covered 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.

GENERAL PROVISIONS

Access to Information

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

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Booklet 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, the Group, 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 the Group Health Plan, specific medical information concerning you received by/from a Provider shall be kept confidential by HOI. 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, specifically including HOI's quality assurance and utilization review activities. Additionally, we may disclose such information to affiliated entities. 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 HOI 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 HOI and Suwannee County Board of Public Instruction, and must execute and submit such consents, releases, assignments, and other documents as may be requested in order to administer, and exercise any rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause as described in the TERMINATION OF COVERAGE section.

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Employer as Plan Administrator

Your employer, as the plan administrator, retains full, final, discretionary authority with respect to the administration of the coverage and benefits described in this Benefit Booklet, including, but not limited to, the authority to establish the benefits and scope of coverage to be provided hereunder; authority to make ultimate coverage and claims payment decisions; authority to determine the eligibility of individuals for coverage; and authority to construe and interpret the terms of coverage under this Benefit Booklet.

Evidence of Coverage

You have been provided with this Booklet and an Identification Card as evidence of coverage under Suwannee County Board of Public Instruction's Group Health Plan.

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 the Blue Cross and Blue Shield of Florida corporate website at www.floridablue.com.

Identification Cards

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

Modification of Provider Network

Our Provider network is subject to change at any time without prior notice to, or approval of, you or the Group. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, you or the Group. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered.

Non-Waiver of Defaults

Any failure by HOI or Suwannee County Board of Public Instruction 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 HOI's or the Group's right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law or this Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as 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 Identification Card.

If to you:

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

If to the Group:

To the address indicated by the Group.

Our Obligations Upon Termination

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

Relationships Between the Parties

HOI and Health Care Providers

Neither HOI nor any of its officers, directors or employees provides health care Services to you. By accepting 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. Neither HOI nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

HOI and the Group

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

You and In-Network Providers

The relationship between you and In-Network Providers shall be that of a health care Provider-patient relationship, in accordance with any applicable professional and ethical standards.

Right of Recovery

Whenever the Plan has made payments in excess of the maximum provided for under this Booklet, we or Suwannee County Board of Public Instruction 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 Booklet or an applicant for enrollment which we deem to be necessary.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan

including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of Suwannee County Board of Public Instruction and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Suwannee County Board of Public Instruction hereby specifically expresses its intent that Providers that have not entered into contracts with HOI to participate in our Provider networks shall not be third-party beneficiaries under the terms of the Suwannee County Board of Public Instruction's Group Health Plan or this Booklet.

COMPLAINT AND GRIEVANCE PROCESS

Introduction

We have established a process for reviewing your Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, your dissatisfaction with us, our administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent In-Network Provider. The Complaint and Grievance Process also permits you or your Physician, or a person acting on your behalf, to expedite our review of certain types of Grievances. The process described in this section must be followed if you have a Complaint or Grievance.

Informal Review

We encourage you to first attempt the informal resolution of any dissatisfaction by calling us. To advise us of a Complaint, you should first contact our customer service department, at the phone number is listed on your ID Card. A service associate, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to your satisfaction. You must provide all of the facts relevant to the Complaint to the service associate. If you do not provide all requested or relevant information, it may delay our review of the Complaint. Consequently, you must cooperate with us in our review of the matter.If you remain dissatisfied with our resolution of the Complaint, you may submit a Grievance in accordance with the Formal Review subsection below.

Formal Review

You, a Provider who has been directly involved in your treatment or diagnosis acting on your behalf, a state agency, or another person designated in writing by you, may submit a Grievance.

In order to begin the formal review process, you may fill out a pre-printed form, write a letter or meet with us in person to explain the facts and circumstances relating to the Grievance. You should provide as much detail as possible and attach copies of any relevant documentation. You are not required to use our form, however, we strongly urge you to use this form, as it was designed to help facilitate logging, identification, processing, and tracking of the Grievance through the review process. Written requests for formal review must be sent to the address listed in the Telephone Numbers and Addresses subsection.

If you need assistance in preparing your Grievance, you may contact us for assistance. If you are hearing impaired you may contact us via TTY/TDD.

Review of Grievances Involving Adverse Benefit Determination

A Grievance involving an Adverse Benefit Determination will be reviewed using the process described below. The Grievance must be submitted to us in writing for an internal Grievance 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 a Complaint or Grievance. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the Complaint or Grievance processed within the time frames set forth in this section.
2. We will offer to meet with you if you believe that such a meeting will help us resolve the Complaint or Grievance to your satisfaction, you may also initiate a request for such meeting by notifying us. You may elect to meet with us in person, by telephone conference call, or by video-conferencing (if facilities are available). We will not pay for your travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video

conferencing to be held at our administrative offices within the Service Area. We will make these telephone or video arrangements with no additional charge to you.

3. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The Expedited Review 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 review will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
4. 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.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date
6. 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 Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews the Adverse Benefit Determination on our behalf will be identified upon request.
10. 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. You may call our expedited phone line at the number listed at the end of this section.
11. 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.
12. If you wish to give someone else permission to file a Grievance for 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 Grievance. An Appointment of Representative form is not required if the Physician is requesting review of 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 customer service phone number on your ID Card.
13. The Internal Review Panel will review the Grievance 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.
14. We will advise you of all Grievance decisions in writing, as outlined in the Timing of Our Grievance Review on Adverse Benefit Determinations subsection.
15. We will provide written confirmation of our decision concerning a Claim Involving Urgent Care within two working days or three calendar days, whichever is less, after providing notification of that decision.
16. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain Grievances, as described in the External Review subsection below.

17. The Panel that reviews appeals is composed of individuals who did not participate in the previous decision, nor are they subordinates of such individual(s).
18. You have the right to an independent external review through an external review organization for certain Grievances, as provided in the Patient Protection and Affordable Care Act of 2010.

Timing of Our Grievance Review on Adverse Benefit Determinations

We will use our best efforts to review Grievances of Adverse Benefit Determinations and communicate the decision in accordance with the following time frames:

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

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.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements ("Deemed Exhaustion") and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Health Plan. If ERISA applies to the Group Health Plan, you are entitled, after exhaustion of the procedures described in this section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

External Review

If we have denied your request for payment of a claim and our decision involved 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 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. 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 HMO
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.

Telephone Numbers and Addresses

You may contact a Grievance Coordinator at the phone number listed on your ID Card or at the phone numbers and addresses listed below.

Florida Blue HMO
Attention: Grievance Department
Post Office Box 41609
Jacksonville, Florida 32230-1609
877-352-2583

877-842-9118 - Expedited Review for a Claim Involving Urgent Care

Dial 7-1-1 for Florida Relay Service assistance with TTY/TDD calls

IMPORTANT INFORMATION FOR YOU

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

Types of HMOs

Staff and Group Model HMOs

In a staff model HMO, the doctors and other Providers rendering care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract services with additional doctors and Providers. Unlike the staff or group model HMOs, the IPA model HMO does not provide Health Care Services itself. Instead, it pays independent, qualified Providers to render health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

Note: This description is not intended to be an exhaustive listing of all HMO organization models in use in the United States.

Health Options is an IPA Model HMO. **It is not a staff or group model HMO**. This means that the doctors and other Providers with whom we contract are independent contractors and not the employees or agents, actual or ostensible, of Health Options. Rather these independent doctors and Providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

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

- To be provided with information about our services and the associated Providers of Health Care Services.
- To receive medical care and treatment from In-Network Providers who have met our credentialing standards.

- To expect health care Providers who participate in our network to permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
- To expect to receive treatment and relevant information about your treatment from our In-Network Providers with courtesy, respect, and concern for your dignity and privacy.
- To appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in this Booklet.
- 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.
- To have access to your medical records, and to be assured that the confidentiality of your records is maintained, in accordance with applicable law and HOI's rules.

Responsibilities

- To seek all non-emergency care through your assigned PCP or another In-Network Provider and to cooperate with anyone providing your care and treatment.
- To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
- To be responsible for understanding and following instructions about your treatment and to ask questions if you do not understand or need an explanation.
- To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
- To pay your Cost Share amounts set forth on the Schedule of Benefits and to provide current information concerning your coverage status to any In-Network Provider.
- To follow the process for filing a grievance about medical or administrative decisions that you feel were made in error.
- To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
- To follow Coverage Access Rules established by us.

Disclosure of Continuing Care Facility Resident/Retirement Facility Resident Rights

If, at the time of enrollment you are a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, your PCP must refer you to that facility's skilled nursing unit or assisted living facility if:

1. you request it and the facility agrees;
2. your PCP finds that such care is Medically Necessary;
3. the facility agrees to be reimbursed at the same contracted rate as similar Providers for the same Covered Services and supplies; and
4. the facility meets all guidelines established by us related to quality of care, utilization, referral authorization, risk assumption, use of our Provider network, and other criteria applicable to Providers under contract with us for the same Services.

If your request to be referred to the skilled nursing unit or assisted living facility that is part of your place of residence is not honored, you have the right to initiate a Complaint or Grievance under the process described in this Booklet.

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, is a complex understanding. 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.

AWAY FROM HOME CARE®

Away From Home Care (AFHC) Guest Membership is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA). AFHC is available to you under the Group Health Plan through HOI, a participating Blue-sponsored HMO when the program's requirements are met. Guest Membership is defined as a courtesy membership for individuals who are temporarily residing outside of their Home HMO service area. Health Options, Inc. (HOI) is your Home HMO. For purposes of the Group Health Plan, you will be a guest member of the Host HMO and will be entitled to coverage and benefits under the terms of the Host HMO's benefit booklet.

Under AFHC, you receive a courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits, including routine and preventive Services. You will receive the benefits of the Host HMO plan while in that HMO Plan's service area. You remain a Covered Plan Participant under your Home HMO under the Group Health Plan and are entitled to payment for Covered Services not payable under your AFHC Guest Membership under the terms of this Booklet. Should your coverage with your Home HMO terminate, you will no longer be eligible for AFHC coverage, and if you are then in this program your AFHC coverage will also be terminated.

The Host HMO pays the Provider the lowest available rate on a fee-for-service basis and then bills the Home HMO for reimbursement. You pay any applicable Cost Share amounts to the Provider in the Host Plan's service area at the time of Service.

Guest Application

You must complete an AFHC Guest Application with the Home HMO, and then work with the Host HMO to locate a PCP in the Host Plan's service area. The AFHC Guest Application form is used to verify your eligibility and to provide the appropriate information for billing and reimbursement.

Guest Membership Types

The types of Guest Memberships are based on your eligibility and the length of time that you will be out of the Home HMO service area. The three types of Guest Memberships are as follows:

Long-Term Traveler

This Guest Membership is available to Covered Persons that are away from home for at least 90 consecutive days (three months) but not more than 180 days (six months).

This Guest Membership is typically used for long-term work assignments or for a retiree with a dual residence. Home HMOs may limit the number of Long-Term Traveler Guest Memberships to two per year.

Families Apart

The Families Apart Guest Membership is available to Covered Dependents that do not reside in the Home HMO service area for 90 or more consecutive days. A Covered Plan Participant is not eligible for this type of Guest Membership.

To qualify for a Families Apart Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

There is no administrative time limit on the length of a Families Apart Guest Membership.

Student

The Student Guest Membership is available to Covered Dependents that are out of the Home HMO Service Area for 90 or more consecutive days attending school.

To qualify for a Student Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

The Student Guest Membership is typically used for students while they are away at school. The student membership should terminate when the student returns to the Home HMO Service Area for the summer. There is no administrative time limit on the length of a Student Guest Membership.

Covered Dependents under a Student Guest Membership that seek care in a third HMO service area (out of the Home HMO area and out of the Host HMO area) should be referred back to HOI, the Home HMO.

Guest Membership Policies

Host HMOs need enough time to process and set up Guest Memberships before the desired effective date. A 15-day notification period is provided for Host HMOs to complete the processing and setup of the Guest Membership. Covered Persons can be under only one Guest Membership at a time.

Guest Membership Renewals

When your Guest Membership expires, you may apply for a separate, consecutive Guest Membership period to begin after your current one expires. The 15-day notification period applies to Guest Membership renewals, so it is important that you apply for renewal far enough in advance to avoid a lapse in Guest Membership.

Guest Membership renewals have the same requirements as initial Guest Memberships, including the 90-day out-of-area requirement. Renewals must be for a minimum of 90 or more consecutive days in length. A renewal requires that the Home HMO Guest Membership Coordinator re-verify eligibility, submit a new Guest Application form, obtain a new signature sticker and pay a new setup and renewal fee.

Renewals typically apply to Families Apart and Student Guest Memberships which commonly renew on an annual basis. A Long Term Traveler Guest Membership can also renew but you would need to re-qualify by being out of area for a minimum of 90 consecutive days from the date of the requested renewal, as well as meeting all other Home HMO eligibility requirements. You are not required to return to the Home HMO Service Area to qualify for a renewal.

DEFINITIONS

The following definitions will help you understand the terms that are used in this Booklet, including the Schedule of Benefits and any Endorsements attached to this Booklet. As you read through this Booklet you can refer to this section; we have identified defined terms in the Booklet, 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.

Administrative Services Agreement or **ASA** means an agreement between Suwannee County Board of Public Instruction and HOI. Under the Administrative Services Agreement, HOI provides claims processing and payment services, customer service, utilization review services, and access to HOI's network of independent contracting providers.

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.

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

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

Allergy Treatment means testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

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 the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and HOI.
2. In the case of Out-of-Network Providers located outside of the Service Area who participate in the BlueCard 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 in the Benefit Booklet for more details.
3. In the case of an Out-of-Network Provider that has not entered into an agreement with HOI 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 HOI 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 an HOI 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 HOI 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.

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

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with HOI 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.

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 date one year after the Effective Date stated in the ASA, and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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:

I. The Department of Veterans Affairs.

II. The Department of Defense.

III. 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.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;

2. Asperger's syndrome;

3. Pervasive developmental disorder not otherwise specified; and

4. Childhood Disintegrative Disorder.

B

Benefit Booklet or **Booklet** means the certificate of coverage, which is evidence of coverage under the Group Health Plan.

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

Birth Center means 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.

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.

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

C

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

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

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

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or 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 the Plan. After your Deductible is met, the Plan 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. Not all plans include coinsurance.

Complaint means an oral (non-written) expression of dissatisfaction, whether or not such dissatisfaction is made in person, by telephone, or by another person acting on your behalf.

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 COVERAGE ACCESS RULES section.

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

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

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

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

Cost Share means the dollar or percentage amount, 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.

Coverage Access Rules means the rules or procedures in this Benefit Booklet, your provider directory, or established by HOI, that you must follow in order for Health Care Services you receive to be covered. Failure to follow applicable Coverage Access Rules may result in the denial of coverage or benefits under this Booklet.

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

Covered Person means a Covered Plan Participant or Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who continues to meet all applicable eligibility requirements described in the ELIGIBILITY FOR COVERAGE section and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Dependent.

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

Custodial or **Custodial Care** means care that serves to assist 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

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider who is recognized for payment under this Booklet, before payment for Covered Services under the Group Health Plan begins. Not all plans include a deductible.

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.

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent;
5. the Covered Plan Participant has submitted acceptable proof of evidence of common residence and joint financial responsibility to the Group.

6. the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

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 for the Group means 12:01 a.m. on the date specified in the ASA; and for you means 12:01 a.m. on the date coverage will begin as specified in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

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

Eligible Employee means an employee who meets and continues to meet all of the eligibility requirements set forth in the ELIGIBILITY FOR COVERAGE section and is eligible to enroll as a Covered Plan Participant. An eligible employee is not a Covered Plan Participant until actually enrolled and accepted for coverage as a Covered Plan Participant by the Group.

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 Booklet. Endorsements may also be referred to as amendments.

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

Enrollment Forms means those forms, electronic or paper, which are used to maintain accurate enrollment files under the Group Health Plan.

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 or Suwannee County Board of Public Instruction:

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 or Suwannee County Board of Public Instruction):

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 or the Group 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.

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.

Gene Therapy means treating disease by replacing, manipulating, or supplementing nonfunctioning or malfunctioning genes.

Generally Accepted Standards of Medical Practice means standards that are based on reliable 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.

Grievance means a written expression of dissatisfaction.

Group means Suwannee County Board of Public Instruction, the employer, labor union, trust, association, partnership, or corporation, department or other organization or entity through which coverage and benefits described in this Booklet are made available to you, and through which you become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or **Plan** means the plan established and maintained by Suwannee County Board of Public Instruction for the provision of health care coverage and benefits to the individuals covered under this Booklet.

H

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.

HOI means Health Options, Inc., a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

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 Covered Plan Participants. 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, the Group Health Plan.

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 Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to provide Covered Services described in this Booklet.

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

Internal Review Panel means a panel established by us to review Grievances related to Adverse Benefit Determinations that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

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 Statues, or a similar applicable law of another state.

M

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 Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

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.

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

Medicare means the 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.

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

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

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, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

N

New Prescription Drug(s) means An FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

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

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

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to provide Covered Services described in this Booklet.

Outpatient Rehabilitation 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. Further, such an entity must meet our criteria for eligibility as an outpatient rehabilitation facility. The term outpatient rehabilitation facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III “specialty rehabilitation hospital” described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

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.

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

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or 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 electric format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

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".

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 Booklet condition payment for the Service (in whole or in part) on approval 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 Booklet 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 Health 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 the Physician who, at the time Covered Services are rendered, was under a primary care physician Provider contract with us. A primary care physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist may elect to contract with us as a primary care physician.

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

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 Booklet, a psychiatric facility is not a Hospital or a Substance Abuse Facility, as defined herein.

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

R

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.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of Rehabilitation Services to be provided to a person with rehabilitation potential. Such plan must have realistic goals which are attainable by the individual within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such Services are to be rendered. The rehabilitation plan must be renewed every 30 days.

Rehabilitation 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.

Rehabilitative Therapies means therapies with the primary purpose of restoring or improving a bodily or mental function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

Rescission or **Rescind** refers to HOI's or Suwannee County Board of Public Instruction's action to retroactively cancel or discontinue coverage under the Group Health Plan. 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.

S

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

Service Area means 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 the applicable service area is available at: https://www.floridablue.com/sites/floridablue.com/files/docs/county_landing_page.pdf.

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.

Specialist means a Physician who limits practice to specific Services or procedures such as surgery, radiology, pathology, certain age categories of patients such as pediatrics, geriatrics, certain body systems such as dermatology, orthopedics, cardiology, internal medicine or types of diseases such as allergy, psychiatry, infectious diseases, oncology. Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board.

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 an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. In-network specialty pharmacies are listed in the Medication Guide. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a specialty pharmacy.

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

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

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 Booklet a substance abuse facility is not a Hospital or a Psychiatric Facility, as defined herein.

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

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 Booklet, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

V

Virtual Care Provider is a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered. An Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications.

W

Waiting Period means the period of time specified by the Group, if any, which must be met by an individual before that individual is eligible to enroll for coverage under the Group Health Plan.

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.

Templates Included

Compliance/Notices/Meaningful Access Notice.jld
Compliance/Notices/Privacy Notice - Breast Reconstruction Notice.jld

78170-123--Schedule-Of-Benefits-1
78170-122--Benefit-Booklet-1

MATCHING CRITERIA

Record Number	476
Request Type	M
Health Product	BLUECARE
Small Group	N
Rx Product	BLUECARE RX
Rx Plan	52
Health Plan	123
IRX	Y
Generic Choices	N
Generic Only	N/A
Closed Formulary	Y
HSA	Y
HSA-BRX	N
Standard	N
Basic	N
ACA	N
RX Coins	N/A
ICC	N
CP-GF-BEN-IND	N
CP-GF-STATUS-IND	N
CP-GROUP-SUB	G
CP-GENERATION-IND	3
CP-EXCHANGE-IND	N
CP-RX-DED-IND	N

CP-RX-NGF-2012-HCR-IND	Y
CP-RX-GF-2012-HCR-IND	N
TAG-RX-SUFFIX	
AON	N/A
CP-ASO-IND	Y
Commerical	Y
CP-BCR-PEP-IND	N
Standard Or Basic	N
ROUTE	GROUP
EFF-YEAR	21
GRP-PKG-EFF-YEAR	21
GRP-NO	78170
DIV-NO	R12
PKG-NO	01
FEEDER1	0
FEEDER2	0
FEEDER3	0
FEEDER4	0
FEEDER5	0
FEEDER6	0
COE	,,,,,,,,,
DATE	6/5/21 10:53 AM

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

SUWANNEE CNTY BOARD OF PUBLIC
ATTN TERESA JONES
1740 OHIO AVE S
LIVE OAK FL 32064-4500

Thanks for choosing Florida Blue! See the enclosed **Welcome brochure** for everything you need to get the most value from your health plan. For plan info on the go, download the Florida Blue app or log in to your account at floridablue.com.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of
Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

This Master Contract is for SUWANNEE CNTY BOARD OF PUBLIC

Group Number 78170

Division(s)	Package	Division	Package

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

In the pursuit of health®

Notice Regarding Prior Authorization (Preapproval) of Medical and Pharmacy Services

MAKE SURE YOUR SERVICES ARE COVERED –
CHECK FIRST FOR PREAPPROVAL

For some services or drugs, your doctor needs to get preapproval before your plan will cover them. This does three important things: ensures coverage from your plan, guides you to quality care and helps you save money.

If your doctor doesn't get approval, you may have to pay the entire medical bill.

For an updated list of services that need preapproval, go to floridablue.com/authorization. You can also click the link in the "Authorizations" section on the homepage of your member account.

Talk with your doctor to find out if they've gotten preapproval. You can also call us at 800-352-2583.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc., d/b/a/ Florida Blue, Health Options, Inc., d/b/a Florida Blue HMO, and BeHealthy Florida, Inc., d/b/a Florida Blue Preferred HMO, collectively referred to as Florida Blue in this Notice) understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:
We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information, and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:
We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.
There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:
To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to

a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
- **Note:** If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Notice Regarding Coverage for Breast Reconstruction Surgery

If you have to have a mastectomy, your breast reconstruction surgery is covered under your health coverage. It can be done at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

BlueOptions **with Integrated Prescription Drug Coverage**

Schedule of Benefits - Plan 05192 Single Coverage

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

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

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

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$3,500	$5,000
Per Family per Benefit Period	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	$500
Coinsurance - The percentage of the Allowed Amount **you pay** for Covered Services	30%	40%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$6,500	$11,600
Per Family per Benefit Period	Not Applicable	Not Applicable

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

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

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

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

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office Visits rendered by Family Physicians	DED + 30%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 30%	DED + 40%
Allergy Injections rendered by Family Physicians	DED + 30%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 30%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by Family Physicians	DED + 30%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 30%	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 30%	DED + 40%
Convenient Care Centers	DED + 30%	DED + 40%

Virtual Health

Benefit Description	You Pay
Virtual Visits General Medicine and Urgent Care rendered by a designated Virtual Care Provider	DED + 20%
Specialized Care rendered by a designated Virtual Care Provider	DED + 20%

Please visit http://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by: Family Physicians	DED + 20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 50%
Out-of-Pocket Maximum per Person per Month (applies only after DED is satisfied)	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Adult Well Woman Services Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	DED	DED + 40%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 30%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 30%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 30%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 30%	DED + 30%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	DED + 30%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 30%	In-Network DED + 30%
Other health care professional Services rendered by all other Providers	DED + 30%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	DED + 30%	DED + 35%	**PAD + DED + 40%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%
Outpatient			
Facility (per visit)	DED + 30%	DED + 35%	DED + 40%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%
Therapy Services	DED + 30%	DED + 35%	DED + 40%
Emergency Room Visits			
Facility	DED + 30%		DED + 30%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and In-Network Coinsurance will apply to that 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. This plan 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. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

BlueScript® Pharmacy Program

All Covered Prescription Drugs, Covered Over-the-counter (OTC) Drugs and Covered Prescription Supplies purchased from a Pharmacy are subject to the **In-Network DED**, which must be satisfied by you before any payment will be made by us. To verify if a Pharmacy is a Participating Pharmacy, you may access a current pharmacy directory, refer to our website at www.floridablue.com, or call the customer service phone number on your Benefit Booklet or Identification Card.

Retail Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a One-Month Supply	DED + $10	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a One-Month Supply	DED + $50	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $80	DED + 50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a Three-Month Supply	DED + $25	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $125	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $200	DED + 50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a One-Month Supply	DED + $10	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a One-Month Supply	DED + $50	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $80	DED + 50% of the Non-Participating Pharmacy Allowance

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

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

Other Important information affecting what you will pay:

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

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

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

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;

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

  3. Emergency contraceptives indicated as covered in the Medication Guide.

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

    1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**

    2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

  - The Specialty Pharmacies designated, solely by us, are the only "Participating Pharmacy" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us in the Medication Guide as a Specialty Pharmacy is considered a Non-Participating Pharmacy for payment purposes under this BlueScript Pharmacy Program.

  - 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.

  - Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

  - You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. This note does not apply to Specialty Drugs, which are covered only up to a One-Month Supply.

  - Amounts incurred for Covered Prescription Drugs, Over-the-Counter Drugs and Covered Prescription Supplies will be applied to the In-Network Out-of-Pocket Maximum as indicated in this Schedule of Benefits.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room	DED + 30%	In-Network DED + 30%
Hospital	DED + 30%	DED + 40%
Physician Services at Hospital and ER	DED + 30%	In-Network DED + 30%
Physician and other health care professionals licensed to perform such Services rendered at: Family Physician office	DED + 30%	DED + 40%
Specialist office	DED + 30%	DED + 40%
All other locations	DED + 30%	DED + 40%
Inpatient Facility Services	DED + 30%	PAD + DED + 40%
Physician and other health care professionals licensed to perform such Services	DED + 30%	In-Network DED + 30%

Benefit Maximums

Home Health Care Visits per Benefit Period 20

Inpatient Rehabilitation days per Benefit Period 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility Days per Benefit Period 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

BlueOptions

With Integrated Prescription Drug Coverage Benefit Booklet for the Suwannee County Board of Public Instruction Group Health Plan

A Self-funded Group Health Benefit Plan

Effective: May 1, 2021

For Customer Service Assistance: 800-664-5295

Group 78170
Plans 05192, 05193

Benefit Booklet

BlueOptions

for Self-Funded Groups
Benefit Booklet

CUSTOMER SERVICE ASSISTANCE:
800-664-5295

Group 78170
Plans 05192, 05193

Benefit Booklet

Table of Contents

Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet ("Booklet"). It describes your coverage, benefits, limitations and exclusions for the self-funded Group Health Benefit Plan ("Group Health Plan" or "Group Plan") established and maintained by Suwannee County Board of Public Instruction.

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

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

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

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

When reading your Booklet, please remember that:

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.
- references to "we", "us", and "our" throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as "BCBSF."

- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section or defined within the particular section where it is used.

Where do you find information on…

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

  Read the "What Is Covered?", "BlueScript® Pharmacy Program", and "What Is Not Covered?" sections.

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

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

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

  Read the "BlueCard® Program" section.

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

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

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

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

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

  Read the "Termination of Coverage" section.

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

  Read the "Definitions" section.

Overview of How BlueOptions Works

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

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

Section 2: What Is Covered?

Introduction

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

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

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

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

BCBSF or Suwannee County Board of Public Instruction will determine whether Services are Covered Services under this Booklet after you have obtained the Services and a claim has been received for the Services. In some circumstances BCBSF or Suwannee County Board of Public Instruction may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, BCBSF or Suwannee County Board of Public Instruction may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. Neither BCBSF nor Suwannee County Board of Public Instruction are obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

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

For information on Prescription Drug coverage, please refer to the "BlueScript® Pharmacy Program" section.

Our Benefit Guidelines

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

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

Covered Services Categories

Accident Care

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

Exclusion:

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

Allergy Testing and Treatments

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

Ambulance Services

Ground Ambulance

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

1. For Emergency Medical Conditions – it is Medically Necessary to transport you from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
   a) from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;

b) to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;

c) to the nearest more cost-effective acute care facility as determined solely by us; or

d) from an acute facility to the nearest cost-effective sub-acute setting.

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

Air and Water Ambulance

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

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

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

Exclusion:

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

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

Ambulatory Surgical Centers

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

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered (except for take home Drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

Anesthesia Administration Services

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

Exclusion:

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

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section 393.17 of the Florida Statutes or licensed under Chapters 490 or 491 of the Florida Statutes; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion:

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

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 Booklet;
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician; and
4. Residential Treatment Services, as defined in this Booklet.

Exclusion:

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;
8. Services to test aptitude, ability, intelligence or interest except as covered under the Autism Spectrum Disorder subsection;
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. You acknowledge that we do not have any Contractual or other formal arrangements with the Provider of such services.

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

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

Child Cleft Lip and Cleft Palate Treatment

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

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

Consultations

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

Contraceptive Injections

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

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental Services provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
    a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that:
        i. Dental treatment is necessary due to a dental Condition that is significantly complex; or
        ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or

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

Exclusion:

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

Diabetes Outpatient Self-Management

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

Diagnostic Services

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

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

Dialysis Services

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

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, limited to the most cost effective equipment as determined by BCBSF or Suwannee County Board of Public Instruction is covered.

Payment Guidelines for Durable Medical Equipment

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

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

Exclusion:

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

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.

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 when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period are covered.

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

Eye Care

Coverage includes the following Services:

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

Exclusion:

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

Home Health Care

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

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan which has been reviewed and renewed by the prescribing Physician every 30 days. In order to determine whether such Services are covered under this Booklet, you may be required to provide a copy of any written treatment plan;
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide Services;

2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
3. medical social Services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen); and
6. Physical Therapy by a Physical Therapist, Occupational Therapy by a 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 a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

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

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

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. Drugs and medicines administered (except for take home Drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the “What Is Not Covered?” section);
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;

12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, and Cardiac Therapies; and
14. transplants as described in the Transplant Services subsection.

Exclusion:

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

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

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

Inpatient Rehabilitation

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

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

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

Exclusion:

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

Mammograms

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

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

Mastectomy Services

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

Maternity Services

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

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

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

Medical Pharmacy

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

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

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

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

Newborn Care

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

Newborn Assessment:

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

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

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

Orthotic Devices

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

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

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

Exclusion:

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

Osteoporosis Screening, Diagnosis, and Treatment

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

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;

3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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

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

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

Occupational Therapy Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition are covered.

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

Physical Therapy Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition are covered.

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

Payment Guidelines for Massage and Physical Therapy

1. Payment for covered Massage Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
2. Payment for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
3. Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day not to exceed fifteen (15) minutes in length.

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

Payment Guidelines for Spinal Manipulation

1. Payment for covered spinal manipulation is limited to no more than 26 spinal manipulations per Benefit Period, **or** the maximum benefit listed in the Schedule of Benefits, whichever occurs first.
2. Payment for covered Physical Therapy Services rendered on the same day as a spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

Your Schedule of Benefits sets forth the maximum number of visits covered under this plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example,

even if you may have only been administered two (2) of the spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy visit maximum with other Services.

Oxygen

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

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility.

Exclusion:

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

Prescription Drugs and Supplies Purchased from a Pharmacy

Please see the BlueScript® Pharmacy Program section.

Preventive Health Services

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

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

More detailed information, such as medical management programs or limitations, on Services that are covered under the Preventive Health 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 Health 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 Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

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

Exclusion:

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

Prosthetic Devices

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

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

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

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

Exclusion:

Expenses for cosmetic enhancements to artificial limbs

Self-Administered Injectable Prescription Drugs

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

Skilled Nursing Facilities

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

1. room and board;
2. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered while an inpatient (except take-home Drugs);
4. intravenous solutions;

5. Administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the “What Is Not Covered?” section);
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease; and
10. Physical, Speech, and Occupational Therapies.
11. A treatment plan from your Physician may be required in order to determine coverage and payment.

Exclusion:

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

Surgical Assistant Services

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

Surgical Procedures

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

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

   Exclusions:

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

   a) reduction thyroid chondroplasty;
   b) liposuction;
   c) rhinoplasty;
   d) facial bone reconstruction;

e) face lift;

f) blepharoplasty;

g) voice modification surgery;

h) hair removal/hairplasty; or

i) breast augmentation.

Payment Guidelines for Surgical Procedures

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

Transplant Services

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to BCBSF or Suwannee County Board of Public Instruction, subject to the conditions and limitations described below.

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

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. Coverage will be provided for the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;

8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

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

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

Exclusion:

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Benefit Booklet;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant; and
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.

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

Virtual Visits between you and a Virtual Care Provider that is designated by us and under contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion:

1. Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

Section 3: BlueScript® Pharmacy Program

Introduction

Coverage for Prescription Drugs and Supplies and select Over-the-Counter (OTC) Drugs is provided through the BlueScript® Pharmacy Program described in this section. We provide coverage to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits, you must pay, at the time of purchase, the applicable Copayment or percentage of the Participating Pharmacy Allowance indicated on the Schedule of Benefits. Please note that before any payment will be made for Covered Prescription Drugs or Covered OTC Drugs purchased from a Participating Pharmacy, the applicable Deductible must be met and the Copayment, if applicable to your plan, or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance as set forth in the Schedule of Benefits, must be satisfied by you for each Prescription Drug and/or OTC Drug.

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

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

Covered Prescription Drugs and Supplies and Covered OTC Drugs

A Prescription Drug, Covered OTC Drug or Self-Administered Injectable Prescription Drug is covered

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;
3. Medically Necessary, as defined in this Booklet 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 by us, as indicated with a unique identifier in the Medication Guide then in effect;
8. not specifically or generally limited or excluded herein; and
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 for Covered Prescription Drugs and Supplies and Covered OTC Drugs category listed in this section.

A Supply is covered **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.

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

In providing benefits under the BlueScript Pharmacy Program, we may apply the benefit guidelines set forth below, as well as any other applicable payment rules specific to particular Covered Services listed in this section.

Contraceptive Coverage

Prescription diaphragms, oral contraceptives and contraceptive patches will be covered unless indicated as not covered on the Schedule of Benefits and subject to the limitations and exclusions listed in this Benefit Booklet.

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

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

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

   You can obtain an Exception Request Form on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.
2. Diaphragms indicated as covered in the Medication Guide; and
3. Emergency contraceptives indicated as covered in the Medication Guide.

Exclusion:

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants (e.g., Norplant, IUD, etc.) inserted for any purpose are excluded from coverage.

Covered Over-the-Counter (OTC) Drugs

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

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed on our website at www.floridablue.com, or you may call the customer service phone number on your Identification Card and one will be mailed to you upon request.

Diabetic Coverage

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered, subject to the limitations and exclusions listed in this Benefit Booklet. 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 BlueScript Pharmacy Program: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and/or syringes and needles.

Exclusion:

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

Mineral Supplements, Fluoride or Vitamins

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

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

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 excluded from coverage.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the cost share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

Preventive Medications

Certain medications may be available at no Cost Share if they are considered a Preventive Service as outlined in the "What Is Covered?" Section of the Benefit Booklet. Please see the Medication Guide for a list of these medications.

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 will also be split between the two fills.

Limitations and Exclusions

Limitations

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

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 Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
4. Specialty Drugs (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., 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

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific subsection of the "What Is Covered?" section of this Benefit Booklet, (e.g., Prescription Drugs which are dispensed and billed by a Hospital).
2. Except as covered in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for emergency contraceptives, insulin and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this Benefit Booklet.
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes); regardless of the intended use (except for Covered Prescription Supplies).
7. Prescription Drugs and Supplies and OTC Drugs that are:
    a) in excess of the limitations specified in this section or in the Schedule of Benefits;
    b) furnished to you without cost;
    c) Experimental or Investigational;
    d) indicated or used for the treatment of infertility, except when indicated as covered on the Schedule of Benefits;
    e) used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova;

f) prescribed by a Pharmacist;

g) used for smoking cessation, except as indicated as covered under the Preventive Health 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 (e.g., Cialis, Levitra, Viagra, Caverject), except when indicated as covered on the Schedule of Benefits. The exception described in exclusion number 11 does not apply to sexual dysfunction Drugs excluded under this paragraph;

k) purchased from any source (including a pharmacy) outside of the United States;

l) prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America; and

m) OTC Drugs not listed in the Medication Guide.

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

9. Any appetite suppressant, Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control , except when indicated as covered on the Schedule of Benefits.

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

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

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

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

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

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

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

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

16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy

literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by:

a) American Medical Association;

b) National Heart Lung and Blood Institute;

c) American Cancer Society;

d) American Heart Association;

e) National Institutes of Health;

f) American Gastroenterological Association;

g) Agency for Health Care Policy and Research;

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

17. Any amount you are required to pay under this section as indicated on the Schedule of Benefits.
18. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance.
19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.
20. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.
21. Food or medical food products, whether prescribed or not.
22. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a) the Drug is 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 Benefit Booklet.

23. New Prescription Drugs.

Payment Rules

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

1. the participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. the terms of the Pharmacy's agreement with us or our Pharmacy Benefit Manager;

3. whether you have satisfied the applicable Deductible and the amount of Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance you are required to pay as set forth in the Schedule of Benefits;
4. whether the Prescription Drug is a Generic Prescription Drug or a Brand Name Prescription Drug or Covered OTC Drug;
5. whether the Prescription Drug is on the Preferred Medication List;
6. whether the Prescription Drug is purchased from the Mail Order Pharmacy;
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and
8. If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
    a) the Cost Share amount that applies to the Brand Name Prescription Drugs you received as indicated on your Schedule of Benefits; and
    b) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug is Medically Necessary.

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

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

Pharmacy Alternatives

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

Participating Pharmacies

Participating 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 Participating Pharmacy, you may refer to the provider directory then in effect at www.floridablue.com or call the customer service phone number on your ID Card.

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

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

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

Specialty Pharmacy

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

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

The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueScript Pharmacy Program.

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

Mail Order Pharmacy

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

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

Non-Participating Pharmacies

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

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

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

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

Pharmacy Utilization Review Programs

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

We may, at our sole discretion, require that Prescriptions for select Prescription Drugs and Supplies or OTC Drugs be reviewed under our pharmacy utilization review programs, then in effect, in order for there

to be coverage for them. Under these programs, there may be limitations or conditions on coverage for select Prescription Drugs and Supplies and OTC Drugs, depending on the quantity, frequency or type of Prescription Drug, Supply or OTC Drug Prescribed.

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

Our pharmacy utilization review programs include the following:

Responsible Steps

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

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

Responsible Quantity Program

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

Prior Coverage Authorization Program

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

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

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

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

Ultimate Responsibility for Medical Decisions

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

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

Definitions

Certain important terms applicable to the BlueScript Pharmacy Program are set forth below. For additional applicable definitions, please refer to the definitions in the "Definitions" section of this Benefit Booklet.

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

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

Biosimilar Prescription Drug is 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.

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.

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

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under the BlueScript 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:

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

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

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

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

FDA means the United States Food and Drug Administration.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (i) has been approved by the FDA for sale or distribution as the bioequivelant of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (ii) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of BCBSF, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic 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.

Mail Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug and Covered Prescription Supply as set forth in your Schedule of Benefits. Please note, under this BlueScript Pharmacy Program, you must meet the applicable Deductible before the Mail Order Copayment, if applicable, will apply.

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

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

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

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

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

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

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

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

1. In the case of Generic Prescription Drugs and Supplies and OTC Drugs, the Non-Participating Pharmacy Allowance shall be approximately 33 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable Drug is less, the amount billed.
2. In the case of Brand Name Prescription Drugs and Supplies, the Non-Participating Pharmacy Allowance shall be approximately 82 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable Drug is less, the amount billed.

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

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

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

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

Participating Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

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

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

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

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

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 and limitations in this “BlueScript Pharmacy 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.

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

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

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.

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

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy. Specialty Drugs 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 an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program, to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

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.

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

Section 4: What Is Not Covered?

Introduction

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

Abortions which are elective.

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

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

Autopsy or postmortem examination Services, unless specifically requested by BCBSF or Suwannee County Board of Public Instruction.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the Preventive Health Services category of the "What Is Covered?" or “BlueScript® Pharmacy Program” sections.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants,or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, breast augmentation.

Costs related to telephone consultations (except as indicated as covered under the Preventive Health Services category of the "What Is Covered?” section), failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial Care and any Service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home

parents; domestic maid services; respite care; and provision of Services which are for the sole purposes of allowing a family member or caregiver of a Covered Person to return to work.

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

Drugs

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All Drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to Drugs dispensed to you when:
    a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
    b) you are in the outpatient department of a Hospital;
    c) dispensed to your Physician for administration to you in the Physician's office:
        i. by a Specialty Pharmacy under contract with us to provide such medications; and
        ii. prior coverage authorization has been obtained (if required); and
        iii. is indicated as covered in the Medication Guide; or
    d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for Self-Administered Prescription Drugs in connection with a nursing visit.
3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods, except as described in the Preventive Health Services category of the "What Is Covered?" section.
4. Any Drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction Drugs excluded under this paragraph.
5. Any Self-Administered Prescription Drug except when covered under the "BlueScript® Pharmacy Program" section or the "What Is Covered?" section of this Benefit Booklet.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
    a) emergency stabilization;
    b) during a covered inpatient stay, or
    c) when proximately related to a surgical procedure.

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

7. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.
8. New Prescription Drug(s), as defined in the Definitions section.
9. Convenience Kits, as defined in the Definitions section of the Booklet.
10. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Medical Policy Committee or any other nationally recognized source.

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

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

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

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

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

Immunizations except those covered under the Preventive Health Services category of the "What Is Covered?" section.

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

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

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

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

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

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

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;

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

Private Duty Nursing Care rendered at any location.

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

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

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCBSF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Smoking Cessation Programs including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.), except as indicated as covered under the Preventive Health Services category of the "What Is Covered?" section.

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

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

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

Virtual Visits, except as described in the "What Is Covered?" section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and/or does not have a contract with us to provide access to Virtual Visits under this Booklet.

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

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, 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. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a) a licensed outdoor youth program, and/or
    b) a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Section 5: Medical Necessity

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

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

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

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

1. staying in the Hospital because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;
3. staying in the Hospital because supervision in the home, or care in the home, is not available or 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 Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by this Benefit Booklet) or a Covered Service. Please refer to the "Definitions" section for the definitions of "Medically Necessary" or "Medical Necessity".

Section 6: Understanding Your Share of Health Care Expenses

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

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 you 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.

Deductible Requirement

Individual Deductible

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

Family Deductible

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

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.

1. Office Services Copayment:

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

2. Inpatient Facility Copayment:

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

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

3. Outpatient Facility Copayment:

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

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

4. Copayment for Emergency Room Facility Services:

   The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit.

   - If you are admitted to an In-Network Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.
   - If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the Out-of-network Deductible, In-Network Coinsurance and/or Emergency Room Copayment will apply to that admission. Please see your Schedule of Benefits for the applicable Cost Share.

<u>Embedded Out-of-Pocket Maximum</u>

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.

Note: The Deductible, any applicable Copayments and Coinsurance amounts, including those for Covered Prescription Drugs and Supplies, will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums.

Prior Coverage Credit

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

Prior Coverage Credit for Deductible

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

Prior Coverage Credit for Coinsurance

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

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

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

Benefit Maximum Carryover

If immediately before the Effective Date of coverage under this Benefit Booklet, you were covered under a prior group policy issued by BCBSF to Suwannee County Board of Public Instruction, amounts applied to your benefit maximums under the prior BCBSF policy, will be applied toward your benefit maximums under this Booklet, unless otherwise specified on your Schedule of Benefits.

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

Additional Expenses You Must Pay

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

1. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., the Benefit Period maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept the Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any contribution amount required by Suwannee County Board of Public Instruction.

Special Payment Rules

Emergency Services in an Emergency Room

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

Additionally, payments for Emergency Services by an Out-of-Network Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center; and
- you do not have the ability and opportunity to choose an In-Network Provider at the In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center who is available to treat you; and,
- section 627.64194(3) of the Florida Statutes is applicable to the Services rendered.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

How Benefit Maximums Will Be Credited

Only amounts actually paid for Covered Services will be credited towards any applicable benefit maximums. The amounts paid which are credited towards your benefit maximums will be based on the Allowed Amount for the Covered Services provided.

Section 7: Physicians, Hospitals and Other Provider Options

Introduction

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

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

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard Traditional Program Providers, in conformity with the "BlueCard Program" section of this Benefit Booklet.

For information on Pharmacy Provider options, please refer to the "BlueScript® Pharmacy Program" section of this Benefit Booklet.

Provider Participation Status

With BlueOptions, you may choose to receive Services from any Provider. However, you may be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider.

Family Physician Program

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

- Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs.
- Developing and continuing a relationship with a Family Physician allows the Physician to become knowledgeable about you and your family's health history.
- A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs.
- Care rendered by Family Physicians usually results in lower out-of-pocket expenses for you.

We will check our records periodically to see if you have visited a Family Physician. If not, we may provide your name and contact information to an In-Network Family Physician who will call you and offer to schedule a wellness visit. This program is completely voluntary and although we encourage you to schedule this visit, you are not obligated to do so. The applicable Family Physician Cost Share will apply to this visit.

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-Network, refer to the current Provider directory at www.floridablue.com or call the customer service phone number on your ID Card.

Location of Service

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

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

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

In-Network Providers

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

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

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. Payment will be based on the Allowed Amount and will be 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, payment to such Provider may be under the terms of that Provider's contract. If your Schedule of Benefits and BlueOptions Provider directory do not include a Provider as In-Network under your Benefit Plan, the Provider is considered Out-of-Network.

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

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

Other Providers

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

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

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

Assignment of Benefits to Providers

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

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

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard PPO Program Provider; 5) is a BlueCard Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, Florida Statutes ; or 7) is an Ambulance Provider that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, Florida Statutes. A written attestation of the assignment of benefits may be required.

Section 8: BlueCard® Program

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard Program

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees

that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

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

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside Florida

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

Blue Cross Blue Shield Global Core® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Section 9: Blueprint for Health Programs

Introduction

BCBSF has established (and from time to time establishes) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. Under the terms of the ASO Agreement between BCBSF and Suwannee County Board of Public Instruction, BCBSF has agreed to make these programs available to you. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health; 2) help facilitate the management and review of coverage and benefits provided under this Booklet; and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services.

Admission Notification

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

In-Network

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

Out-of-Network

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

Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, 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. The review is conducted solely to determine whether we should provide coverage and/or payment for a particular admission or Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals, including in advance of a transfer from one inpatient facility to another. We will provide notification to your Physician when inpatient coverage criteria are no longer

met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

Provider Focused Utilization Management Program

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

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

Exception for Certain NetworkBlue Physicians

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

a) they give you a written estimate of your financial obligation for the Service;

b) they specifically identify the proposed Service that BCBSF has determined not to be Medically Necessary; and

c) you agree to assume financial responsibility for such Service.

Prior Coverage Authorization/Pre-Service Notification Programs

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

You or your Physician will be required to obtain prior coverage authorization from us for Covered Services listed below. You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

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

Services that Require Prior Authorization

Advanced Diagnostic Imaging Services

You must obtain an authorization for advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, when rendered or referred by a Provider **before** the advanced diagnostic

imaging Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Applied Behavioral Analysis

You must obtain an authorization for Applied Behavioral Analysis for Autism Spectrum Disorder or Down Syndrome, **before** the Services are provided. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Approved Clinical Trials

You must obtain an authorization for Services rendered in connection with Approved Clinical Trials, 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 this plan will not make any payment for such Services**.

Prescription Drugs

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

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

Other Health Care Services

In the case of other Health Care Services under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

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

Additional Information

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.

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 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.

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
   a) the termination date of your plan, or
   b) the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

Member Focused Programs

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

Personal Case Management Program

The personal case management program focuses on members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, BCBSF may, in its sole discretion, assign a personal case manager to you to help coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

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

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

Health Information, Promotion, Prevention and Illness Management Programs

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

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

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

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

Section 10: Eligibility for Coverage

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

Eligibility Requirements for Covered Plan Participants

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

1. The employee must be a bona fide employee of Suwannee County Board of Public Instruction;
2. The employee's job must fall within a job classification identified by Suwannee County Board of Public Instruction;
3. The employee must have completed any applicable Waiting Period identified by Suwannee County Board of Public Instruction; and
4. The employee must meet any additional eligibility requirement(s) required by Suwannee County Board of Public Instruction.

Suwannee County Board of Public Instruction's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of Suwannee County Board of Public Instruction provided such companies and Suwannee County Board of Public Instruction are under common control; and
4. other individuals as determined by Suwannee County Board of Public Instruction (e.g., members of associations or labor unions).

Suwannee County Board of Public Instruction shall have sole discretion concerning the expansion of eligibility classifications.

Eligibility Requirements for Dependent(s)

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

1. The Covered Plan Participant's spouse under a legally valid existing marriage.
2. The Covered Plan Participant's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Plan Participant 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 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Plan Participant, whether the

dependent child resides with the Covered Plan Participant, or whether the dependent child is eligible for or enrolled in any other group health plan.

Section 11: Enrollment and Effective Date of Coverage

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

Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Booklet. Neither BCBSF nor Suwannee County Board of Public Instruction will have any obligation whatsoever to any individual who is not properly enrolled.

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

Enrollment Forms/Electing Coverage

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

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

When making application for coverage, you must elect one of the types of coverage available under Suwannee County Board of Public Instruction's program. Such types may include:

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

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

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

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

There may be additional contribution amounts for each Covered Dependent based on the coverage selected by Suwannee County Board of Public Instruction.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

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

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in Suwannee County Board of Public Instruction’s health benefit program. The period is established by Suwannee County Board of Public

Instruction, occurs annually, and will take place when specified by Suwannee County Board of Public Instruction.

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

Employee Enrollment

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

Dependent Enrollment

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

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must submit an Enrollment Form to BCBSF through Suwannee County Board of Public Instruction during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

If timely notice is given, no additional contribution will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child if the Covered Plan Participant provides notice to Suwannee County Board of Public Instruction and an Enrollment Form is received within the 60-day period of the birth of the child and any applicable contribution is paid back to the date of birth.

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

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

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

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

contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for an adopted newborn child if the Covered Plan Participant provides notice to Suwannee County Board of Public Instruction and an Enrollment Form is received within the 60-day period of the birth of the adopted newborn child and any applicable contribution is paid back to the date of birth.

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

If the adopted newborn child is not ultimately placed in the residence of the Covered Plan Participant, there shall be no coverage for the adopted newborn child. It is your responsibility as the Covered Plan Participant to notify Suwannee County Board of Public Instruction within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

Adopted/Foster Children – To enroll an adopted or Foster Child, the Covered Plan Participant must submit an Enrollment Form during the 30-day period immediately following the date of placement. The Effective Date for an adopted or Foster Child (other than an adopted newborn child) will be the date such adopted or Foster Child is placed in the residence of the Covered Plan Participant in compliance with Florida law. The Covered Plan Participant may be required to provide any information and/or documents deemed necessary, in order to properly administer this section.

In the event Suwannee County Board of Public Instruction is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as Covered Plan Participant provides notice to Suwannee County Board of Public Instruction, and we receive the Enrollment Form within 60 days of the placement. If the adopted or Foster Child is not enrolled within sixty days of the date of placement, the adopted or Foster Child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted Child. Proof of final adoption must be submitted to BCBSF through Suwannee County Board of Public Instruction. It is the responsibility of the Covered Plan Participant to notify BCBSF through Suwannee County Board of Public Instruction if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Plan Participant to notify BCBSF through Suwannee County Board of Public Instruction that the Foster Child is no longer in the Covered Plan Participant's care. Upon receipt of this notification, coverage for the child will be terminated on the date the Covered Plan Participant's status as a foster parent terminated.

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

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

Annual Open Enrollment Period

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

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the date established by Suwannee County Board of Public Instruction.

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

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependent(s) must complete the applicable Enrollment Form and forward it to the Group within the time periods noted below for each special enrollment event.

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

1. If you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Program (CHIP) or Medicaid, see #3 below), or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:

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

   b) you lost your other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and

   c) you submit the applicable Enrollment Form to the Group within 30 days of the date your coverage was terminated

   Note: Loss of coverage for failure to pay your required contribution/premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

   or

2. If when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption and you submit the applicable Enrollment Form to the Group within 30 days of the date of the event.

or

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

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

Other Provisions Regarding Enrollment and Effective Date of Coverage

Rehired Employees

Individuals who are rehired as employees of Suwannee County Board of Public Instruction are considered newly hired employees for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Group Health Plan (which includes this Booklet), which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, and Waiting Period) are applicable to rehired employees and their Eligible Dependents if the employee does not qualify for the federal exception.

Section 12: Termination of Coverage

Termination of a Covered Plan Participant's Coverage

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

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

Termination of a Covered Dependent's Coverage

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

1. the Group Health Plan terminates;
2. the Covered Plan Participant's coverage terminates for any reason;
3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group Health Plan;
4. last day of the Calendar Year that the Covered Dependent child no longer meets any of the applicable eligibility requirements;
5. the Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

In the event you as the Covered Plan Participant wish to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to BCBSF through Suwannee County Board of Public Instruction prior to the termination date requested.

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

Termination of an Individual's Coverage for Cause

In the event any of the following occurs, Suwannee County Board of Public Instruction may terminate an individual's coverage for cause:

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

Notice of Termination

It is Suwannee County Board of Public Instruction's responsibility to immediately notify you of your termination or that of your Covered Dependents for any reason.

Section 13: Continuing Coverage Under COBRA

Federal Continuation of Coverage Law

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

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

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

The following is a summary of what you may elect, if COBRA applies to Suwannee County Board of Public Instruction and you are eligible for such coverage:

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

   ***Note:** You and your Covered Dependents are eligible for an 11-month extension of the 18-month COBRA continuation option above (to a total of 29 months) if you or your Covered Dependent is totally disabled, as defined by the Social Security Administration (SSA) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Person must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.
2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
   a) the Covered Plan Participant's entitlement to Medicare;
   b) divorce or legal separation of the Covered Plan Participant;
   c) death of the Covered Plan Participant;
   d) the employer filing bankruptcy (subject to bankruptcy court approval); or
   e) a Dependent child may elect the 36-month extension if the Dependent child ceases to be an Eligible Dependent under the terms of Suwannee County Board of Public Instruction's coverage.

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

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

1. Suwannee County Board of Public Instruction must notify you of your continuation of coverage rights under COBRA within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify Suwanne County

Board of Public Instruction, in writing, within 60 days of any of these events. Suwannee County Board of Public Instruction's 14-day notice requirement runs from the date of receipt of such notice.

2. You must elect to continue the coverage within 60 days of the later of:
   a) the date that the coverage terminates; or
   b) the date the notification of continuation of coverage rights is sent by Suwannee County Board of Public Instruction.
3. COBRA coverage will terminate if you become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the Social Security Administration that you are no longer disabled. You must inform Suwannee County Board of Public Instruction of the Social Security Administration's determination within 30 days of such determination.
6. You must meet all contribution requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in the Group Health Plan.
7. Suwannee County Board of Public Instruction must continue to provide group health coverage to its employees.

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Benefit Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to Suwannee County Board of Public Instruction.

Section 14: Conversion Privilege

Eligibility Criteria for Conversion

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

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

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

We must receive a completed application for a converted policy, and the applicable premium payment, within the 63-day period beginning on the date the coverage under the Group Health Plan terminated. If coverage has been terminated due to the non-payment of employee contribution by Suwannee County Board of Public Instruction, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Health Plan terminated.

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

Additionally, you are not entitled to a converted policy if

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

    b) the benefits provided under the sources referred to in paragraph 4.a.i or the benefits provided or available under the source referred to in paragraph 4.a.ii. and 4.a.iii. above, together with the benefits

provided by our converted policy would result in over insurance in accordance with our over insurance standards, as determined by us.

Neither Suwannee County Board of Public Instruction nor BCBSF has any obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial premium payment to us within 63 days of the termination of your coverage under this Benefit Booklet. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under this Benefit Booklet is terminated.

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

Section 15: Extension of Benefits

Extension of Benefits

In the event the Group Health Plan is terminated, coverage will not be provided under this Benefit Booklet for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire Group Health Plan is terminated. The extension of benefits described in this section does not apply when your coverage terminates, if the Group Health Plan remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

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

1. In the event you are totally disabled on the termination date of the Group Health Plan as a result of a specific Accident or illness incurred while you were covered under this Booklet, as determined by us, a limited extension of benefits will be provided under this Benefit Booklet for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. In any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

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

2. In the event you are receiving covered dental treatment as of the termination date of the Group Health Plan, a limited extension of such covered dental treatment will be provided under this Benefit Booklet if:

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

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

   c) the dental procedures were performed within 90 days after the Group Health Plan terminated.

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

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

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

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

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

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

If you become 65 or become eligible for Medicare due to End Stage Renal Disease ("ESRD"), you must notify Suwannee County Board of Public Instruction.

Individuals With End Stage Renal Disease

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

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

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

Disabled Active Individuals

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

Suwannee County Board of Public Instruction employed at least 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year. If the Group Health Plan is a multi-employer plan, as defined by Medicare, Medicare benefits will be secondary if at least one employer participating in the plan covered 100 or more employees under the plan on 50% or more of its regular business days during the previous Calendar Year.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Benefit Booklet.
2. BCBSF will not be liable to Suwannee County Board of Public Instruction or to any individual covered under this Benefit Booklet on account of any nonpayment of primary benefits resulting from any failure of performance of Suwannee County Board of Public Instruction's obligations as described in this section.

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

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided under this Benefit Booklet.

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

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

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

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

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

1. 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 Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
   a) the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;

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

4. When we cover a dependent child whose parents are not married, or are separated or divorced:
   a) the plan of the parent with custody is primary;
   b) the plan of the remarried parent with custody is primary; the step-parent's plan is secondary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; and
   c) the plan of the parent without custody is last;
   d) regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:
   a) the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:
   a) first, the plan covering the person as an employee, or as the employee's dependent; and
   b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.
7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.
8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

Non-Duplication of Government Programs and Workers' Compensation

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

Section 18: Claims Processing

Introduction

This section is intended to:

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

Under no circumstances will we be held responsible for, nor will we accept liability relating to, the failure of your Group Plan's sponsor or plan administrator to: 1) comply with applicable disclosure requirements; 2) provide you with a Summary Plan Description (SPD) or 3) comply with any other legal requirements. You should contact Suwannee County Board of Public Instruction if you have questions relating to your Group Plan's SPD. We are not your Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

The Processing of Post-Service Claims

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

- Payment for Post-Service Claims

When payment is due under the terms of this Benefit Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more or additional information, we may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims

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

- Denial of Post-Service Claims

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

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

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

Additional Processing Information for Post-Service Claims

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

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

Pre-Service Claims

How to File a Pre-Service Claim

This Benefit Booklet may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the “What Is Covered?” section and other applicable sections of your Benefit Booklet. You may also call the customer service number on your Identification card for assistance.
We are not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to you unless the terms of this Benefit Booklet require (or condition payment upon) approval by us for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

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

reasons for it. We will use our best efforts to provide notification of the decision on your Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by us.

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

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

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

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

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of your request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: 1) we need additional information; or 2) you or your representative failed to follow proper procedures in your request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination:

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

1. the date the Service or supply was provided;

2. the Provider's name;
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;
7. a description of the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
8. a description of any additional information that might change the determination and why that information is necessary;
9. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures;
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; and
11. You have the right to an independent external review through an external review organization for certain appeals, as provided in the Patient Protection and Affordable Care Act of 2010.

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 three days after the oral notification.

How to Appeal an Adverse Benefit Determination

Except as described below, only you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the review process described below. Your appeal must be submitted to us in writing for an internal appeal within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

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. We must receive your appeal of an Adverse Benefit Determination in person or in writing.
4. 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.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the

final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.

6. 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 the Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.
10. 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.
11. 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.
12. 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.
13. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.
14. 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.
15. 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 Decision subsection below.

Appeals must be sent to the address below:

Blue Cross and Blue Shield of Florida
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:

- Pre-Service Claims: within 30 days of the receipt of your appeal; or
- Post-Service Claims: within 60 days of the receipt of your appeal; or

- Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

Note: The nature of a claim for Services (i.e. whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements ("Deemed Exhaustion") and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

How to Request External Review of Our Appeal Decision

If we deny your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational, you are entitled to request an independent, external review of our decision. Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

Blue Cross and Blue Shield of Florida
Attention: Member External Reviews DCC9-5
Post Office Box 44197
Jacksonville, FL 32231-4197

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

If the External Reviewer decides to overturn our decision, we will provide coverage or payment for your health care item or Service.

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.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

   In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

   In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a health care Provider of our choice as often as is reasonably necessary while a claim is pending. Failure by you to fully cooperate with such examination shall result in a denial of the pending claim and we shall have no liability for such claim.

3. Legal Actions:

   No legal action arising out of or in connection with coverage under this Benefit Booklet may be brought against BCBSF or Suwannee County Board of Public Instruction within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

   The information provided on the itemized statement and the claim form is relied upon by BCBSF 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 available legal remedy, in denial of the claim or cancellation or rescission of your coverage.

5. Explanation of Benefits Form:

   All claims decisions, including denial and claims review decisions, will be communicated to you in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

   a) The specific reason or reasons for the Adverse Benefit Determination;

   b) Reference to the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

   c) A description of any additional information that would change the initial determination and why that information is necessary;

   d) A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

e) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond Our Control:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Services, taking into account the impact of the event. For purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

ERISA Civil Action Provision

If a federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, applies to your Group Benefit Plan. You or your Covered Dependents may be entitled, after exhaustion of the appeal procedures provided for in this section, to pursue a civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Section 19: Relationships Between the Parties

BCBSF/Suwannee County Board of Public Instruction and Health Care Providers

Neither BCBSF nor Suwannee County Board of Public Instruction nor any of their respective officers, directors or employees provides Health Care Services to you. Rather, BCBSF and Suwannee County Board of Public Instruction are engaged in making coverage and benefit decisions under this Booklet. By accepting the Group health care coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those Services are not employees or agents of BCBSF or Suwannee County Board of Public Instruction. **In this regard, we and Suwannee County Board of Public Instruction hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and Suwannee County Board of Public Instruction 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 under the Group Health Plan concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. Neither BCBSF nor Suwannee County Board of Public Instruction will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and Suwannee County Board of Public Instruction

Neither Suwannee County Board of Public Instruction nor any person covered under this Booklet is BCBSF's agent or representative, and neither shall be liable for any acts or omissions by BCBSF's agents, servants, employees, or us. Additionally, neither BCBSF nor Suwannee County Board of Public Instruction will be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. BCBSF is not your agent, servant, or representative nor is BCBSF an agent, servant, or representative of Suwannee County Board of Public Instruction and we will not be liable for any acts or omissions, or those of Suwannee County Board of Public Instruction, its agents, servants, employees, or any person or organization with which Suwannee County Board of Public Instruction has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical Services or supplies, must be made solely by your family and your treating Physician in accordance with the patient/physician relationship. It is possible that you or your treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 20: General Provisions

Access to Information

BCBSF and Suwannee County Board of Public Instruction have the right to receive, from you and any health care Provider rendering Services to you, information that is reasonably necessary, as determined by BCBSF and Suwannee County Board of Public Instruction, in order to administer the coverage and benefits provided, subject to all applicable confidentiality requirements listed below. By accepting coverage, you authorize every health care Provider who renders Services to you, to disclose to BCBSF and Suwannee County Board of Public Instruction 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 BCBSF and/or Suwannee County Board of Public Instruction to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, BCBSF or Suwannee County Board of Public Instruction may, without the consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to any person covered under this Booklet or applicant for enrollment which BCBSF or Suwannee County Board of Public Instruction deems to be necessary.

Right to Recovery

Whenever the Group Health Plan has made payments in excess of the maximum provided for under this Booklet, BCBSF or Suwannee County Board of Public Instruction will have the right to recover any such payments, to the extent of such excess, from you or any person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Benefit Booklet shall be deemed to have been modified and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or Services under this Booklet. Further, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

BCBSF's arrangements with a Provider may require that we release certain claims and medical information about persons covered under this Booklet to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any such Provider to evaluate your financial responsibility under this Booklet.

Benefit Booklet

You have been provided with this Benefit Booklet and an Identification Card as evidence of coverage under Suwannee County Board of Public Instruction's Group Health Plan.

Modification of Provider Network and the Participation Status

NetworkBlue, and the participation status of individual Providers available under this Booklet, are subject to change at any time by BCBSF without prior notice to you or your approval or that of Suwannee County Board of Public Instruction. Additionally, BCBSF may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to you or your approval, or that of, Suwannee County Board of Public Instruction. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time the Health Care Service is rendered. Under this Booklet, your financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of You and Your Covered Dependents

You must cooperate with BCBSF and Suwannee County Board of Public Instruction, and must execute and submit to us any consents, releases, assignments, and other documents requested in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause (See the "Termination of an Individual's Coverage for Cause" subsection in the "Termination of Coverage" section).

Non-Waiver of Defaults

Any failure by BCBSF or Suwannee County Board of Public Instruction at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect BCBSF's or Suwannee County Board of Public Instruction's right at any time to enforce any terms or conditions under this Benefit Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

If to BCBSF:

To the address printed on the Identification Card.

If to you:

To the latest address provided by you or to your latest address on Enrollment Forms actually delivered to us.

You must notify us immediately of any address change.

If to Suwannee County Board of Public Instruction:

To the address indicated by Suwannee County Board of Public Instruction.

Our Obligations upon Termination

Upon termination of your coverage for any reason, there will be no further liability or responsibility to you under the Group Health Plan, except as specifically described herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Booklet.

Florida Agency for Health Care Administration Performance Data

The performance outcome and financial data published by the Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute, located at the web site address www.floridahealthfinder.gov, may be accessed through the link provided on the Blue Cross and Blue Shield of Florida corporate web site at www.floridablue.com.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its

representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of, Suwannee County Board of Public Instruction and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Suwannee County Board of Public Instruction hereby specifically expresses its intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the terms of the Suwannee County Board of Public Instruction Group Health Plan or this Benefit Booklet.

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Section 21: Definitions

The following definitions are used in this Benefit Booklet. Other definitions may be found in the particular section or subsection where they are used. For other important definitions, please refer to the definition subsection within the "BlueScript® Pharmacy Program" section.

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Administrative Services Only Agreement or **ASO Agreement** means an agreement between Suwannee County Board of Public Instruction and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to BCBSF's NetworkBlue and BCBSF's network of Traditional Insurance Providers.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Benefit Booklet with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in the Claims Processing section, shall also constitute an Adverse Benefit Determination.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard 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 BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by BCBSF that may be based on several factors including (but not necessarily limited to): (i) payment for such Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as

participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by BCBSF, with BCBSF's provider network strategies (e.g., does not result in payment that encourages Providers participating in a BCBSF network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the Allowed Amount for the specific Covered Services provided to you may be based upon the amount provided to BCBSF by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating Providers in its geographic area for such Services.

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular Services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What Is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much will be paid.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between such Allowed Amount and the amount billed for such Services by any such Out-of-Network Provider.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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:

i. The Department of Veterans Affairs.

ii. The Department of Defense.

iii. 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.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;

2. Asperger's syndrome;

3. Pervasive developmental disorder not otherwise specified; and

4. Childhood Disintegrative Disorder.

Benefit Period means a consecutive period of time, specified by BCBSF and the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your Benefit Period is listed on your Schedule of Benefits, and will not be less than 12 months unless indicated as such.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the Florida Statutes, or a similar applicable law of another state, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.

BlueCard® Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. 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 PPO Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard 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 Traditional Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard 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 PPO Program Provider means a Provider designated as a BlueCard PPO Program Provider by the Host Blue.

BlueCard Traditional Program Provider means a Provider designated as a BlueCard Traditional Program Provider by the Host Blue.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary Services).

Calendar Year begins January 1st and ends December 31st.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or 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 your share of health care expenses for Covered Services. After your Deductible requirement is met, a percentage of the Allowed Amount will be paid for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management program as described in the "Blueprint for Health Programs" section of the Benefit Booklet.

Condition means a disease, illness, ailment, injury, or pregnancy.

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

Convenient Care Center means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one master's level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

Copayment means the dollar amount established solely by Suwannee County Board of Public Instruction which is required to be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to Coinsurance, Copayment, Deductible and/or Per Admission Deductible (PAD) amounts. Applicable Cost Share amounts are identified in your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Plan Participant (See the "Eligibility Requirements for Dependent(s)" subsection of the "Eligibility for Coverage" section).

Covered Person means a Covered Plan Participant or a Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under this Benefit Booklet other than as a Covered Dependent.

Covered Services means those Health Care Services which meet the criteria listed in the "What Is Covered?" section.

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Booklet, before payment for Covered Services begins.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) and the Florida Agency for Health Care Administration or a similar regulatory agency of another state to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services.

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent;
5. the Covered Plan Participant has submitted acceptable proof of evidence of common residence and joint financial responsibility to the Group; and
6. the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law or a similar applicable law of another state to provide home medical equipment, oxygen therapy Services, or dialysis supplies in the patient’s home under a Physician’s prescription.

Effective Date means, with respect to Suwannee County Board of Public Instruction, 12:01 a.m. on the date the ASO Agreement went into effect. With respect to individuals covered under this Benefit Booklet, 12:01 a.m. on the date Suwannee County Board of Public Instruction specifies that the coverage will commence as further described in the “Enrollment and Effective Date of Coverage” section of this Benefit Booklet.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section in this Benefit Booklet, and is eligible to enroll as a Covered Dependent.

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the "Eligibility Requirements for Covered Plan Participants" subsection of the "Eligibility for Coverage" section in this Benefit Booklet and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Plan Participant until such individual has actually enrolled with, and been accepted for coverage as a Covered Plan Participant by Suwannee County Board of Public Instruction.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

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 an amendment to the Group Health Plan or this Benefit Booklet.

Enrollment Date means the date of enrollment of the individual under the Group Health Plan or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under this Benefit Booklet..

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by BCBSF or Suwannee County Board of Public Instruction:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or
4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently

published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific evidence" shall mean (as determined by BCBSF or Suwannee County Board of Public Instruction):

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services which are determined by BCBSF or Suwannee County Board of Public Instruction to be Experimental or Investigational are excluded (see the “What Is Not Covered?” section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF or Suwannee County Board of Public Instruction 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.

FDA means the United States Food and Drug Administration.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with Florida Statutes or by a similar regulatory agency of another state in compliance with that state’s applicable laws.

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Group means the employer, labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits are provided, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or Group Plan means the plan established and maintained by Suwannee County Board of Public Instruction for the provision of health care coverage and benefits to the individuals covered under this Benefit Booklet.

Health Care Services or Services includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds, and other Services rendered or supplied, by or at the direction of, Providers.

Home Health Agency means a properly licensed agency or organization which provides Health Care Services in the home pursuant to Chapter 400 of the Florida Statutes, or a similar applicable law of another state.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization which is duly licensed by the state of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Identification Card means the card(s) issued to Covered Plan Participants. The card is not transferable to another person. Possession of such card in no way guarantees that a particular individual is eligible for, or covered under, this Benefit Booklet.

Independent Clinical Laboratory means a laboratory properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Facility means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all

applicable Florida law or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an Independent Diagnostic Testing Facility.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on the Schedule of Benefits under the heading “In-Network”. Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Benefit Booklet.

In-Network Provider means any health care Provider who, at the time Covered Services were rendered to you, was under contract with BCBSF to participate in BCBSF’s NetworkBlue and included in the panel of providers designated by BCBSF as “In-Network” for your specific plan. (Please refer to your Schedule of Benefits). For payment purposes under this Benefit Booklet only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard 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 a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statues, or a similar applicable law of another state.

Massage Therapist means a person properly licensed to practice Massage, pursuant to Chapter 480 of the Florida Statutes, or a similar applicable law of another state.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Benefit Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means 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, or 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 Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Benefit Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Medication Guide for the purpose of this Benefit Booklet means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

Note: The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card for current information.

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 ICD 10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state.

NetworkBlue means, or refers to, the preferred provider network established and so designated by BCBSF which is available to individuals covered under this Benefit Booklet. Please note that BCBSF's Preferred Patient Care (PPC) preferred provider network is not available to individuals covered under this Benefit Booklet.

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Occupational Therapist means a person properly licensed to practice Occupational Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on the Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of this Benefit Booklet.

Out-of-Network Provider means a Provider who, at the time Health Care Services were rendered:

1. did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or
2. did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard PPO Program but was participating, for purposes of the BlueCard Program, as a BlueCard Traditional Program Provider; or
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue or our Traditional Program; or
5. did not have a contract with a Host Blue to participate for purposes of the BlueCard Program as a BlueCard Traditional Program Provider.

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; outpatient Cardiac Therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet BCBSF's criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, Florida Administrative Code or the similar law or laws of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 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.

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the Florida Statutes, or a similar applicable law of another state.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

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 this Benefit Booklet.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of the Benefit Booklet condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of the Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

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".

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Health Services covered under your plan. **Note:** The Preventive Services Guide is subject to change Please refer to our website at www.floridablue.com/healthresources for the most current guide.

Prosthetist/Orthotist means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide Services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

Provider means any facility, person or entity recognized for payment by BCBSF under this Booklet.

Provider Incentive means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse First Assistant (RNFA) means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

Rehabilitation Services means Services for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to cardiac rehabilitation, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage Therapy.

Rehabilitative Therapies means therapies, the primary purpose of which, is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

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.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Skilled Nursing Facility means an institution or part thereof which meets BCBSF's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by BCBSF.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

Specialty Drug means an FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs 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.

Speech Therapy means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy Services.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

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: 1) the United States Pharmacopoeia Drug Information; 2) the American Medical Association Drug Evaluation; or 3) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the

purposes of this Booklet, a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's use of alcohol or any other substance injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Traditional Program means, or refers to, BCBSF's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS).

Traditional Program Providers means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, have entered into a contract, then in effect, to participate in BCBSF's Traditional Program as applicable in Florida or in certain counties outside of Florida when such programs exist.

Urgent Care Center means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For purposes of this Benefit Booklet, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

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.

Virtual Care Provider is a licensed Provider that is designated by us to provide care and treatment options by way of Virtual Visits. An In-Network Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications. Virtual Visits shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

Waiting Period means the length of time specified by Suwannee County Board of Public Instruction which must be met by an individual before that individual becomes eligible for coverage under this Benefit Booklet.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

Templates Included

Compliance/Notices/Meaningful Access Notice.jld
Compliance/Notices/Prior Authorization (Preapproval) of Medical and Pharmacy Services Notice.jld
Compliance/Notices/Privacy Notice - Breast Reconstruction Notice.jld

78170-05192--Schedule-Of-Benefits-2
78170-05192--Benefit-Booklet-1

MATCHING CRITERIA

Record Number	949
Request Type	M
Health Product	BLUEOPTIONS
Small Group	N
Rx Product	BLUESCRIPT
Rx Plan	85
Health Plan	05192
IRX	Y
Generic Choices	N
Generic Only	N
Closed Formulary	N
HSA	Y
HSA-BRX	N
Standard	N
Basic	N
ACA	N
RX CoIns	N
ICC	N
CP-GF-BEN-IND	N
CP-GF-STATUS-IND	N
CP-GROUP-SUB	G
CP-GENERATION-IND	3
CP-EXCHANGE-IND	N
CP-RX-DED-IND	N

CP-RX-NGF-2012-HCR-IND	Y
CP-RX-GF-2012-HCR-IND	N
TAG-RX-SUFFIX	G
AON	N
CP-ASO-IND	Y
ROUTE	GROUP
EFF-YEAR	21
PMT_KEY	02116402552010003302003794 9
GRP-PKG-EFF-YEAR	21
GRP-NO	78170
DIV-NO	R07
PKG-NO	01
FEEDER1	0
FEEDER2	0
FEEDER3	0
FEEDER4	0
FEEDER5	0
FEEDER6	0
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DATE	6/5/21 11:25 AM

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

SUWANNEE CNTY BOARD OF PUBLIC
ATTN TERESA JONES
1740 OHIO AVE S
LIVE OAK FL 32064-4500

Thanks for choosing Florida Blue! See the enclosed **Welcome brochure** for everything you need to get the most value from your health plan. For plan info on the go, download the Florida Blue app or log in to your account at floridablue.com.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of
Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

This Master Contract is for SUWANNEE CNTY BOARD OF PUBLIC

Group Number 78170

Division(s)	Package	Division	Package

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

In the pursuit of health®

Notice Regarding Prior Authorization (Preapproval) of Medical and Pharmacy Services

MAKE SURE YOUR SERVICES ARE COVERED –
CHECK FIRST FOR PREAPPROVAL

For some services or drugs, your doctor needs to get preapproval before your plan will cover them. This does three important things: ensures coverage from your plan, guides you to quality care and helps you save money.

If your doctor doesn't get approval, you may have to pay the entire medical bill.

For an updated list of services that need preapproval, go to floridablue.com/authorization. You can also click the link in the "Authorizations" section on the homepage of your member account.

Talk with your doctor to find out if they've gotten preapproval. You can also call us at 800-352-2583.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc., d/b/a/ Florida Blue, Health Options, Inc., d/b/a Florida Blue HMO, and BeHealthy Florida, Inc., d/b/a Florida Blue Preferred HMO, collectively referred to as Florida Blue in this Notice) understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:
We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information, and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:
We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.
There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:
To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to

a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
- **Note:** If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Notice Regarding Coverage for Breast Reconstruction Surgery

If you have to have a mastectomy, your breast reconstruction surgery is covered under your health coverage. It can be done at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

BlueOptions **with Integrated Prescription Drug Coverage**

Schedule of Benefits - Plan 05193 Family Coverage

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period .....01/01 - 12/31

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED) - Embedded*		
Per Person per Benefit Period	$3,500	$10,000
Per Family per Benefit Period	$7,000	$10,000
Per Admission Deductible (PAD)	Not Applicable	$500
Coinsurance - The percentage of the Allowed Amount **you pay** for Covered Services	30%	40%
Out-of-Pocket Maximums - Embedded*		
Per Person per Benefit Period	$6,500	$23,200
Per Family per Benefit Period	$13,000	$23,200

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the DED and Out-of-Pocket Maximum amounts.

*Refer to the Understanding Your Share of Health Care Expenses section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Out-Of-Pocket Maximums amounts are satisfied.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office Visits rendered by Family Physicians	DED + 30%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 30%	DED + 40%
Allergy Injections rendered by Family Physicians	DED + 30%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 30%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by Family Physicians	DED + 30%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 30%	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 30%	DED + 40%
Convenient Care Centers	DED + 30%	DED + 40%

Virtual Health

Benefit Description	You Pay
Virtual Visits General Medicine and Urgent Care rendered by a designated Virtual Care Provider	DED + 30%
Specialized Care rendered by a designated Virtual Care Provider	DED + 30%

Please visit http://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by: Family Physicians	DED + 30%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	DED + 30%	DED + 50%
Out-of-Pocket Maximum per Person per Month (applies only after DED is satisfied)	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Adult Well Woman Services Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	DED	DED + 40%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 30%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 30%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 30%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 30%	DED + 30%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	DED + 30%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 30%	In-Network DED + 30%
Other health care professional Services rendered by all other Providers	DED + 30%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	DED + 30%	DED + 35%	**PAD + DED + 40%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%
Outpatient			
Facility (per visit)	DED + 30%	DED + 35%	DED + 40%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%
Therapy Services	DED + 30%	DED + 35%	DED + 40%
Emergency Room Visits			
Facility	DED + 30%		DED + 30%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and In-Network Coinsurance will apply to that 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. This plan 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. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

BlueScript® Pharmacy Program

All Covered Prescription Drugs, Covered Over-the-counter (OTC) Drugs and Covered Prescription Supplies purchased from a Pharmacy are subject to the **In-Network DED**, which must be satisfied by you before any payment will be made by us. To verify if a Pharmacy is a Participating Pharmacy, you may access a current pharmacy directory, refer to our website at www.floridablue.com, or call the customer service phone number on your Benefit Booklet or Identification Card.

Retail Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a One-Month Supply	DED + $10	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a One-Month Supply	DED + $50	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $80	DED + 50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a Three-Month Supply	DED + $25	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $125	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $200	DED + 50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a One-Month Supply	DED + $10	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a One-Month Supply	DED + $50	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $80	DED + 50% of the Non-Participating Pharmacy Allowance

* Our payment for Covered Prescription Drugs is based on the **Participating Pharmacy Allowance.**

** Our payment for Covered Prescription Drugs is based on the **Non-Participating Pharmacy Allowance** and may be less than the cost of the Drug or Supply. You are responsible for any charges in excess of the Non-Participating Pharmacy Allowance for purchases at Non-Participating Pharmacies.

Other Important information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

     Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;

  2. Diaphragms indicated as covered in the Medication Guide; and

  3. Emergency contraceptives indicated as covered in the Medication Guide.

- The Specialty Pharmacies designated, solely by us, are the only "Participating Pharmacy" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us in the Medication Guide as a Specialty Pharmacy is considered a Non-Participating Pharmacy for payment purposes under this BlueScript Pharmacy Program.
- 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.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
- You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. This note does not apply to Specialty Drugs, which are covered only up to a One-Month Supply.
- Amounts incurred for Covered Prescription Drugs, Over-the-Counter Drugs and Covered Prescription Supplies will be applied to the In-Network Out-of-Pocket Maximum as indicated in this Schedule of Benefits.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services		
Outpatient		
Facility Services rendered at:		
Emergency Room	DED + 30%	In-Network DED + 30%
Hospital	DED + 30%	DED + 40%
Physician Services at Hospital and ER	DED + 30%	In-Network DED + 30%
Physician and other health care professionals licensed to perform such Services rendered at:		
Family Physician office	DED + 30%	DED + 40%
Specialist office	DED + 30%	DED + 40%
All other locations	DED + 30%	DED + 40%
Inpatient		
Facility Services	DED + 30%	PAD + DED + 40%
Physician and other health care professionals licensed to perform such Services	DED + 30%	In-Network DED + 30%

Benefit Maximums

Home Health Care Visits per Benefit Period 20

Inpatient Rehabilitation days per Benefit Period 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility Days per Benefit Period 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

BlueOptions

With Integrated Prescription Drug Coverage Benefit Booklet for the Suwannee County Board of Public Instruction Group Health Plan

A Self-funded Group Health Benefit Plan

Effective: May 1, 2021

For Customer Service Assistance: 800-664-5295

Group 78170
Plans 05192, 05193

Benefit Booklet

BlueOptions

for Self-Funded Groups
Benefit Booklet

CUSTOMER SERVICE ASSISTANCE:
800-664-5295

Group 78170
Plans 05192, 05193

Benefit Booklet

Table of Contents

Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet ("Booklet"). It describes your coverage, benefits, limitations and exclusions for the self-funded Group Health Benefit Plan ("Group Health Plan" or "Group Plan") established and maintained by Suwannee County Board of Public Instruction.

The sponsor of your Group Health Plan has contracted with Blue Cross Blue Shield of Florida, Inc. (BCBSF), under an Administrative Services Only Agreement ("ASO Agreement"), to provide certain third party administrative services, including claims processing, customer service, and other services, and access to certain of its Provider networks. BCBSF provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to Covered Persons or claims submitted for processing under this Benefit Booklet for such Services. The payment of claims under the Group Health Plan depends exclusively upon the funding provided by or through Suwannee County Board of Public Instruction.

You should read your Benefit Booklet carefully before you need Health Care Services. It contains valuable information about:

- your BlueOptions benefits;
- what is covered;
- what is excluded or not covered;
- coverage and payment rules;
- Blueprint for Health Programs;
- how and when to file a claim;
- how much, and under what circumstances, payment will be made;
- what you will have to pay as your share;
- and other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how benefits will be coordinated with other policies or plans; the Group Health Plan's subrogation rights; and right of reimbursement.

You will need to refer to the Schedule of Benefits to determine how much you have to pay for particular Health Care Services.

When reading your Booklet, please remember that:

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.
- references to "we", "us", and "our" throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as "BCBSF."

- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section or defined within the particular section where it is used.

Where do you find information on…

- **what particular types of Health Care Services are covered?**

  Read the "What Is Covered?", "BlueScript® Pharmacy Program", and "What Is Not Covered?" sections.

- **how much will be paid under your Group Health Plan and how much you have to pay?**

  Read the "Understanding Your Share of Health Care Expenses" section along with the Schedule of Benefits.

- **how to take advantage of the BlueCard® Program when you receive Services out-of-state?**

  Read the "BlueCard® Program" section.

- **how to add or remove a Dependent?**

  Read the "Enrollment and Effective Date of Coverage" section.

- **what happens if you are covered under this Benefit Booklet and another health plan**?

  Read the "Duplication of Coverage Under Other Health Plans/Programs" section.

- **what happens when your coverage ends?**

  Read the "Termination of Coverage" section.

- **what do the terms used throughout this Booklet mean?**

  Read the "Definitions" section.

Overview of How BlueOptions Works

Whenever you need care, you have a choice. If you visit an:	
In-Network Provider	**Out-of-Network Provider**
You receive In-Network benefits, the highest level of coverage available.	You receive the Out-of-Network level of benefits – you will share more of the cost of your care.
You do not have to file a claim; the claim will be filed by the In-Network Provider for you.	You may be required to submit a claim form.
The In-Network Provider* is responsible for Admission Notification if you are admitted to the Hospital.	You should notify BCBSF of inpatient admissions.

* For Services rendered by an In-Network Provider located outside of Florida, you should notify us of inpatient admissions

Section 2: What Is Covered?

Introduction

This section describes the Health Care Services that are covered under this Benefit Booklet. All benefits for Covered Services are subject to your share of the cost and the benefit maximums listed on your Schedule of Benefits, the applicable Allowed Amount, any limitations and/or exclusions, as well as other provisions contained in this Booklet, and any Endorsement(s) in accordance with BCBSF's Medical Necessity coverage criteria and benefit guidelines then in effect.

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the "What Is Not Covered?" section. More than one limitation or exclusion may apply to a specific Service or a particular situation.

Expenses for the Health Care Services listed in this section will be covered under this Booklet only if the Services are:

1. within the Health Care Services categories in this "What Is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this Benefit Booklet and for which an itemized statement or description of the procedure or Service, which was rendered is received, including any applicable procedure code, diagnosis code and other information required in order to process a claim for the Service;
3. Medically Necessary, as defined in this Booklet and determined by BCBSF or Suwannee County Board of Public Instruction in accordance with BCBSF's Medical Necessity coverage criteria then in effect, except as specified in this section;
4. in accordance with our benefit guidelines listed below;
5. rendered while your coverage is in force; and
6. not specifically or generally limited or excluded under this Booklet.

BCBSF or Suwannee County Board of Public Instruction will determine whether Services are Covered Services under this Booklet after you have obtained the Services and a claim has been received for the Services. In some circumstances BCBSF or Suwannee County Board of Public Instruction may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, BCBSF or Suwannee County Board of Public Instruction may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. Neither BCBSF nor Suwannee County Board of Public Instruction are obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

In determining whether Health Care Services are Covered Services under this Booklet, no written or verbal representation by any employee or agent of BCBSF or Suwannee County Board of Public Instruction, or by any other person shall waive or otherwise modify the terms of this Booklet and, therefore, neither you, nor any health care Provider or other person should rely on any such written or verbal representation.

For information on Prescription Drug coverage, please refer to the "BlueScript® Pharmacy Program" section.

Our Benefit Guidelines

In providing benefits for Covered Services, the benefit guidelines listed below will apply as well as any other applicable payment rules specific to particular categories of Services:

1. Payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable for any such Services.
2. Payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service nor the day of the week nor the time of day the procedure is performed.
3. Payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Accident Care

Health Care Services to treat an injury or illness resulting from an Accident not related to your job or employment are covered.

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum are covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

Ambulance Services

Ground Ambulance

Ground Ambulance Services for Emergency Medical Conditions and limited non-emergency ground transport may be covered only when:

1. For Emergency Medical Conditions – it is Medically Necessary to transport you from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
   a) from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;

b) to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;

c) to the nearest more cost-effective acute care facility as determined solely by us; or

d) from an acute facility to the nearest cost-effective sub-acute setting.

Note: Non-emergency Ambulance transportation meets the definition of Medical Necessity only when the patient's Condition requires treatment at another facility and when another mode of transportation, whether by Ambulance or otherwise (regardless of whether covered by us or not) would endanger the patient's medical Condition. If another mode of transportation could be used safely and effectively, regardless of time, or mode (e.g. air, ground, water) then Ambulance transportation is not Medically Necessary.

Air and Water Ambulance

Air and water Ambulance coverage is specifically limited to transport due to an Emergency Medical Condition when the patient's destination is an acute care Hospital, and:

1. the pick-up point is not accessible by ground Ambulance, or
2. speed in excess of the ground vehicle is critical for your health or safety.

Air and water Ambulance transport for non-emergency transport is excluded unless it is specifically approved by us in advance of the transport.

Exclusion:

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
   a) the crew renders aid until a helicopter can be sent;
   b) the patient refuses care or transport; or
   c) only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
   a) patient wants to be at a certain Hospital or facility for personal/preference reasons;
   b) patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment), or after being discharged from inpatient care; or
   c) patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
6. Air or water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center are covered and include:

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered (except for take home Drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

Anesthesia Administration Services

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, payment for Covered Services, if any, will be made for both the CRNA and the Physician Health Care Services at the lower directed-services Allowed Amount in accordance with BCBSF's payment program for such Covered Services then in effect.

Exclusion:

Coverage does not include anesthesia Services by an operating Physician, his or her partner or associate.

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section 393.17 of the Florida Statutes or licensed under Chapters 490 or 491 of the Florida Statutes; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion:

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

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 Booklet;
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician; and
4. Residential Treatment Services, as defined in this Booklet.

Exclusion:

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;
8. Services to test aptitude, ability, intelligence or interest except as covered under the Autism Spectrum Disorder subsection;
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. You acknowledge that we do not have any Contractual or other formal arrangements with the Provider of such services.

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

Surgery to reestablish symmetry between two breasts and implanted prostheses incident to Mastectomy is covered. In order to be covered, such surgery must be provided in a manner chosen by your Physician, consistent with prevailing medical standards, and in consultation with you.

Child Cleft Lip and Cleft Palate Treatment

Treatment and Services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition Services for treatment of a child under the age of 18 who has cleft lip or cleft palate are covered. In order for such Services to be covered, your Covered Dependent's Physician must specifically prescribe such Services and such Services must be consequent to treatment of the cleft lip or cleft palate.

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 Booklet, 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 Booklet 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 Physician care Services are covered, provided: (a) the additional Physician actively participates in your treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the same specialty with different sub-specialties.

Consultations

Consultations provided by a Physician are covered if your attending Physician requests the consultation and the consulting Physician prepares a written report.

Contraceptive Injections

Medication by injection is covered when provided and administered by a Physician, for the purpose of contraception, and is limited to the medication and administration.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental Services provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
    a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that:
        i. Dental treatment is necessary due to a dental Condition that is significantly complex; or
        ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or

b) you or your Covered Dependent has one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Exclusion:

1. Dental Services provided more than 62 days after the date of an Accidental Dental Injury, regardless of whether or not such Services could have been rendered within 62 days; and
2. Dental implants.

Diabetes Outpatient Self-Management

Diabetes outpatient self-management training and educational Services and nutrition counseling to treat diabetes, if your treating Physician or a Physician who specializes in the treatment of diabetes certifies that such Services are Medically Necessary, are covered. In order to be covered, diabetes outpatient self-management training and educational Services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed Dietitian. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diagnostic Services

Diagnostic Services when ordered by a Physician are limited to the following:

1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);
2. laboratory and pathology Services;
3. Services involving bones or joints of the jaw (e.g., Services to treat temporomandibular joint [TMJ] dysfunction) or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. approved machine testing (e.g., electrocardiogram [EKG], electroencephalograph [EEG], and other electronic diagnostic medical procedures); and
5. genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

Dialysis Services

Dialysis Services including equipment, training, and medical supplies, when provided at any location by a Provider licensed to perform dialysis including a Dialysis Center are covered.

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, limited to the most cost effective equipment as determined by BCBSF or Suwannee County Board of Public Instruction is covered.

Payment Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Payment for Durable Medical Equipment will be based on the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) the Allowed Amount. The Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of Durable Medical Equipment due to growth of a child or significant change in functional status is a Covered Service.

Exclusion:

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used are excluded.

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.

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 when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period are covered.

Coverage to treat inherited diseases of amino acid and organic acids, for you up to your 25th birthday, shall include coverage for food products modified to be low protein.

Eye Care

Coverage includes the following Services:

1. Physician Services, soft lenses or sclera shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician Services to treat an injury to or disease of the eyes.

Exclusion:

Health Care Services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercises or visual training; eye glasses and contact lenses and their fitting are excluded. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK) are excluded.

Home Health Care

The Home Health Care Services listed below are covered when the following criteria are met:

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan which has been reviewed and renewed by the prescribing Physician every 30 days. In order to determine whether such Services are covered under this Booklet, you may be required to provide a copy of any written treatment plan;
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide Services;

2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
3. medical social Services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen); and
6. Physical Therapy by a Physical Therapist, Occupational Therapy by a 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 a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is:

1. approved by your Physician; and
2. your doctor has certified to us in writing that your life expectancy is 12 months or less.

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. Drugs and medicines administered (except for take home Drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the “What Is Not Covered?” section);
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;

12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, and Cardiac Therapies; and
14. transplants as described in the Transplant Services subsection.

Exclusion:

Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital: 1) room and board provided during the admission; 2) Physician visits provided while you were an inpatient; 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and 4) other Services provided while you were an inpatient.

In addition, expenses for the following and similar items are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home Drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

Inpatient Rehabilitation

Inpatient Rehabilitation Services are covered when the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Inpatient Rehabilitation Services are subject to the inpatient facility Copayment, if applicable, and the benefit maximum set forth in the Schedule of Benefits.

Exclusion:

All Substance Dependency, drug and alcohol related diagnoses, Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening are Covered Services.

Benefits for mammograms may not be subject to the Deductible, Coinsurance, or Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by you and your attending Physician are covered. Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Services

Health Care Services, including prenatal care, delivery and postpartum care and assessment, provided to you, by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife may be Covered Services. Care for the mother includes the postpartum assessment.

In order for the postpartum assessment to be covered, such assessment must be provided at a Hospital, an attending Physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in care for a mother. Coverage under this Booklet for the postpartum assessment includes coverage for the physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards.

Under Federal law, your Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Pharmacy

Physician-administered Prescription Drugs which are rendered in a Physician's office may be subject to a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug and does not include the administration of the Prescription Drug.

Your plan may also include a maximum monthly amount you will be required to pay out-of-pocket for Medical Pharmacy, when such Services are provided by an In-Network Provider or Specialty Pharmacy. If your plan includes a Medical Pharmacy out-of-pocket monthly maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

Please refer to your Schedule of Benefits for the additional Cost Share amount and/or monthly maximum out-of-pocket applicable to Medical Pharmacy for your plan.

Note: For purposes of this benefit, allergy injections and immunizations are not considered Medical Pharmacy.

Newborn Care

A newborn child will be covered from the moment of birth provided that the newborn child is eligible for coverage and properly enrolled. Covered Services shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment:

An assessment of the newborn child is covered provided the Services were rendered at a Hospital, the attending Physician's office, a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These Services are not subject to the Deductible.

Ambulance Services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn child's Condition, as determined by us and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child, are covered.

Under Federal law, your Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Orthotic Devices

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets are covered when prescribed by a Physician and designed and fitted by an Orthotist.

Benefits may be provided for necessary replacement of an Orthotic Device which is owned by you when due to irreparable damage, wear, a change in your Condition, or when necessitated due to growth of a child.

Payment for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six-month period unless a more frequent replacement is determined by BCBSF or Suwannee County Board of Public Instruction to be Medically Necessary.

Exclusion:

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease;
2. Expenses for orthotic appliances or devices which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets), except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
3. Expenses for devices necessary to exercise, train, or participate in sports, e.g. custom-made knee braces.

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;

3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulation Services

Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

Cardiac Therapy Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.

Occupational Therapy Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition are covered.

Speech Therapy Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition are covered.

Physical Therapy Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition are covered.

Massage Therapy Services provided by a Physician, Massage Therapist, or Physical Therapist when the Massage is prescribed as being Medically Necessary by a Physician licensed pursuant to Florida Statutes Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Physician's prescription must specify the number of treatments.

Payment Guidelines for Massage and Physical Therapy

1. Payment for covered Massage Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
2. Payment for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
3. Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day not to exceed fifteen (15) minutes in length.

Spinal Manipulations: Services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered.

Payment Guidelines for Spinal Manipulation

1. Payment for covered spinal manipulation is limited to no more than 26 spinal manipulations per Benefit Period, **or** the maximum benefit listed in the Schedule of Benefits, whichever occurs first.
2. Payment for covered Physical Therapy Services rendered on the same day as a spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

Your Schedule of Benefits sets forth the maximum number of visits covered under this plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example,

even if you may have only been administered two (2) of the spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy visit maximum with other Services.

Oxygen

Expenses for oxygen, the equipment necessary to administer it, and the administration of oxygen are covered.

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility.

Exclusion:

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

Prescription Drugs and Supplies Purchased from a Pharmacy

Please see the BlueScript® Pharmacy Program section.

Preventive Health Services

Preventive Services are covered for both adults and children based on prevailing medical standards and recommendations which are explained further below. Some examples of preventive health Services include, but are not limited to, periodic routine health exams, routine gynecological exams, immunizations and related preventive Services such as Prostate Specific Antigen (PSA), routine mammograms and pap smears. In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. with respect to infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph number one as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

More detailed information, such as medical management programs or limitations, on Services that are covered under the Preventive Health 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 Health 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 Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

For example, if the USPSTF adds a new recommendation for a preventive Service that we do not cover and you are already covered under this Benefit Booklet; that new Service will not be a Covered Service under this category right away. The coverage for a new Service will start on your Group's Anniversary Date one year after the new recommendation goes into effect.

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph one above.

Prosthetic Devices

The following Prosthetic Devices are covered when prescribed by a Physician and designed and fitted by a Prosthetist:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers and prosthetic devices incident to a Mastectomy;
2. appliances needed to effectively use artificial limbs or corrective braces; or
3. penile prosthesis.

Covered Prosthetic Devices (except cardiac pacemakers, and Prosthetic Devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessitated due to growth of a child.

Exclusion:

Expenses for cosmetic enhancements to artificial limbs

Self-Administered Injectable Prescription Drugs

Unless otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet, only Self-Administered Injectable Prescription Drugs used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when you are an inpatient in a Skilled Nursing Facility:

1. room and board;
2. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered while an inpatient (except take-home Drugs);
4. intravenous solutions;

5. Administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the “What Is Not Covered?” section);
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease; and
10. Physical, Speech, and Occupational Therapies.
11. A treatment plan from your Physician may be required in order to determine coverage and payment.

Exclusion:

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other Service primarily for the convenience of you and/or your family members or the Provider are excluded. Expenses for any inpatient days beyond the per person maximum number of days per Benefit Period listed on the Schedule of Benefits are also excluded.

Surgical Assistant Services

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary are covered.

Surgical Procedures

Surgical procedures performed by a Physician may be covered including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;
4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and
6. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Exclusions:

   The following Services, which are considered cosmetic in nature, are not covered when used to improve the gender-specific appearance of an individual. Examples of Services which are considered cosmetic include, but are not limited to:

   a) reduction thyroid chondroplasty;
   b) liposuction;
   c) rhinoplasty;
   d) facial bone reconstruction;

e) face lift;

f) blepharoplasty;

g) voice modification surgery;

h) hair removal/hairplasty; or

i) breast augmentation.

Payment Guidelines for Surgical Procedures

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed. In addition the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits will apply. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in BCBSF's or Suwannee County Board of Public Instruction's opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example).
3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

Transplant Services

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to BCBSF or Suwannee County Board of Public Instruction, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge Services, and treatment of complications after transplantation. Benefits will only be paid for Services, care and treatment received or provided in connection with a:

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. Coverage will be provided for the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;

8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

Coverage will be provided for donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

You may call the customer service phone number indicated in this Booklet or on your Identification Card in order to determine which Bone Marrow Transplants are covered under this Booklet.

Exclusion:

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Benefit Booklet;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant; and
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.

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

Virtual Visits between you and a Virtual Care Provider that is designated by us and under contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion:

1. Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

Section 3: BlueScript® Pharmacy Program

Introduction

Coverage for Prescription Drugs and Supplies and select Over-the-Counter (OTC) Drugs is provided through the BlueScript® Pharmacy Program described in this section. We provide coverage to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits, you must pay, at the time of purchase, the applicable Copayment or percentage of the Participating Pharmacy Allowance indicated on the Schedule of Benefits. Please note that before any payment will be made for Covered Prescription Drugs or Covered OTC Drugs purchased from a Participating Pharmacy, the applicable Deductible must be met and the Copayment, if applicable to your plan, or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance as set forth in the Schedule of Benefits, must be satisfied by you for each Prescription Drug and/or OTC Drug.

The Medication Guide contains a listing of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. You may be able to reduce your out-of-pocket expenses by: 1) using Participating Pharmacies; 2) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com, call the customer service phone number on your Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

Covered Prescription Drugs and Supplies and Covered OTC Drugs

A Prescription Drug, Covered OTC Drug or Self-Administered Injectable Prescription Drug is covered

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;
3. Medically Necessary, as defined in this Booklet 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 by us, as indicated with a unique identifier in the Medication Guide then in effect;
8. not specifically or generally limited or excluded herein; and
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 for Covered Prescription Drugs and Supplies and Covered OTC Drugs category listed in this section.

A Supply is covered **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.

Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs

In providing benefits under the BlueScript Pharmacy Program, we may apply the benefit guidelines set forth below, as well as any other applicable payment rules specific to particular Covered Services listed in this section.

Contraceptive Coverage

Prescription diaphragms, oral contraceptives and contraceptive patches will be covered unless indicated as not covered on the Schedule of Benefits and subject to the limitations and exclusions listed in this Benefit Booklet.

The following are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

   Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an "Exception Request Form" from your Physician.

   You can obtain an Exception Request Form on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.
2. Diaphragms indicated as covered in the Medication Guide; and
3. Emergency contraceptives indicated as covered in the Medication Guide.

Exclusion:

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants (e.g., Norplant, IUD, etc.) inserted for any purpose are excluded from coverage.

Covered Over-the-Counter (OTC) Drugs

Select OTC Drugs, listed in the Medication Guide, may be covered when you obtain a Prescription for the OTC Drug from your Physician. Only those OTC Drugs listed in the Medication Guide are covered.

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed on our website at www.floridablue.com, or you may call the customer service phone number on your Identification Card and one will be mailed to you upon request.

Diabetic Coverage

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered, subject to the limitations and exclusions listed in this Benefit Booklet. 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 BlueScript Pharmacy Program: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and/or syringes and needles.

Exclusion:

All Supplies used in the treatment of diabetes except those that are Covered Prescription Supplies are excluded from coverage.

Mineral Supplements, Fluoride or Vitamins

The following Drugs are covered **only** when state or federal law requires a Prescription and when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license:

1. prenatal vitamins;
2. oral single-product fluoride (non-vitamin supplementation);
3. sustained release niacin;
4. folic acid;
5. oral hematinic agents;
6. dihydrotachysterol; or
7. calcitriol.

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 excluded from coverage.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the cost share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

Preventive Medications

Certain medications may be available at no Cost Share if they are considered a Preventive Service as outlined in the "What Is Covered?" Section of the Benefit Booklet. Please see the Medication Guide for a list of these medications.

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 will also be split between the two fills.

Limitations and Exclusions

Limitations

Coverage and benefits for Covered Prescription Drugs and Supplies and Covered OTC Drugs are subject to the following limitations, in addition to all other provisions and exclusions of this Benefit Booklet:

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 Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
4. Specialty Drugs (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., 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

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific subsection of the "What Is Covered?" section of this Benefit Booklet, (e.g., Prescription Drugs which are dispensed and billed by a Hospital).
2. Except as covered in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for emergency contraceptives, insulin and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this Benefit Booklet.
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes); regardless of the intended use (except for Covered Prescription Supplies).
7. Prescription Drugs and Supplies and OTC Drugs that are:
    a) in excess of the limitations specified in this section or in the Schedule of Benefits;
    b) furnished to you without cost;
    c) Experimental or Investigational;
    d) indicated or used for the treatment of infertility, except when indicated as covered on the Schedule of Benefits;
    e) used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova;

f) prescribed by a Pharmacist;

g) used for smoking cessation, except as indicated as covered under the Preventive Health 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 (e.g., Cialis, Levitra, Viagra, Caverject), except when indicated as covered on the Schedule of Benefits. The exception described in exclusion number 11 does not apply to sexual dysfunction Drugs excluded under this paragraph;

k) purchased from any source (including a pharmacy) outside of the United States;

l) prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America; and

m) OTC Drugs not listed in the Medication Guide.

8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.

9. Any appetite suppressant, Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control , except when indicated as covered on the Schedule of Benefits.

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 that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce.

13. Drugs that do not have a valid National Drug Code.

14. Drugs that are compounded except those that have at least one active ingredient that is an FDA-approved Prescription Drug with a valid National Drug Code.

15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:

    a) the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

    b) the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by: i) American Medical Association; ii) National Heart Lung and Blood Institute; iii) American Cancer Society; iv) American Heart Association; v) National Institutes of Health; vi) American Gastroenterological Association; vii) Agency for Health Care Policy and Research; or

    c) we, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.

16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy

literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by:

a) American Medical Association;

b) National Heart Lung and Blood Institute;

c) American Cancer Society;

d) American Heart Association;

e) National Institutes of Health;

f) American Gastroenterological Association;

g) Agency for Health Care Policy and Research;

h) unless we, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.

17. Any amount you are required to pay under this section as indicated on the Schedule of Benefits.
18. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance.
19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.
20. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.
21. Food or medical food products, whether prescribed or not.
22. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a) the Drug is 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 Benefit Booklet.

23. New Prescription Drugs.

Payment Rules

Under the BlueScript Pharmacy Program, the amount you must pay for Covered Prescription Drugs and Supplies or a Covered OTC Drug may vary depending on:

1. the participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. the terms of the Pharmacy's agreement with us or our Pharmacy Benefit Manager;

3. whether you have satisfied the applicable Deductible and the amount of Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance you are required to pay as set forth in the Schedule of Benefits;
4. whether the Prescription Drug is a Generic Prescription Drug or a Brand Name Prescription Drug or Covered OTC Drug;
5. whether the Prescription Drug is on the Preferred Medication List;
6. whether the Prescription Drug is purchased from the Mail Order Pharmacy;
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and
8. If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
    a) the Cost Share amount that applies to the Brand Name Prescription Drugs you received as indicated on your Schedule of Benefits; and
    b) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug is Medically Necessary.

A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Non-Preferred Prescription Drugs are subject to a higher Cost Share amount, as set forth in the Schedule of Benefits.

We reserve the right to add, remove or reclassify any Prescription Drug in the Medication Guide at any time.

Pharmacy Alternatives

For purposes of this section, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

Participating 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 Participating Pharmacy, you may refer to the provider directory then in effect at www.floridablue.com or call the customer service phone number on your ID Card.

Prior to purchase, you must pay your Cost Share amount as listed in the Schedule of Benefits and present your ID Card and the Pharmacy must be able to verify that you are, in fact, covered by us.

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by a Participating Pharmacy are less than the required Copayment, the amount you pay will depend on the agreement then in effect between the Pharmacy and us or our Pharmacy Benefit Manager, and will be one of the following:

1. the usual and customary charge of such Pharmacy as if it were not a Participating Pharmacy;
2. the charge under the Pharmacy's agreement with us or our Pharmacy Benefit Manager; or
3. the Copayment, if less than the usual and customary charge of such Pharmacy.

Specialty Pharmacy

Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions are typically more difficult to maintain, administer and monitor when compared to traditional Drugs. Specialty Drugs may require frequent dosage adjustments, special storage and handling and may not be readily available at local pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require.

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications, while helping to preserve your benefits.

The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueScript Pharmacy Program.

For additional details on how to obtain Covered Prescription Specialty Drugs from a Specialty Pharmacy, refer to the Medication Guide.

Mail Order Pharmacy

For details on how to obtain Covered Prescription Drugs and Supplies and OTC Drugs from the Mail Order Pharmacy, refer to the Medication Guide or the Mail Order Pharmacy Brochure.

Note: Specialty Drugs are not available through the Mail Order Pharmacy.

Non-Participating Pharmacies

Our payment to you for Covered Prescription Drugs and Supplies and Covered OTC Drugs is based upon our Non-Participating Pharmacy Allowance. Non-Participating Pharmacies have not agreed to accept our Participating Pharmacy Allowance or our Pharmacy Benefit Manager’s Participating Pharmacy Allowance as payment in full less any applicable Cost Share amounts due from you.

You may be responsible for paying the full cost of the Covered Prescription Drugs and Supplies and Covered OTC Drugs at the time of purchase and must submit a claim to us for reimbursement. Our reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs will be based on the Non-Participating Pharmacy Allowance less the applicable Deductible, if any, and the Copayment or percentage of the Non-Participating Pharmacy Allowance set forth in the Out-of-Network Cost Share column of the Schedule of Benefits.

In order to obtain reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs purchased at a Non-Participating Pharmacy, you must obtain an itemized paid receipt and submit it with a properly completed claim form (with any required documentation) to:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Prescription Drug Program
P. O. Box 1798
Jacksonville, Florida 32231

Pharmacy Utilization Review Programs

Our pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and Supplies and OTC Drugs.

We may, at our sole discretion, require that Prescriptions for select Prescription Drugs and Supplies or OTC Drugs be reviewed under our pharmacy utilization review programs, then in effect, in order for there

to be coverage for them. Under these programs, there may be limitations or conditions on coverage for select Prescription Drugs and Supplies and OTC Drugs, depending on the quantity, frequency or type of Prescription Drug, Supply or OTC Drug Prescribed.

Note: If coverage is not available, or is limited, this does not mean that you cannot obtain the Prescription Drug, Supply or OTC Drug from the Pharmacy. It only means that we will not cover or pay for the Prescription Drug, Supply or OTC Drug. You are always free to purchase the Prescription Drug, Supply or OTC Drug at your sole expense.

Our pharmacy utilization review programs include the following:

Responsible Steps

Under this program, we may exclude from coverage certain Prescription Drugs and OTC Drugs unless you have first tried designated Drug(s) identified in the Medication Guide in the order indicated. In order for there to be coverage for such Prescription Drugs and OTC Drugs prescribed by your Physician, we must receive written documentation from you and your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Prior to filling your Prescription, your Physician may, but is not required to, contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

Responsible Quantity Program

Under this program, we may exclude from coverage any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

Prior Coverage Authorization Program

You are required to obtain prior coverage authorization from us in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **Failure to obtain authorization will result in denial of coverage.** Prescription Drugs and Supplies and OTC Drugs requiring prior coverage authorization are designated in the Medication Guide.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

For additional details on how to obtain prior coverage authorization, refer to the Medication Guide.

Information on our pharmacy utilization review programs is published in the Medication Guide at www.floridablue.com, or you may call the customer service phone number on your Identification Card. Your Pharmacist may also advise you if a Prescription Drug requires prior coverage authorization.

Ultimate Responsibility for Medical Decisions

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the applicable terms of this Benefit Booklet. Ultimately, the final decision concerning whether a Prescription Drug, Supply or OTC Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us in authorizing coverage are made only to determine whether coverage or benefits are available under this Benefit Booklet and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug, Supply, or OTC Drug, must be made solely by you and your treating Physician in accordance with the patient/Physician relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug, Supply or OTC Drug is needed, appropriate, or desirable, even though such Prescription Drug, Supply or OTC Drug may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if we have indicated that coverage and payment will not be made for such Prescription Drug, Supply or OTC Drug.

Definitions

Certain important terms applicable to the BlueScript Pharmacy Program are set forth below. For additional applicable definitions, please refer to the definitions in the "Definitions" section of this Benefit Booklet.

Average Wholesale Price ("AWP") means the average wholesale price of a Prescription Drug at the time a claim is processed as established by BCBSF based upon its utilization of a national drug database as determined by BCBSF, provided that any such national drug database must be accepted in the industry as a provider of average wholesale price, or similar pricing, data on a national scale.

Brand Name Prescription Drug means a Prescription Drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

Biosimilar Prescription Drug is 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.

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.

Covered OTC Drug means an Over-the-Counter Drug that is designated in the Medication Guide as a Covered OTC Drug.

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under the BlueScript 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:

1. Prescription diaphragms indicated as covered in the Medication Guide;
2. syringes and needles prescribed in conjunction with insulin, or a covered Self-Administered Injectable Prescription Drug which is authorized for coverage by us;
3. syringes and needles prescribed in conjunction with a Prescription Drug authorized for coverage by us;
4. syringes and needles which are contained in anaphylactic kits; or
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.

Day Supply means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

Dispensing Fee means the fee a Pharmacy is paid for filling a Prescription in addition to payment for the Drug.

Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

FDA means the United States Food and Drug Administration.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (i) has been approved by the FDA for sale or distribution as the bioequivelant of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (ii) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of BCBSF, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic 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.

Mail Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug and Covered Prescription Supply as set forth in your Schedule of Benefits. Please note, under this BlueScript Pharmacy Program, you must meet the applicable Deductible before the Mail Order Copayment, if applicable, will apply.

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

Maximum means the amount designated in our Medication Guide as the Maximum, including but not limited to, frequency, dosage and duration of therapy.

Medication Guide means the guide then in effect, issued by us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Preferred Brand Name Prescription Drugs; and Non-Preferred Prescription Drugs. The Medication Guide does not list all Non-Preferred Prescription Drugs due to space limitations, but some Non-Preferred Prescription Drugs and potential alternatives are provided for your information. **Note:** The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card.

National Drug Code (NDC) means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

National Network Pharmacy means a Pharmacy located outside of Florida that is part of the national network of Pharmacies established by our contracting Pharmacy Benefit Manager.

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Non-Participating Pharmacy means a Pharmacy that has not agreed to participate in the network for this Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Non-Participating Pharmacy Allowance means the amount upon which payment in such situations will be based for Covered Prescription Drugs and Supplies and Covered OTC Drugs:

1. In the case of Generic Prescription Drugs and Supplies and OTC Drugs, the Non-Participating Pharmacy Allowance shall be approximately 33 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable Drug is less, the amount billed.
2. In the case of Brand Name Prescription Drugs and Supplies, the Non-Participating Pharmacy Allowance shall be approximately 82 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable Drug is less, the amount billed.

It is further provided, however, that if either: 1) a national drug database then used by BCBSF makes a "material modification" to its AWP data (as determined by BCBSF), or; 2) BCBSF elects to utilize a new national drug database, BCBSF may modify the 33 percent of AWP figure and/or the 82 percent of AWP figure set out above so that the applicable modified figure sets out a replacement percent figure that is between: 1) the percent figure calculated to approximate the applicable Non-Participating Pharmacy Allowance in effect immediately prior to the applicable AWP database change, and; 2) the 33 percent of AWP figure or the 82 percent of AWP figure, whichever is applicable.

Non-Preferred Prescription Drug means a Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect. 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 number on your Identification Card. New Prescription Drugs are not a Non-Preferred Prescription Drug.

One-Month Supply means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's dosing recommendations. Certain Drugs, e.g. Specialty Drugs, may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

Over-the-Counter (OTC) Drug means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

Participating Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

Participating Pharmacy Allowance means the maximum amount allowed to be charged by a Participating Pharmacy per Prescription for a Covered Prescription Drug, Covered Prescription Supply or Covered OTC Drug under the BlueScript Pharmacy Program.

Pharmacist means a person properly licensed to practice the profession of Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state that regulates the profession of Pharmacy.

Pharmacy means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state, where a Pharmacist dispenses Prescription Drugs.

Pharmacy Benefit Manager means an organization that has established, and manages, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

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 and limitations in this “BlueScript Pharmacy 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.

Prescription means an order for Drugs, or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or Supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of this section, emergency contraceptives and insulin are considered a Prescription Drug because, in order to be covered, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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.

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding insulin. Covered Self-Administered Injectable Prescription Drugs are denoted with a symbol in the Medication Guide.

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy. Specialty Drugs 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 an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program, to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

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.

Three-Month Supply means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer's dosing recommendations.

Section 4: What Is Not Covered?

Introduction

Your Booklet expressly excludes expenses for the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the "What Is Covered?" section or any other section of the Booklet.

Abortions which are elective.

Arch Supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Assisted Reproductive Therapy (Infertility) including, but not limited to, associated Services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; and infertility treatment medication.

Autopsy or postmortem examination Services, unless specifically requested by BCBSF or Suwannee County Board of Public Instruction.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the Preventive Health Services category of the "What Is Covered?" or “BlueScript® Pharmacy Program” sections.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants,or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, breast augmentation.

Costs related to telephone consultations (except as indicated as covered under the Preventive Health Services category of the "What Is Covered?” section), failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial Care and any Service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home

parents; domestic maid services; respite care; and provision of Services which are for the sole purposes of allowing a family member or caregiver of a Covered Person to return to work.

Dental Services or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to an Accidental Dental Injury or the Child Cleft Lip and Cleft Palate Treatment Services category as described in the "What Is Covered?" section.

Drugs

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All Drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to Drugs dispensed to you when:
    a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
    b) you are in the outpatient department of a Hospital;
    c) dispensed to your Physician for administration to you in the Physician's office:
        i. by a Specialty Pharmacy under contract with us to provide such medications; and
        ii. prior coverage authorization has been obtained (if required); and
        iii. is indicated as covered in the Medication Guide; or
    d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for Self-Administered Prescription Drugs in connection with a nursing visit.
3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods, except as described in the Preventive Health Services category of the "What Is Covered?" section.
4. Any Drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction Drugs excluded under this paragraph.
5. Any Self-Administered Prescription Drug except when covered under the "BlueScript® Pharmacy Program" section or the "What Is Covered?" section of this Benefit Booklet.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
    a) emergency stabilization;
    b) during a covered inpatient stay, or
    c) when proximately related to a surgical procedure.

The exceptions to the exclusion for Drugs purchased or dispensed by a pharmacy described in subparagraph number two do not apply to hemophilia Drugs excluded under this subparagraph.

7. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.
8. New Prescription Drug(s), as defined in the Definitions section.
9. Convenience Kits, as defined in the Definitions section of the Booklet.
10. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Medical Policy Committee or any other nationally recognized source.

Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category.

Food and Food Products whether prescribed or not, except as covered in the Enteral Formulas subsection of the "What Is Covered?" section.

Foot Care which is routine, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to: non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails corns, or calluses.

Genetic screening, including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition, except as provided under the Preventive Health Services category of the "What Is Covered?" section.

Hearing Aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair.

Immunizations except those covered under the Preventive Health Services category of the "What Is Covered?" section.

Motor Vehicle Accidents Injuries and Services you incur due to an accident involving any motor vehicle for which no-fault insurance is available.

Oral Surgery except as provided under the "What Is Covered?" section.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Oversight of a medical laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion shall, include, but is not limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. the calibration of laboratory machines or testing of laboratory equipment;
3. the preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and
4. laboratory equipment or laboratory personnel for any reason.

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to your treatment including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;

5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the "What Is Covered?" section of this Booklet.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations categories of the "What Is Covered?" section. Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.

Reversal of Voluntary, Surgically-Induced Sterility including the reversal of tubal ligations and vasectomies.

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCBSF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Smoking Cessation Programs including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.), except as indicated as covered under the Preventive Health Services category of the "What Is Covered?" section.

Sports-Related devices and Services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

Training and Educational Programs, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation, except as provided under the "Diabetes Outpatient Self Management" category of the "What Is Covered?" section.

Travel or vacation expenses even if prescribed or ordered by a Provider.

Virtual Visits, except as described in the "What Is Covered?" section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and/or does not have a contract with us to provide access to Virtual Visits under this Booklet.

Volunteer Services or Services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment (if applicable) requirements which are waived by a health care Provider.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, 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. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a) a licensed outdoor youth program, and/or
    b) a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Section 5: Medical Necessity

In order for Health Care Services to be covered under this Booklet, such Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as defined by this Benefit Booklet.

It is important to remember that any review of Medical Necessity BCBSF or Suwannee County Board of Public Instruction undertakes is solely for the purposes of determining coverage, benefits, or payment under the terms of this Booklet and not for the purpose of recommending or providing medical care. In conducting a review of Medical Necessity, BCBSF or Suwannee County Board of Public Instruction may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining whether a Health Care Service provided or proposed meets the definition of Medical Necessity in this Booklet. In applying the definition of Medical Necessity in this Booklet to a specific Health Care Service, coverage and payment guidelines then in effect may be applied by BCBSF or Suwannee County Board of Public Instruction.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. Suwannee County Board of Public Instruction retains ultimate responsibility for determining whether expenses incurred for medical care are covered under this Booklet. In making coverage decisions, neither BCBSF nor Suwannee County Board of Public Instruction will be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to:

1. staying in the Hospital because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;
3. staying in the Hospital because supervision in the home, or care in the home, is not available or 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 Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by this Benefit Booklet) or a Covered Service. Please refer to the "Definitions" section for the definitions of "Medically Necessary" or "Medical Necessity".

Section 6: Understanding Your Share of Health Care Expenses

This section explains what your share of the health care expenses will be for Covered Services you receive. In addition to the information explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

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 you 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.

Deductible Requirement

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by us. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount. Please see your Schedule of Benefits for more information.

Family Deductible

If your plan includes a family Deductible, after the family Deductible has been met by your family, neither you nor your Covered Dependents will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible, if applicable, is the amount applied toward the individual Deductible. Please see your Schedule of Benefits for more information.

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.

1. Office Services Copayment:

If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office must be paid by you, for each office visit before any payment will be made by us. The office Services Copayment applies regardless of the reason for the office visit and applies to all Covered Services rendered during that visit, with the exception of Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Office Services Copayment, as set forth on your Schedule of Benefits.

2. Inpatient Facility Copayment:

   The Copayment for inpatient facility Services, if applicable to your plan, must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions to a Hospital, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals for inpatient admissions.

   Note: Copayments for inpatient facility Services vary depending on the facility chosen. Please see the Schedule of Benefits for more information.

3. Outpatient Facility Copayment:

   The Copayment for outpatient facility Services, if applicable to your plan, must be satisfied by you, for each outpatient visit to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Facility, Psychiatric Facility or Substance Abuse Facility, before any payment will be made for any claim for outpatient Covered Services. The Copayment for outpatient facility Services, if applicable to your plan, applies regardless of the reason for the visit, and applies to all outpatient visits to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Facility, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other healthcare professionals.

   Note: Copayments for outpatient facility Services vary depending on the facility chosen. Please see the Schedule of Benefits for more information.

4. Copayment for Emergency Room Facility Services:

   The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit.

   - If you are admitted to an In-Network Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.
   - If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the Out-of-network Deductible, In-Network Coinsurance and/or Emergency Room Copayment will apply to that admission. Please see your Schedule of Benefits for the applicable Cost Share.

<u>Embedded Out-of-Pocket Maximum</u>

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.

Note: The Deductible, any applicable Copayments and Coinsurance amounts, including those for Covered Prescription Drugs and Supplies, will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums.

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Deductible and Coinsurance maximums met by you under a prior group insurance, blanket insurance, franchise insurance or group Health Maintenance Organization (HMO) policy maintained by the Group if the coverage provided hereunder replaces such a policy or plan. This provision only applies if the prior group insurance, blanket insurance, franchise insurance or HMO coverage purchased by the Group was in effect immediately preceding the Effective Date of this Benefit Booklet. This provision is only applicable for you during the initial Benefit Period of coverage under this Benefit Booklet and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage under this Benefit Booklet only, charges credited by the Group's prior insurer, toward your Deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of this Benefit Booklet, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

Charges credited by the Group's prior insurer, toward your Coinsurance maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of this Benefit Booklet, will be credited to your out-of-pocket maximum under this Booklet.

Prior coverage credit toward the Deductible or out-of-pocket maximums will only be given for Health Care Services, which would have been Covered Services under this Booklet.

Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group. You and/or the Group are responsible for providing us with any information necessary for us to apply this prior coverage credit.

Benefit Maximum Carryover

If immediately before the Effective Date of coverage under this Benefit Booklet, you were covered under a prior group policy issued by BCBSF to Suwannee County Board of Public Instruction, amounts applied to your benefit maximums under the prior BCBSF policy, will be applied toward your benefit maximums under this Booklet, unless otherwise specified on your Schedule of Benefits.

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

Additional Expenses You Must Pay

In addition to your share of the expenses described above, you are also responsible for:

1. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., the Benefit Period maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept the Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any contribution amount required by Suwannee County Board of Public Instruction.

Special Payment Rules

Emergency Services in an Emergency Room

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

Additionally, payments for Emergency Services by an Out-of-Network Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center; and
- you do not have the ability and opportunity to choose an In-Network Provider at the In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center who is available to treat you; and,
- section 627.64194(3) of the Florida Statutes is applicable to the Services rendered.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

How Benefit Maximums Will Be Credited

Only amounts actually paid for Covered Services will be credited towards any applicable benefit maximums. The amounts paid which are credited towards your benefit maximums will be based on the Allowed Amount for the Covered Services provided.

Section 7: Physicians, Hospitals and Other Provider Options

Introduction

It is important for you to understand how the Provider you select and the setting in which you receive Health Care Services affects how much you are responsible for paying under this Booklet. This section, along with the Schedule of Benefits and BCBSF's Provider Directory, describes the health care Provider options available to you and the payment rules for Services you receive.

As used throughout this section "out-of-pocket expenses" or "out-of-pocket" refers to the amounts you are required to pay including any applicable Copayments, the Deductible and/or Coinsurance amounts for Covered Services.

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard Traditional Program Providers, in conformity with the "BlueCard Program" section of this Benefit Booklet.

For information on Pharmacy Provider options, please refer to the "BlueScript® Pharmacy Program" section of this Benefit Booklet.

Provider Participation Status

With BlueOptions, you may choose to receive Services from any Provider. However, you may be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider.

Family Physician Program

We encourage you to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians).

- Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs.
- Developing and continuing a relationship with a Family Physician allows the Physician to become knowledgeable about you and your family's health history.
- A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs.
- Care rendered by Family Physicians usually results in lower out-of-pocket expenses for you.

We will check our records periodically to see if you have visited a Family Physician. If not, we may provide your name and contact information to an In-Network Family Physician who will call you and offer to schedule a wellness visit. This program is completely voluntary and although we encourage you to schedule this visit, you are not obligated to do so. The applicable Family Physician Cost Share will apply to this visit.

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-Network, refer to the current Provider directory at www.floridablue.com or call the customer service phone number on your ID Card.

Location of Service

In addition to the participation status of the Provider, the location or setting where you receive Services can affect the amount you pay. For example, the amount you are responsible for paying out-of-pocket will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. Please refer to your Schedule of Benefits for specific information regarding your out-of-pocket expenses for such situations. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the "What Is Covered?" section and your Schedule of Benefits to find out if the specific Health Care Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

To verify if a Provider is In-Network for your plan you can:

1. review your current BlueOptions Provider Directory;
2. access the BlueOptions Provider directory at BCBSF's web-site at www.floridablue.com; and/or
3. call the customer service phone number in this Booklet or on your Identification Card.

In-Network Providers

When you use In-Network Providers, your out- of-pocket expenses for Covered Services will be lower. Payment will based on the Allowed Amount and your share of the cost will be at the In-Network benefit level listed in the Schedule of Benefits.

Please remember that changes to Provider network participation can occur at any time. Consequently, it is your responsibility to determine whether a specific Provider is In-Network at the time you receive Covered Services.

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. Payment will be based on the Allowed Amount and will be 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, payment to such Provider may be under the terms of that Provider's contract. If your Schedule of Benefits and BlueOptions Provider directory do not include a Provider as In-Network under your Benefit Plan, the Provider is considered Out-of-Network.

	In-Network	Out-of-Network
What expenses are you responsible for paying?	• Any applicable Copayments, Deductible(s) and/or Coinsurance requirements; • Expenses for Services which are not covered; • Expenses for Services in excess of any benefit maximum limitations; • Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and • Expenses for Services which are excluded.	
Who is responsible for filing your claims?	• The Provider will file the claim for you and payment will be made directly to the Provider.	• You are responsible for filing the claim and payment will be made directly to the Covered Plan Participant. If you receive Services from a Provider who participates in our Traditional Program or is a BlueCard Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.
Can you be billed the difference between what we pay the Provider and the Provider's charge?	• **NO.** You are protected from being billed for the difference in our Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept the Allowed Amount as payment in full for Covered Services except as otherwise permitted under the terms of the Provider's contract and this Booklet.	• **YES.** You are responsible for paying the difference between the Allowed Amount and the Provider's charge. However, if you receive Services from a Provider who participates in BCBSF's Traditional Program, the Provider will accept the Allowed Amount as payment in full for Covered Services since such Traditional Program Providers have agreed not to bill you for the difference. Further, under the BlueCard Program, when you receive Services from a BlueCard Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.

Note: You are solely responsible for selecting a Provider when obtaining Health Care Services and for verifying whether that Provider is In-Network or Out-of-Network at the time Health Care Services are rendered. You are also responsible for determining the corresponding payment options, if any, at the time the Health Care Services are rendered.

Other Providers

With BlueOptions you have access to other Providers in addition to the ones previously described in this section. Other Providers include facilities that provide alternative outpatient settings or other persons and entities that specialize in a specific Service(s). While these Providers may be recognized for payment, they may not be included as In-Network Providers for your plan. Additionally, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Booklet. Please refer to the "What Is Covered?" and "What Is Not Covered?" sections of this Booklet and your Schedule of Benefits to determine your out-of-pocket expenses for Covered Services rendered by these Providers.

You may be able to receive certain outpatient Services at a location other than a Hospital. The amount you are responsible for paying for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Remember that the location of Service can impact the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs. When Services are rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense for the facility Provider as well as an out-of-pocket expense for other types of Providers.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, any of the following assignments, or attempted assignments, by you to any Provider will not be honored:

- an assignment of the benefits due to you for Covered Services under this Benefit Booklet;
- an assignment of your right to receive payments for Covered Services under this Benefit Booklet; or
- an assignment of a claim for damage resulting from a breach, or an alleged breach, of the terms of this Benefit Booklet.

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard PPO Program Provider; 5) is a BlueCard Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, Florida Statutes ; or 7) is an Ambulance Provider that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, Florida Statutes. A written attestation of the assignment of benefits may be required.

Section 8: BlueCard® Program

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

BlueCard Program

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees

that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

Blue Cross Blue Shield Global Core® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these Services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Section 9: Blueprint for Health Programs

Introduction

BCBSF has established (and from time to time establishes) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. Under the terms of the ASO Agreement between BCBSF and Suwannee County Board of Public Instruction, BCBSF has agreed to make these programs available to you. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health; 2) help facilitate the management and review of coverage and benefits provided under this Booklet; and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services.

Admission Notification

The admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network.

In-Network

Under the admission notification requirement, we must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric Facilities, Substance Abuse Facilities or Skilled Nursing Facilities. While it is the sole responsibility of the In-Network Provider located in Florida to comply with the admission notification requirements, you should ask the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) if we have been notified of your admission. For an admission outside of Florida, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) may notify us of your admission by calling the toll free customer service number on your Identification card.

Out-of-Network

For admissions to an Out-of-Network Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility should notify BCBSF of the admission. Notifying BCBSF of your admission will enable BCBSF to provide you information about the Blueprint for Health Programs available to you. You or the Hospital may notify BCBSF of your admission by calling the toll free customer service number on your ID card.

Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, 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. The review is conducted solely to determine whether we should provide coverage and/or payment for a particular admission or Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals, including in advance of a transfer from one inpatient facility to another. We will provide notification to your Physician when inpatient coverage criteria are no longer

met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

Provider Focused Utilization Management Program

Certain NetworkBlue Providers have agreed to participate in our focused utilization management program. This pre-service review program is intended to promote the efficient delivery of medically appropriate Health Care Services by NetworkBlue Providers. Under this program we may perform focused prospective reviews of all or specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit to us specific medical information relating to Health Care Services proposed for you. These NetworkBlue Providers have agreed not to bill, or collect, any payment whatsoever from you or us, or any other person or entity, with respect to a specific Health Care Service if:

1. they fail to submit the Health Care Service for a focused prospective review when required under the terms of their agreement with us; or
2. we perform a focused review under the focused utilization management program and we determine that a Health Care Service is not Medically Necessary in accordance with our Medical Necessity criteria or inconsistent with our benefit guidelines then in effect unless the following exception applies.

Exception for Certain NetworkBlue Physicians

Certain NetworkBlue Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only may bill you for Services determined to be not Medically Necessary by BCBSF under this focused utilization management program if, before you receive the Service:

a) they give you a written estimate of your financial obligation for the Service;

b) they specifically identify the proposed Service that BCBSF has determined not to be Medically Necessary; and

c) you agree to assume financial responsibility for such Service.

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you will have to pay under this Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for Covered Services listed below. You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

For details on how to obtain prior coverage authorization for these Services, please call the customer service phone number on your ID Card.

Services that Require Prior Authorization

Advanced Diagnostic Imaging Services

You must obtain an authorization for advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, when rendered or referred by a Provider **before** the advanced diagnostic

imaging Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Applied Behavioral Analysis

You must obtain an authorization for Applied Behavioral Analysis for Autism Spectrum Disorder or Down Syndrome, **before** the Services are provided. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Approved Clinical Trials

You must obtain an authorization for Services rendered in connection with Approved Clinical Trials, 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 this plan will not make any payment for such Services**.

Prescription Drugs

In the case of Prescription Drugs, it is your sole responsibility to obtain prior coverage authorization **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, this plan will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

All Prescription Drugs covered under the Medical Pharmacy category in the "What Is Covered?" section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

Other Health Care Services

In the case of other Health Care Services under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

Additional Information

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.

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 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.

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
   a) the termination date of your plan, or
   b) the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

Member Focused Programs

The Blueprint for Health Programs may include voluntary programs for certain members. These programs may address health promotion, prevention and early detection of disease, chronic illness management programs, case management programs and other member focused programs.

Personal Case Management Program

The personal case management program focuses on members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, BCBSF may, in its sole discretion, assign a personal case manager to you to help coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the personal case management program, you may be offered alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available on a case-by-case basis when you meet BCBSF's case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing. In addition, Suwannee County Board of Public Instruction will be required to specifically agree to such treatment plan and the alternative benefits or payments.

The fact that certain Health Care Services under the personal case management program have been provided or payment has been made in no way obligates BCBSF, Suwannee County Board of Public Instruction, or the Group Health Plan to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of our right to enforce this Benefit Booklet in strict accordance with its terms. The terms of this Booklet will continue to apply, except as specifically modified in writing in accordance with the personal case management program rules then in effect

Health Information, Promotion, Prevention and Illness Management Programs

These Blueprint for Health Programs may include health information that supports member education and choices for healthcare issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help members with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include prenatal educational programs and illness management programs for conditions such as diabetes, cancer and heart disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll free customer service number on your Identification card for more information. Your participation in this program is completely voluntary.

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and the responsibility of your Physicians and other health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Booklet. In fulfilling this responsibility, neither BCBSF nor Suwannee County Board of Public Instruction will be deemed to participate in or override the medical decisions of your health care Provider.

Please note that the hospital admission notification requirement and any Blueprint for Health Program may be discontinued or modified at any time without notice to you or your consent.

Section 10: Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Group Health Plan, and who meets and continues to meet the eligibility requirements described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members. No changes in the eligibility requirements will be permitted except as permitted by Suwannee County Board of Public Instruction. Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Covered Plan Participant as the legal guardian or appropriate adoption documentation described in the "Enrollment and Effective Date of Coverage" section.

Eligibility Requirements for Covered Plan Participants

In order to be eligible to enroll as a Covered Plan Participant, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. The employee must be a bona fide employee of Suwannee County Board of Public Instruction;
2. The employee's job must fall within a job classification identified by Suwannee County Board of Public Instruction;
3. The employee must have completed any applicable Waiting Period identified by Suwannee County Board of Public Instruction; and
4. The employee must meet any additional eligibility requirement(s) required by Suwannee County Board of Public Instruction.

Suwannee County Board of Public Instruction's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of Suwannee County Board of Public Instruction provided such companies and Suwannee County Board of Public Instruction are under common control; and
4. other individuals as determined by Suwannee County Board of Public Instruction (e.g., members of associations or labor unions).

Suwannee County Board of Public Instruction shall have sole discretion concerning the expansion of eligibility classifications.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Plan Participant's spouse under a legally valid existing marriage.
2. The Covered Plan Participant's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Plan Participant 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 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Plan Participant, whether the

dependent child resides with the Covered Plan Participant, or whether the dependent child is eligible for or enrolled in any other group health plan.

Section 11: Enrollment and Effective Date of Coverage

Eligible Employees and Eligible Dependents may enroll for coverage according to the provisions below.

Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Booklet. Neither BCBSF nor Suwannee County Board of Public Instruction will have any obligation whatsoever to any individual who is not properly enrolled.

Any Employee or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage according to the provisions set forth below.

Enrollment Forms/Electing Coverage

To apply for coverage, you as the Eligible Employee must:

1. complete and submit, through Suwannee County Board of Public Instruction, the Enrollment Form;
2. provide any additional information needed to determine eligibility, at the request of BCBSF or Suwannee County Board of Public Instruction;
3. pay any required contribution; and
4. complete and submit, through Suwannee County Board of Public Instruction an Enrollment Form to add Eligible Dependents.

When making application for coverage, you must elect one of the types of coverage available under Suwannee County Board of Public Instruction's program. Such types may include:

Employee Only Coverage - This type of coverage provides coverage for the Employee only.

Employee/Spouse Coverage - This type of coverage provides coverage for the Employee and the employee's spouse under a legally valid existing marriage.

Employee/Child(ren) Coverage - This type of coverage provides coverage for the Employee and the employee's covered child(ren) only.

Employee/Family Coverage - This type of coverage provides coverage for the Employee and the employee's Covered Dependents.

There may be additional contribution amounts for each Covered Dependent based on the coverage selected by Suwannee County Board of Public Instruction.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee’s or Eligible Dependent’s initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in Suwannee County Board of Public Instruction’s health benefit program. The period is established by Suwannee County Board of Public

Instruction, occurs annually, and will take place when specified by Suwannee County Board of Public Instruction.

Special Enrollment Period is the 30-day period of time immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for coverage. Special circumstances are described in the "Special Enrollment Period" subsection.

Employee Enrollment

1. An Eligible Employee must enroll during the Initial Enrollment Period in order to become covered as of the Effective Date of Suwannee County Board of Public Instruction. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) will be the same as the Covered Plan Participant's Effective Date.
2. An individual who becomes an Eligible Employee after Suwannee County Board of Public Instruction's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will begin on the date specified in writing by Suwannee County Board of Public Instruction.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Plan Participant. Below are special rules for certain Eligible Dependents.

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must submit an Enrollment Form to BCBSF through Suwannee County Board of Public Instruction during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

If timely notice is given, no additional contribution will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child if the Covered Plan Participant provides notice to Suwannee County Board of Public Instruction and an Enrollment Form is received within the 60-day period of the birth of the child and any applicable contribution is paid back to the date of birth.

If the newborn is not enrolled within sixty days of the date of birth, the newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

Note: Coverage for a newborn child of a Covered Dependent will automatically terminate 18 months after the birth of the newborn child.

Adopted Newborn Child – To enroll an adopted newborn child, the Covered Plan Participant must submit an Enrollment Form through Suwannee County Board of Public Instruction to BCBSF during the 30-day period immediately following the date of birth. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents, which are deemed necessary in order to administer this provision.

If timely notice is given, no additional contribution will be charged for coverage of the adopted newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable

contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for an adopted newborn child if the Covered Plan Participant provides notice to Suwannee County Board of Public Instruction and an Enrollment Form is received within the 60-day period of the birth of the adopted newborn child and any applicable contribution is paid back to the date of birth.

If the adopted newborn child is not enrolled within sixty days of the date of birth, the adopted newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Plan Participant, there shall be no coverage for the adopted newborn child. It is your responsibility as the Covered Plan Participant to notify Suwannee County Board of Public Instruction within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

Adopted/Foster Children – To enroll an adopted or Foster Child, the Covered Plan Participant must submit an Enrollment Form during the 30-day period immediately following the date of placement. The Effective Date for an adopted or Foster Child (other than an adopted newborn child) will be the date such adopted or Foster Child is placed in the residence of the Covered Plan Participant in compliance with Florida law. The Covered Plan Participant may be required to provide any information and/or documents deemed necessary, in order to properly administer this section.

In the event Suwannee County Board of Public Instruction is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as Covered Plan Participant provides notice to Suwannee County Board of Public Instruction, and we receive the Enrollment Form within 60 days of the placement. If the adopted or Foster Child is not enrolled within sixty days of the date of placement, the adopted or Foster Child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted Child. Proof of final adoption must be submitted to BCBSF through Suwannee County Board of Public Instruction. It is the responsibility of the Covered Plan Participant to notify BCBSF through Suwannee County Board of Public Instruction if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Plan Participant to notify BCBSF through Suwannee County Board of Public Instruction that the Foster Child is no longer in the Covered Plan Participant's care. Upon receipt of this notification, coverage for the child will be terminated on the date the Covered Plan Participant's status as a foster parent terminated.

Marital Status –The Covered Plan Participant may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered Plan Participant must complete the Enrollment Form through Suwannee County Board of Public Instruction and forward it to BCBSF. The Covered Plan Participant must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Plan Participant may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under their plan. To apply for coverage, the Covered Plan Participant must complete an Enrollment Form through Suwannee County Board of Public Instruction and forward it to BCBSF. The Covered Plan Participant must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Enrollment Form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the date established by Suwannee County Board of Public Instruction.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee or the Eligible Dependent is enrolled due to a special circumstance as outlined in the "Special Enrollment Period" subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependent(s) must complete the applicable Enrollment Form and forward it to the Group within the time periods noted below for each special enrollment event.

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage if one of the following special enrollment events occurs and the applicable Enrollment Form is submitted to the Group within the indicated time periods:

1. If you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Program (CHIP) or Medicaid, see #3 below), or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:

   a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

   b) you lost your other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and

   c) you submit the applicable Enrollment Form to the Group within 30 days of the date your coverage was terminated

   Note: Loss of coverage for failure to pay your required contribution/premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

   or

2. If when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption and you submit the applicable Enrollment Form to the Group within 30 days of the date of the event.

or

3. If you or your Eligible Dependent(s) lose coverage under a CHIP or Medicaid due to loss of eligibility for such coverage or become eligible for the optional state premium assistance program and you submit the applicable Enrollment Form to the Group within 60 days of the date such coverage was terminated or the date you become eligible for the optional state premium assistance program.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees or Eligible Dependents who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Plan Participant).

Other Provisions Regarding Enrollment and Effective Date of Coverage

Rehired Employees

Individuals who are rehired as employees of Suwannee County Board of Public Instruction are considered newly hired employees for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Group Health Plan (which includes this Booklet), which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, and Waiting Period) are applicable to rehired employees and their Eligible Dependents if the employee does not qualify for the federal exception.

Section 12: Termination of Coverage

Termination of a Covered Plan Participant's Coverage

A Covered Plan Participant's coverage will automatically terminate at 12:01 a.m.:

1. on the date the Group Health Plan terminates;
2. on the date the Administrative Services Only Agreement between BCBSF and Suwannee County Board of Public Instruction terminates;
3. on the last day of the first month that the Covered Plan Participant fails to continue to meet any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause (see the "Termination of an Individual Coverage for Cause" subsection); or
5. on the date specified by Suwannee County Board of Public Instruction that the Covered Plan Participant's coverage terminates.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage will automatically terminate at 12:01 a.m. on the date:

1. the Group Health Plan terminates;
2. the Covered Plan Participant's coverage terminates for any reason;
3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group Health Plan;
4. last day of the Calendar Year that the Covered Dependent child no longer meets any of the applicable eligibility requirements;
5. the Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

In the event you as the Covered Plan Participant wish to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to BCBSF through Suwannee County Board of Public Instruction prior to the termination date requested.

In the event you as the Covered Plan Participant wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit an Enrollment Form to Suwannee County Board of Public Instruction, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

Termination of an Individual's Coverage for Cause

In the event any of the following occurs, Suwannee County Board of Public Instruction may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits; or
2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed, by or on your behalf.

Notice of Termination

It is Suwannee County Board of Public Instruction's responsibility to immediately notify you of your termination or that of your Covered Dependents for any reason.

Section 13: Continuing Coverage Under COBRA

Federal Continuation of Coverage Law

A Federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to your Group Health Plan. If COBRA applies, you or your Covered Dependents may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

You must contact Suwannee County Board of Public Instruction to determine if you or your Covered Dependent are entitled to COBRA continuation of coverage. Suwannee County Board of Public Instruction is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Covered Persons of their rights under COBRA. If you fail to meet your obligations under COBRA and this Benefit Booklet, Suwannee County Board of Public Instruction will not be liable for any claims incurred by you or your Covered Dependent(s) after termination of coverage.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below.

The following is a summary of what you may elect, if COBRA applies to Suwannee County Board of Public Instruction and you are eligible for such coverage:

1. You may elect to continue this coverage for a period not to exceed 18 months* in the case of:
   a) termination of employment of the Covered Plan Participant other than for gross misconduct; or
   b) reduced hours of employment of the Covered Plan Participant.

   ***Note:** You and your Covered Dependents are eligible for an 11-month extension of the 18-month COBRA continuation option above (to a total of 29 months) if you or your Covered Dependent is totally disabled, as defined by the Social Security Administration (SSA) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Person must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.
2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
   a) the Covered Plan Participant's entitlement to Medicare;
   b) divorce or legal separation of the Covered Plan Participant;
   c) death of the Covered Plan Participant;
   d) the employer filing bankruptcy (subject to bankruptcy court approval); or
   e) a Dependent child may elect the 36-month extension if the Dependent child ceases to be an Eligible Dependent under the terms of Suwannee County Board of Public Instruction's coverage.

Children born to, or placed for adoption with, the Covered Plan Participant during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

Additional requirements applicable to continuation of coverage under COBRA are set forth below:

1. Suwannee County Board of Public Instruction must notify you of your continuation of coverage rights under COBRA within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify Suwanne County

Board of Public Instruction, in writing, within 60 days of any of these events. Suwannee County Board of Public Instruction's 14-day notice requirement runs from the date of receipt of such notice.

2. You must elect to continue the coverage within 60 days of the later of:
   a) the date that the coverage terminates; or
   b) the date the notification of continuation of coverage rights is sent by Suwannee County Board of Public Instruction.
3. COBRA coverage will terminate if you become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the Social Security Administration that you are no longer disabled. You must inform Suwannee County Board of Public Instruction of the Social Security Administration's determination within 30 days of such determination.
6. You must meet all contribution requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in the Group Health Plan.
7. Suwannee County Board of Public Instruction must continue to provide group health coverage to its employees.

An election by a Covered Plan Participant or Covered Dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that Covered Plan Participant or Covered Dependent spouse, unless otherwise specified in the election form.

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Benefit Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to Suwannee County Board of Public Instruction.

Section 14: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for a BCBSF individual policy (hereinafter referred to as a "converted policy" or "conversion policy") if:

1. you were continuously covered for at least three months under the Group Health Plan, and/or under another group policy that provided similar benefits immediately prior to the Group Health Plan; and
2. your coverage was terminated for any reason, including discontinuance of the Group Health Plan in its entirety and termination of continued coverage under COBRA.

Notify us in writing or by telephone if you are interested in a conversion policy. Within 14 days of such notice, we will send you a conversion policy application, premium notice and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

We must receive a completed application for a converted policy, and the applicable premium payment, within the 63-day period beginning on the date the coverage under the Group Health Plan terminated. If coverage has been terminated due to the non-payment of employee contribution by Suwannee County Board of Public Instruction, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Health Plan terminated.

In the event we do not receive the converted policy application and the initial premium payment within such 63-day period, your converted policy application will be denied and you will not be entitled to a converted policy.

Additionally, you are not entitled to a converted policy if

1. you are eligible for or covered under the Medicare program;
2. you failed to pay, on a timely basis, the contribution required for coverage under this Group Health Plan;
3. the Group Health Plan was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under this Booklet; or
4. a) you fall under one of the following categories and meet the requirements of 4.b. below:
    i. you are covered under any hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Booklet; or
    ii. you are eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Booklet; or
    iii. benefits similar to the benefits provided under this Booklet are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and

    b) the benefits provided under the sources referred to in paragraph 4.a.i or the benefits provided or available under the source referred to in paragraph 4.a.ii. and 4.a.iii. above, together with the benefits

provided by our converted policy would result in over insurance in accordance with our over insurance standards, as determined by us.

Neither Suwannee County Board of Public Instruction nor BCBSF has any obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial premium payment to us within 63 days of the termination of your coverage under this Benefit Booklet. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under this Benefit Booklet is terminated.

Note: Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Booklet. When applying for our converted policy, you have two options:
1) a converted policy providing major medical coverage meeting the requirements of 627.6675(10) Florida Statutes or 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) Florida Statutes. In any event, we will not be required to issue a converted policy unless required to do so by Florida law. We may have other options available to you. Call the telephone number on your Identification card for more information.

Section 15: Extension of Benefits

Extension of Benefits

In the event the Group Health Plan is terminated, coverage will not be provided under this Benefit Booklet for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire Group Health Plan is terminated. The extension of benefits described in this section does not apply when your coverage terminates, if the Group Health Plan remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is your sole responsibility to provide acceptable documentation showing that you are entitled to an extension of benefits.

1. In the event you are totally disabled on the termination date of the Group Health Plan as a result of a specific Accident or illness incurred while you were covered under this Booklet, as determined by us, a limited extension of benefits will be provided under this Benefit Booklet for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. In any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

   For purposes of this section, you will be considered "totally disabled" only if, in our opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. You are totally disabled only if, in our opinion, you are unable to perform those normal day-to-day activities which you would otherwise perform and you require regular care and attendance by a Physician.

2. In the event you are receiving covered dental treatment as of the termination date of the Group Health Plan, a limited extension of such covered dental treatment will be provided under this Benefit Booklet if:

   a) a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while you were covered under the Group Health Plan;

   b) the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic Services; and

   c) the dental procedures were performed within 90 days after the Group Health Plan terminated.

3. This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Group Health Plan or on the date you become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. You are not required to be totally disabled in order to be eligible for this extension of benefits.

   Please refer to the "Dental Care" category of the "What Is Covered?" section for a description of the dental care Services covered under this Booklet.

4. In the event you are pregnant as of the termination date of the Group Health Plan, a limited extension of the maternity expense benefits will be available, provided the pregnancy commenced while the pregnant individual was covered under the Group Health Plan, as determined by us. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. You are not required to be totally disabled in order to be eligible for this extension of benefits.

Section 16: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When you become covered under Medicare and continue to be eligible and covered under this Benefit Booklet, coverage under this Benefit Booklet will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, coverage under this Benefit Booklet will be secondary to any Medicare benefits. To the extent the benefits under this Benefit Booklet are primary, claims for Covered Services should be filed with BCBSF first.

Under Medicare, Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you . Also, Suwannee County Board of Public Instruction MAY NOT induce you to decline or terminate your group health insurance coverage and elect Medicare as primary payer.

If you become 65 or become eligible for Medicare due to End Stage Renal Disease ("ESRD"), you must notify Suwannee County Board of Public Instruction.

Individuals With End Stage Renal Disease

If you are entitled to Medicare coverage because of ESRD, coverage under this Benefit Booklet will be provided on a primary basis for 30 months beginning with the earlier of:

1. the month in which you became entitled to Medicare Part A ESRD benefits; or
2. the first month in which you would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the time you became eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health insurance coverage will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, coverage will be provided, as described in this section, on a primary basis for 30 months.

Disabled Active Individuals

If you are entitled to Medicare coverage because of a disability other than ESRD, Medicare benefits will be secondary to the benefits provided under this Benefit Booklet provided that:

Suwannee County Board of Public Instruction employed at least 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year. If the Group Health Plan is a multi-employer plan, as defined by Medicare, Medicare benefits will be secondary if at least one employer participating in the plan covered 100 or more employees under the plan on 50% or more of its regular business days during the previous Calendar Year.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Benefit Booklet.
2. BCBSF will not be liable to Suwannee County Board of Public Instruction or to any individual covered under this Benefit Booklet on account of any nonpayment of primary benefits resulting from any failure of performance of Suwannee County Board of Public Instruction's obligations as described in this section.

Section 17: Duplication of Coverage Under Other Health Plans/Programs

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided under this Benefit Booklet.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is your responsibility to provide BCBSF and Suwannee County Board of Public Instruction with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify BCBSF and Suwannee County Board of Public Instruction in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies which may be subject to COB include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage in which the law permits us to coordinate benefits;
4. Medicare, as described in "The Effect of Medicare Coverage/Medicare Secondary Payer Provisions" section; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of our payment, if any, when benefits are coordinated under this section, is based on whether or not the benefits under this Benefit Booklet are primary. When primary, payment will be made for Covered Services without regard to coverage under other plans. When the benefits under this Benefit Booklet are not primary, payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event you receive Covered Services from a NetworkBlue Provider or an Out-of-Network Provider who participates in our Traditional Program, "total reasonable expenses" shall mean the amount required to be paid to the Provider pursuant to the applicable agreement BCBSF has with such Provider. **In the event that the primary payer's payment exceeds the Allowed Amount, no payment will be made for such Services.**

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. 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 Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
   a) the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;

b) if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.

4. When we cover a dependent child whose parents are not married, or are separated or divorced:
   a) the plan of the parent with custody is primary;
   b) the plan of the remarried parent with custody is primary; the step-parent's plan is secondary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; and
   c) the plan of the parent without custody is last;
   d) regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:
   a) the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:
   a) first, the plan covering the person as an employee, or as the employee's dependent; and
   b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.
7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.
8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

We will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare Supplement policy.

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Booklet shall not duplicate any benefits to which you or your Covered Dependents are entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 18: Claims Processing

Introduction

This section is intended to:

- help you understand what you or your treating Providers must do, under the terms of this Benefit Booklet, in order to obtain payment for expenses for Covered Services they have rendered or will render to you; and
- provide you with a general description of the applicable procedures we will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying you when we deny benefits.

Under no circumstances will we be held responsible for, nor will we accept liability relating to, the failure of your Group Plan's sponsor or plan administrator to: 1) comply with applicable disclosure requirements; 2) provide you with a Summary Plan Description (SPD) or 3) comply with any other legal requirements. You should contact Suwannee County Board of Public Instruction if you have questions relating to your Group Plan's SPD. We are not your Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

The Processing of Post-Service Claims

We will use our best efforts to pay, contest, or deny all Post-Service Claims for which we have all of the necessary information, as determined by us. Post-Service Claims will be paid, contested, or denied within the timeframes described below.

- Payment for Post-Service Claims

When payment is due under the terms of this Benefit Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more or additional information, we may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. Our notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- Denial of Post-Service Claims

In the event we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and

the reason(s) for denial. It is your responsibility to ensure that we receive all information determined by us as necessary to adjudicate a Post-Service Claim. **If we do not receive the necessary information, the claim or a portion of the claim may be denied.**

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Additional Processing Information for Post-Service Claims

In any event, we will use our best efforts to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by us or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by us within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

We will investigate any allegation of improper billing by a Provider upon receipt of written notification from you. If we determine that you were billed for a Service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due solely to the notification from you, we will pay you 20 percent of the amount of the reduction, up to a total of $500.

Pre-Service Claims

How to File a Pre-Service Claim

This Benefit Booklet may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the “What Is Covered?” section and other applicable sections of your Benefit Booklet. You may also call the customer service number on your Identification card for assistance.
We are not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to you unless the terms of this Benefit Booklet require (or condition payment upon) approval by us for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, we will use our best efforts to provide notice of our determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, we will use our best efforts to provide notice within 24 hours of:
1) the need for additional information; 2) the specific information that you or your Provider may need to provide; and 3) the date that we reasonably expect to provide notice of the decision. If we request additional information, we must receive it within 48 hours of our request. We will use our best efforts to provide notice of the decision on your Pre-Service Claim within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period you were afforded to provide the specified additional information as described above.

Benefit Determinations on Pre-Service Claims that Do Not Involve Urgent Care

We will use our best efforts to provide notice of a decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. This 15-day determination period may be extended by us one time for up to an additional 15 days. If such an extension is necessary, we will use our best efforts to provide notice of the extension and

reasons for it. We will use our best efforts to provide notification of the decision on your Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by us.

If additional information is necessary to make a determination, we will use our best efforts to: 1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; 2) identify the specific information that you or your Provider may need to provide; and 3) inform you of the date that we reasonably expect to notify you of our decision. If we request additional information, we must receive it within 45 days of our request for the information. We will use our best efforts to provide notification of the decision on your Pre-Service Claim within 15 days of receipt of the requested information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

A reduction or termination of coverage or benefits for Services will be considered an Adverse Benefit Determination when:

- we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of Services; and
- the reduction or termination of coverage or benefits by us was not due to an amendment of this Benefit Booklet or termination of your coverage as provided by this Benefit Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of your request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: 1) we need additional information; or 2) you or your representative failed to follow proper procedures in your request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination:

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

1. the date the Service or supply was provided;

2. the Provider's name;
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;
7. a description of the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
8. a description of any additional information that might change the determination and why that information is necessary;
9. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures;
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; and
11. You have the right to an independent external review through an external review organization for certain appeals, as provided in the Patient Protection and Affordable Care Act of 2010.

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 three days after the oral notification.

How to Appeal an Adverse Benefit Determination

Except as described below, only you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the review process described below. Your appeal must be submitted to us in writing for an internal appeal within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

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. We must receive your appeal of an Adverse Benefit Determination in person or in writing.
4. 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.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the

final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.

6. 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 the Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.
10. 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.
11. 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.
12. 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.
13. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.
14. 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.
15. 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 Decision subsection below.

Appeals must be sent to the address below:

Blue Cross and Blue Shield of Florida
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:

- Pre-Service Claims: within 30 days of the receipt of your appeal; or
- Post-Service Claims: within 60 days of the receipt of your appeal; or

- Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

Note: The nature of a claim for Services (i.e. whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements ("Deemed Exhaustion") and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

How to Request External Review of Our Appeal Decision

If we deny your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational, you are entitled to request an independent, external review of our decision. Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

Blue Cross and Blue Shield of Florida
Attention: Member External Reviews DCC9-5
Post Office Box 44197
Jacksonville, FL 32231-4197

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

If the External Reviewer decides to overturn our decision, we will provide coverage or payment for your health care item or Service.

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.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

   In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

   In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a health care Provider of our choice as often as is reasonably necessary while a claim is pending. Failure by you to fully cooperate with such examination shall result in a denial of the pending claim and we shall have no liability for such claim.

3. Legal Actions:

   No legal action arising out of or in connection with coverage under this Benefit Booklet may be brought against BCBSF or Suwannee County Board of Public Instruction within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

   The information provided on the itemized statement and the claim form is relied upon by BCBSF 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 available legal remedy, in denial of the claim or cancellation or rescission of your coverage.

5. Explanation of Benefits Form:

   All claims decisions, including denial and claims review decisions, will be communicated to you in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

   a) The specific reason or reasons for the Adverse Benefit Determination;

   b) Reference to the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

   c) A description of any additional information that would change the initial determination and why that information is necessary;

   d) A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

e) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond Our Control:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Services, taking into account the impact of the event. For purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

ERISA Civil Action Provision

If a federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, applies to your Group Benefit Plan. You or your Covered Dependents may be entitled, after exhaustion of the appeal procedures provided for in this section, to pursue a civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Section 19: Relationships Between the Parties

BCBSF/Suwannee County Board of Public Instruction and Health Care Providers

Neither BCBSF nor Suwannee County Board of Public Instruction nor any of their respective officers, directors or employees provides Health Care Services to you. Rather, BCBSF and Suwannee County Board of Public Instruction are engaged in making coverage and benefit decisions under this Booklet. By accepting the Group health care coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those Services are not employees or agents of BCBSF or Suwannee County Board of Public Instruction. **In this regard, we and Suwannee County Board of Public Instruction hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and Suwannee County Board of Public Instruction 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 under the Group Health Plan concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. Neither BCBSF nor Suwannee County Board of Public Instruction will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and Suwannee County Board of Public Instruction

Neither Suwannee County Board of Public Instruction nor any person covered under this Booklet is BCBSF's agent or representative, and neither shall be liable for any acts or omissions by BCBSF's agents, servants, employees, or us. Additionally, neither BCBSF nor Suwannee County Board of Public Instruction will be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. BCBSF is not your agent, servant, or representative nor is BCBSF an agent, servant, or representative of Suwannee County Board of Public Instruction and we will not be liable for any acts or omissions, or those of Suwannee County Board of Public Instruction, its agents, servants, employees, or any person or organization with which Suwannee County Board of Public Instruction has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical Services or supplies, must be made solely by your family and your treating Physician in accordance with the patient/physician relationship. It is possible that you or your treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 20: General Provisions

Access to Information

BCBSF and Suwannee County Board of Public Instruction have the right to receive, from you and any health care Provider rendering Services to you, information that is reasonably necessary, as determined by BCBSF and Suwannee County Board of Public Instruction, in order to administer the coverage and benefits provided, subject to all applicable confidentiality requirements listed below. By accepting coverage, you authorize every health care Provider who renders Services to you, to disclose to BCBSF and Suwannee County Board of Public Instruction 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 BCBSF and/or Suwannee County Board of Public Instruction to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, BCBSF or Suwannee County Board of Public Instruction may, without the consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to any person covered under this Booklet or applicant for enrollment which BCBSF or Suwannee County Board of Public Instruction deems to be necessary.

Right to Recovery

Whenever the Group Health Plan has made payments in excess of the maximum provided for under this Booklet, BCBSF or Suwannee County Board of Public Instruction will have the right to recover any such payments, to the extent of such excess, from you or any person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Benefit Booklet shall be deemed to have been modified and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or Services under this Booklet. Further, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

BCBSF's arrangements with a Provider may require that we release certain claims and medical information about persons covered under this Booklet to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any such Provider to evaluate your financial responsibility under this Booklet.

Benefit Booklet

You have been provided with this Benefit Booklet and an Identification Card as evidence of coverage under Suwannee County Board of Public Instruction's Group Health Plan.

Modification of Provider Network and the Participation Status

NetworkBlue, and the participation status of individual Providers available under this Booklet, are subject to change at any time by BCBSF without prior notice to you or your approval or that of Suwannee County Board of Public Instruction. Additionally, BCBSF may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to you or your approval, or that of, Suwannee County Board of Public Instruction. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time the Health Care Service is rendered. Under this Booklet, your financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of You and Your Covered Dependents

You must cooperate with BCBSF and Suwannee County Board of Public Instruction, and must execute and submit to us any consents, releases, assignments, and other documents requested in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause (See the "Termination of an Individual's Coverage for Cause" subsection in the "Termination of Coverage" section).

Non-Waiver of Defaults

Any failure by BCBSF or Suwannee County Board of Public Instruction at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect BCBSF's or Suwannee County Board of Public Instruction's right at any time to enforce any terms or conditions under this Benefit Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

If to BCBSF:

To the address printed on the Identification Card.

If to you:

To the latest address provided by you or to your latest address on Enrollment Forms actually delivered to us.

You must notify us immediately of any address change.

If to Suwannee County Board of Public Instruction:

To the address indicated by Suwannee County Board of Public Instruction.

Our Obligations upon Termination

Upon termination of your coverage for any reason, there will be no further liability or responsibility to you under the Group Health Plan, except as specifically described herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Booklet.

Florida Agency for Health Care Administration Performance Data

The performance outcome and financial data published by the Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute, located at the web site address www.floridahealthfinder.gov, may be accessed through the link provided on the Blue Cross and Blue Shield of Florida corporate web site at www.floridablue.com.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its

representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of, Suwannee County Board of Public Instruction and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Suwannee County Board of Public Instruction hereby specifically expresses its intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the terms of the Suwannee County Board of Public Instruction Group Health Plan or this Benefit Booklet.

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Section 21: Definitions

The following definitions are used in this Benefit Booklet. Other definitions may be found in the particular section or subsection where they are used. For other important definitions, please refer to the definition subsection within the "BlueScript® Pharmacy Program" section.

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Administrative Services Only Agreement or **ASO Agreement** means an agreement between Suwannee County Board of Public Instruction and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to BCBSF's NetworkBlue and BCBSF's network of Traditional Insurance Providers.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Benefit Booklet with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in the Claims Processing section, shall also constitute an Adverse Benefit Determination.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard 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 BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by BCBSF that may be based on several factors including (but not necessarily limited to): (i) payment for such Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as

participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by BCBSF, with BCBSF's provider network strategies (e.g., does not result in payment that encourages Providers participating in a BCBSF network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the Allowed Amount for the specific Covered Services provided to you may be based upon the amount provided to BCBSF by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating Providers in its geographic area for such Services.

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular Services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What Is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much will be paid.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between such Allowed Amount and the amount billed for such Services by any such Out-of-Network Provider.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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:

i. The Department of Veterans Affairs.

ii. The Department of Defense.

iii. 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.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;

2. Asperger's syndrome;

3. Pervasive developmental disorder not otherwise specified; and

4. Childhood Disintegrative Disorder.

Benefit Period means a consecutive period of time, specified by BCBSF and the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your Benefit Period is listed on your Schedule of Benefits, and will not be less than 12 months unless indicated as such.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the Florida Statutes, or a similar applicable law of another state, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.

BlueCard® Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. 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 PPO Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard 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 Traditional Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard 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 PPO Program Provider means a Provider designated as a BlueCard PPO Program Provider by the Host Blue.

BlueCard Traditional Program Provider means a Provider designated as a BlueCard Traditional Program Provider by the Host Blue.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary Services).

Calendar Year begins January 1st and ends December 31st.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or 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 your share of health care expenses for Covered Services. After your Deductible requirement is met, a percentage of the Allowed Amount will be paid for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management program as described in the "Blueprint for Health Programs" section of the Benefit Booklet.

Condition means a disease, illness, ailment, injury, or pregnancy.

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

Convenient Care Center means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one master's level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

Copayment means the dollar amount established solely by Suwannee County Board of Public Instruction which is required to be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to Coinsurance, Copayment, Deductible and/or Per Admission Deductible (PAD) amounts. Applicable Cost Share amounts are identified in your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Plan Participant (See the "Eligibility Requirements for Dependent(s)" subsection of the "Eligibility for Coverage" section).

Covered Person means a Covered Plan Participant or a Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under this Benefit Booklet other than as a Covered Dependent.

Covered Services means those Health Care Services which meet the criteria listed in the "What Is Covered?" section.

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Booklet, before payment for Covered Services begins.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) and the Florida Agency for Health Care Administration or a similar regulatory agency of another state to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services.

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent;
5. the Covered Plan Participant has submitted acceptable proof of evidence of common residence and joint financial responsibility to the Group; and
6. the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law or a similar applicable law of another state to provide home medical equipment, oxygen therapy Services, or dialysis supplies in the patient’s home under a Physician’s prescription.

Effective Date means, with respect to Suwannee County Board of Public Instruction, 12:01 a.m. on the date the ASO Agreement went into effect. With respect to individuals covered under this Benefit Booklet, 12:01 a.m. on the date Suwannee County Board of Public Instruction specifies that the coverage will commence as further described in the “Enrollment and Effective Date of Coverage” section of this Benefit Booklet.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section in this Benefit Booklet, and is eligible to enroll as a Covered Dependent.

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the "Eligibility Requirements for Covered Plan Participants" subsection of the "Eligibility for Coverage" section in this Benefit Booklet and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Plan Participant until such individual has actually enrolled with, and been accepted for coverage as a Covered Plan Participant by Suwannee County Board of Public Instruction.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

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 an amendment to the Group Health Plan or this Benefit Booklet.

Enrollment Date means the date of enrollment of the individual under the Group Health Plan or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under this Benefit Booklet..

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by BCBSF or Suwannee County Board of Public Instruction:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or
4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently

published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific evidence" shall mean (as determined by BCBSF or Suwannee County Board of Public Instruction):

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services which are determined by BCBSF or Suwannee County Board of Public Instruction to be Experimental or Investigational are excluded (see the “What Is Not Covered?” section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF or Suwannee County Board of Public Instruction 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.

FDA means the United States Food and Drug Administration.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with Florida Statutes or by a similar regulatory agency of another state in compliance with that state’s applicable laws.

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Group means the employer, labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits are provided, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or Group Plan means the plan established and maintained by Suwannee County Board of Public Instruction for the provision of health care coverage and benefits to the individuals covered under this Benefit Booklet.

Health Care Services or Services includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds, and other Services rendered or supplied, by or at the direction of, Providers.

Home Health Agency means a properly licensed agency or organization which provides Health Care Services in the home pursuant to Chapter 400 of the Florida Statutes, or a similar applicable law of another state.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization which is duly licensed by the state of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Identification Card means the card(s) issued to Covered Plan Participants. The card is not transferable to another person. Possession of such card in no way guarantees that a particular individual is eligible for, or covered under, this Benefit Booklet.

Independent Clinical Laboratory means a laboratory properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Facility means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all

applicable Florida law or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an Independent Diagnostic Testing Facility.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on the Schedule of Benefits under the heading “In-Network”. Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Benefit Booklet.

In-Network Provider means any health care Provider who, at the time Covered Services were rendered to you, was under contract with BCBSF to participate in BCBSF’s NetworkBlue and included in the panel of providers designated by BCBSF as “In-Network” for your specific plan. (Please refer to your Schedule of Benefits). For payment purposes under this Benefit Booklet only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard 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 a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statues, or a similar applicable law of another state.

Massage Therapist means a person properly licensed to practice Massage, pursuant to Chapter 480 of the Florida Statutes, or a similar applicable law of another state.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Benefit Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means 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, or 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 Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Benefit Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Medication Guide for the purpose of this Benefit Booklet means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

Note: The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card for current information.

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 ICD 10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state.

NetworkBlue means, or refers to, the preferred provider network established and so designated by BCBSF which is available to individuals covered under this Benefit Booklet. Please note that BCBSF's Preferred Patient Care (PPC) preferred provider network is not available to individuals covered under this Benefit Booklet.

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Occupational Therapist means a person properly licensed to practice Occupational Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on the Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of this Benefit Booklet.

Out-of-Network Provider means a Provider who, at the time Health Care Services were rendered:

1. did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or
2. did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard PPO Program but was participating, for purposes of the BlueCard Program, as a BlueCard Traditional Program Provider; or
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue or our Traditional Program; or
5. did not have a contract with a Host Blue to participate for purposes of the BlueCard Program as a BlueCard Traditional Program Provider.

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; outpatient Cardiac Therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet BCBSF's criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, Florida Administrative Code or the similar law or laws of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 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.

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the Florida Statutes, or a similar applicable law of another state.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

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 this Benefit Booklet.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of the Benefit Booklet condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of the Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

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".

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Health Services covered under your plan. **Note:** The Preventive Services Guide is subject to change Please refer to our website at www.floridablue.com/healthresources for the most current guide.

Prosthetist/Orthotist means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide Services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

Provider means any facility, person or entity recognized for payment by BCBSF under this Booklet.

Provider Incentive means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse First Assistant (RNFA) means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

Rehabilitation Services means Services for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to cardiac rehabilitation, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage Therapy.

Rehabilitative Therapies means therapies, the primary purpose of which, is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

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.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Skilled Nursing Facility means an institution or part thereof which meets BCBSF's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by BCBSF.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

Specialty Drug means an FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs 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.

Speech Therapy means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy Services.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

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: 1) the United States Pharmacopoeia Drug Information; 2) the American Medical Association Drug Evaluation; or 3) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the

purposes of this Booklet, a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's use of alcohol or any other substance injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Traditional Program means, or refers to, BCBSF's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS).

Traditional Program Providers means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, have entered into a contract, then in effect, to participate in BCBSF's Traditional Program as applicable in Florida or in certain counties outside of Florida when such programs exist.

Urgent Care Center means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For purposes of this Benefit Booklet, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

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.

Virtual Care Provider is a licensed Provider that is designated by us to provide care and treatment options by way of Virtual Visits. An In-Network Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications. Virtual Visits shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

Waiting Period means the length of time specified by Suwannee County Board of Public Instruction which must be met by an individual before that individual becomes eligible for coverage under this Benefit Booklet.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

Templates Included

Compliance/Notices/Meaningful Access Notice.jld
Compliance/Notices/Prior Authorization (Preapproval) of Medical and Pharmacy Services Notice.jld
Compliance/Notices/Privacy Notice - Breast Reconstruction Notice.jld

78170-05193--Schedule-Of-Benefits-2
78170-05192--Benefit-Booklet-1

MATCHING CRITERIA

Record Number	950
Request Type	M
Health Product	BLUEOPTIONS
Small Group	N
Rx Product	BLUESCRIPT
Rx Plan	86
Health Plan	05193
IRX	Y
Generic Choices	N
Generic Only	N
Closed Formulary	N
HSA	Y
HSA-BRX	N
Standard	N
Basic	N
ACA	N
RX Coins	N
ICC	N
CP-GF-BEN-IND	N
CP-GF-STATUS-IND	N
CP-GROUP-SUB	G
CP-GENERATION-IND	3
CP-EXCHANGE-IND	N
CP-RX-DED-IND	N

CP-RX-NGF-2012-HCR-IND	Y
CP-RX-GF-2012-HCR-IND	N
TAG-RX-SUFFIX	G
AON	N
CP-ASO-IND	Y
ROUTE	GROUP
EFF-YEAR	21
PMT_KEY	021167025520110033020037950
GRP-PKG-EFF-YEAR	21
GRP-NO	78170
DIV-NO	R08
PKG-NO	01
FEEDER1	0
FEEDER2	0
FEEDER3	0
FEEDER4	0
FEEDER5	0
FEEDER6	0
COE	,,,,,,,,
DATE	6/5/21 11:25 AM

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

SUWANNEE CNTY BOARD OF PUBLIC
ATTN TERESA JONES
1740 OHIO AVE S
LIVE OAK FL 32064-4500

Thanks for choosing Florida Blue! See the enclosed **Welcome brochure** for everything you need to get the most value from your health plan. For plan info on the go, download the Florida Blue app or log in to your account at floridablue.com.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of
Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

This Master Contract is for SUWANNEE CNTY BOARD OF PUBLIC

Group Number 78170

Division(s)	Package	Division	Package

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Florida Blue

In the pursuit of health®

Notice Regarding Prior Authorization (Preapproval) of Medical and Pharmacy Services

MAKE SURE YOUR SERVICES ARE COVERED –
CHECK FIRST FOR PREAPPROVAL

For some services or drugs, your doctor needs to get preapproval before your plan will cover them. This does three important things: ensures coverage from your plan, guides you to quality care and helps you save money.

If your doctor doesn't get approval, you may have to pay the entire medical bill.

For an updated list of services that need preapproval, go to floridablue.com/authorization. You can also click the link in the "Authorizations" section on the homepage of your member account.

Talk with your doctor to find out if they've gotten preapproval. You can also call us at 800-352-2583.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc., d/b/a/ Florida Blue, Health Options, Inc., d/b/a Florida Blue HMO, and BeHealthy Florida, Inc., d/b/a Florida Blue Preferred HMO, collectively referred to as Florida Blue in this Notice) understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the effective date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:
We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.

- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.
- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to create a limited data set or de-identified information, and use and disclose such information as permitted by law.
- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:
We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.
There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:
To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to

a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
- **Note:** If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Florida Blue
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Notice Regarding Coverage for Breast Reconstruction Surgery

If you have to have a mastectomy, your breast reconstruction surgery is covered under your health coverage. It can be done at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

BlueOptions

Schedule of Benefits - Plan 05781

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period .....01/01 - 12/31

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$1,500	$4,500
Per Family per Benefit Period	$4,500	$13,500
Per Admission Deductible (PAD)	Not Applicable	$500
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	30%	50%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$5,500	$11,000
Per Family per Benefit Period	$11,000	$22,000

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office Visits and Services not otherwise outlined in this table rendered by		
Family Physicians	$30	DED + 50%
Other health care professionals licensed to perform such Services	$55	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$250	DED + 50%
Other health care professionals licensed to perform such Services	$250	DED + 50%
Allergy Injections rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 30%	DED + 50%
Convenient Care Centers	$30	DED + 50%

Virtual Health

Benefit Description	You Pay
Virtual Visits	
General Medicine and Urgent Care rendered by a designated Virtual Care Provider	$30
Specialized Care rendered by a designated Virtual Care Provider	$55

Please visit http://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by: Family Physicians	20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	20%	DED + 50%
Out-of-Pocket Maximum per Person per Month	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Adult Well Woman Services Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Child Health Supervision Services Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 50%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250	DED + 50%
All other diagnostic Services (e.g., X-rays)	$50	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 30%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	$60	DED + $60

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	$200	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	$55	$55
Other health care professional Services rendered by all other Providers	$55	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	DED + 30%	DED + 30%	**PAD + DED + 50%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%
Outpatient			
Facility (per visit)	DED + 30%	DED + 30%	DED + 50%
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%
Therapy Services	$55	$70	DED + 50%
Emergency Room Visits			
Facility (Copayment waived if admitted)	$250		$250
Physician and other health care professional Services	DED + 30%		In-Network DED + 30%

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and Emergency Room Copayment will apply to that 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. This plan 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. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room	$0	$0
Hospital	$0	50%
Physician Services at Hospital and ER	$0	$0
Physician and other health care professionals licensed to perform such Services Family Physician office	$0	50%
Specialist office	$0	50%
All other locations	$0	50%
Inpatient Facility Services	$0	50%
Physician and other health care professionals licensed to perform such Services	$0	$0

Benefit Maximums

Home Health Care Visits per Benefit Period 20

Inpatient Rehabilitation days per Benefit Period 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility days per Benefit Period 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

Prescription Drug Program

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.

BlueScript® Pharmacy Program

Schedule of Benefits

You should carefully review this Pharmacy Program Schedule of Benefits. If you did not receive, or cannot find, the BlueScript Pharmacy Program Endorsement, which this Pharmacy Program Schedule of Benefits is a part of, contact us to obtain one. To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on your Identification Card. References to Deductible are abbreviated as “DED” and references to Benefit Period are abbreviated as “BP”.

	Participating Pharmacy	Non-Participating Pharmacy
Pharmacy Deductible Per (BP) **Note:** The Pharmacy Deductible does not apply to Preferred Generic Prescription Drugs or Covered OTC Drugs purchased from a Participating Pharmacy.	$300	
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at: Retail Pharmacy – For up to a One-Month Supply	$10	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$10	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$25	50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs and Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	DED + $60	DED + 50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	DED + $60	DED + 50% of the Non-Participating Pharmacy Allowanc
Mail Order Pharmacy – For up to a Three-Month Supply	DED + $150	DED + 50% of the Non-Participating Pharmacy Allowanc

	Participating Pharmacy	Non-Participating Pharmacy
Non-Preferred Prescription Drugs and Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	DED + $100	DED + 50% of the Non-Participating Pharmacy Allowanc
Specialty Pharmacy - For up to a One-Month Supply	DED + $100	DED + 50% of the Non-Participating Pharmacy Allowanc
Mail Order Pharmacy – For up to a Three-Month Supply	DED + $250	DED + 50% of the Non-Participating Pharmacy Allowanc

Other Important Information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

     Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;

  2. Diaphragms indicated as covered in the Medication Guide; and
  3. Emergency contraceptives indicated as covered in the Medication Guide.

  - If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

    1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
    2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

  - The Specialty Pharmacies designated, solely by us, are the only "In-Network" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes under this BlueScript Pharmacy Program.

- Some Specialty medications 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.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy

BlueOptions

Benefit Booklet for the Suwannee County Board of Public Instruction Group Health Plan

A Self-funded Group Health Benefit Plan

Effective: May 1, 2021

For Customer Service Assistance: 800-664-5295

Group 78170
Plan 05781

Benefit Booklet

BlueOptions

for Self-Funded Groups
Benefit Booklet

CUSTOMER SERVICE ASSISTANCE:
800-664-5295

Group 78170
Plan 05781

Benefit Booklet

Table of Contents

Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet ("Booklet"). It describes your coverage, benefits, limitations and exclusions for the self-funded Group Health Benefit Plan ("Group Health Plan" or "Group Plan") established and maintained by Suwannee County Board of Public Instruction.

The sponsor of your Group Health Plan has contracted with Blue Cross Blue Shield of Florida, Inc. (BCBSF), under an Administrative Services Only Agreement ("ASO Agreement"), to provide certain third party administrative services, including claims processing, customer service, and other services, and access to certain of its Provider networks. BCBSF provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to Covered Persons or claims submitted for processing under this Benefit Booklet for such Services. The payment of claims under the Group Health Plan depends exclusively upon the funding provided by or through Suwannee County Board of Public Instruction.

You should read your Benefit Booklet carefully before you need Health Care Services. It contains valuable information about:

- your BlueOptions benefits;
- what is covered;
- what is excluded or not covered;
- coverage and payment rules;
- Blueprint for Health Programs;
- how and when to file a claim;
- how much, and under what circumstances, payment will be made;
- what you will have to pay as your share;
- and other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how benefits will be coordinated with other policies or plans; the Group Health Plan's subrogation rights; and right of reimbursement.

You will need to refer to the Schedule of Benefits to determine how much you have to pay for particular Health Care Services.

When reading your Booklet, please remember that:

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.
- references to "we", "us", and "our" throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as "BCBSF."

- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section or defined within the particular section where it is used.

Where do you find information on…

- **what particular types of Health Care Services are covered?**

  Read the "What Is Covered?" and "What Is Not Covered?" sections.

- **how much will be paid under your Group Health Plan and how much you have to pay?**

  Read the "Understanding Your Share of Health Care Expenses" section along with the Schedule of Benefits.

- **how to take advantage of the BlueCard® Program when you receive Services out-of-state?**

  Read the "BlueCard® Program" section.

- **how to add or remove a Dependent?**

  Read the "Enrollment and Effective Date of Coverage" section.

- **what happens if you are covered under this Benefit Booklet and another health plan**?

  Read the "Duplication of Coverage Under Other Health Plans/Programs" section.

- **what happens when your coverage ends?**

  Read the "Termination of Coverage" section.

- **what do the terms used throughout this Booklet mean?**

  Read the "Definitions" section.

Overview of How BlueOptions Works

Whenever you need care, you have a choice. If you visit an:	
In-Network Provider	**Out-of-Network Provider**
You receive In-Network benefits, the highest level of coverage available.	You receive the Out-of-Network level of benefits – you will share more of the cost of your care.
You do not have to file a claim; the claim will be filed by the In-Network Provider for you.	You may be required to submit a claim form.
The In-Network Provider* is responsible for Admission Notification if you are admitted to the Hospital.	You should notify BCBSF of inpatient admissions.

* For Services rendered by an In-Network Provider located outside of Florida, you should notify us of inpatient admissions

Section 2: What Is Covered?

Introduction

This section describes the Health Care Services that are covered under this Benefit Booklet. All benefits for Covered Services are subject to your share of the cost and the benefit maximums listed on your Schedule of Benefits, the applicable Allowed Amount, any limitations and/or exclusions, as well as other provisions contained in this Booklet, and any Endorsement(s) in accordance with BCBSF's Medical Necessity coverage criteria and benefit guidelines then in effect.

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the "What Is Not Covered?" section. More than one limitation or exclusion may apply to a specific Service or a particular situation.

Expenses for the Health Care Services listed in this section will be covered under this Booklet only if the Services are:

1. within the Health Care Services categories in this "What Is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this Benefit Booklet and for which an itemized statement or description of the procedure or Service, which was rendered is received, including any applicable procedure code, diagnosis code and other information required in order to process a claim for the Service;
3. Medically Necessary, as defined in this Booklet and determined by BCBSF or Suwannee County Board of Public Instruction in accordance with BCBSF's Medical Necessity coverage criteria then in effect, except as specified in this section;
4. in accordance with our benefit guidelines listed below;
5. rendered while your coverage is in force; and
6. not specifically or generally limited or excluded under this Booklet.

BCBSF or Suwannee County Board of Public Instruction will determine whether Services are Covered Services under this Booklet after you have obtained the Services and a claim has been received for the Services. In some circumstances BCBSF or Suwannee County Board of Public Instruction may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, BCBSF or Suwannee County Board of Public Instruction may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. Neither BCBSF nor Suwannee County Board of Public Instruction are obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

In determining whether Health Care Services are Covered Services under this Booklet, no written or verbal representation by any employee or agent of BCBSF or Suwannee County Board of Public Instruction, or by any other person shall waive or otherwise modify the terms of this Booklet and, therefore, neither you, nor any health care Provider or other person should rely on any such written or verbal representation.

Our Benefit Guidelines

In providing benefits for Covered Services, the benefit guidelines listed below will apply as well as any other applicable payment rules specific to particular categories of Services:

1. Payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable for any such Services.
2. Payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service nor the day of the week nor the time of day the procedure is performed.
3. Payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Accident Care

Health Care Services to treat an injury resulting from an Accident not related to your job or employment are covered.

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum are covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

Ambulance Services

Ground Ambulance

Ground Ambulance Services for Emergency Medical Conditions and limited non-emergency ground transport may be covered only when:

1. For Emergency Medical Conditions – it is Medically Necessary to transport you from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
    a) from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;
    b) to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;

c) to the nearest more cost-effective acute care facility as determined solely by us; or

d) from an acute facility to the nearest cost-effective sub-acute setting.

Note: Non-emergency Ambulance transportation meets the definition of Medical Necessity only when the patient's Condition requires treatment at another facility and when another mode of transportation, whether by Ambulance or otherwise (regardless of whether covered by us or not) would endanger the patient's medical Condition. If another mode of transportation could be used safely and effectively, regardless of time, or mode (e.g. air, ground, water) then Ambulance transportation is not Medically Necessary.

Air and Water Ambulance

Air and water Ambulance coverage is specifically limited to transport due to an Emergency Medical Condition when the patient's destination is an acute care Hospital, and:

1. the pick-up point is not accessible by ground Ambulance, or
2. speed in excess of the ground vehicle is critical for your health or safety.

Air and water Ambulance transport for non-emergency transport is excluded unless it is specifically approved by us in advance of the transport.

Exclusion:

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
   a) the crew renders aid until a helicopter can be sent;
   b) the patient refuses care or transport; or
   c) only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
   a) patient wants to be at a certain Hospital or facility for personal/preference reasons;
   b) patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment), or after being discharged from inpatient care; or
   c) patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
6. Air or water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center are covered and include:

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered (except for take home Drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

Anesthesia Administration Services

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, payment for Covered Services, if any, will be made for both the CRNA and the Physician Health Care Services at the lower directed-services Allowed Amount in accordance with BCBSF's payment program for such Covered Services then in effect.

Exclusion:

Coverage does not include anesthesia Services by an operating Physician, his or her partner or associate.

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section 393.17 of the Florida Statutes or licensed under Chapters 490 or 491 of the Florida Statutes; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion:

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

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 Booklet;
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician; and
4. Residential Treatment Services, as defined in this Booklet.

Exclusion:

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;
8. Services to test aptitude, ability, intelligence or interest except as covered under the Autism Spectrum Disorder subsection;
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. You acknowledge that we do not have any Contractual or other formal arrangements with the Provider of such services.

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

Surgery to reestablish symmetry between two breasts and implanted prostheses incident to Mastectomy is covered. In order to be covered, such surgery must be provided in a manner chosen by your Physician, consistent with prevailing medical standards, and in consultation with you.

Child Cleft Lip and Cleft Palate Treatment

Treatment and Services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition Services for treatment of a child under the age of 18 who has cleft lip or cleft palate are covered. In order for such Services to be covered, your Covered Dependent's Physician must specifically prescribe such Services and such Services must be consequent to treatment of the cleft lip or cleft palate.

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 Booklet, 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 Booklet 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 Physician care Services are covered, provided: (a) the additional Physician actively participates in your treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the same specialty with different sub-specialties.

Consultations

Consultations provided by a Physician are covered if your attending Physician requests the consultation and the consulting Physician prepares a written report.

Contraceptive Injections

Medication by injection is covered when provided and administered by a Physician, for the purpose of contraception, and is limited to the medication and administration.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental Services provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
   a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that:
      i. Dental treatment is necessary due to a dental Condition that is significantly complex; or
      ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
   b) you or your Covered Dependent has one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Exclusion:

1. Dental Services provided more than 62 days after the date of an Accidental Dental Injury, regardless of whether or not such Services could have been rendered within 62 days; and
2. Dental implants.

Diabetes Outpatient Self-Management

Diabetes outpatient self-management training and educational Services and nutrition counseling to treat diabetes, if your treating Physician or a Physician who specializes in the treatment of diabetes certifies that such Services are Medically Necessary, are covered. In order to be covered, diabetes outpatient self-management training and educational Services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed Dietitian. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Notwithstanding the above, if your Benefit Booklet was amended by a Pharmacy Program Endorsement which covers diabetes equipment and supplies, then diabetes equipment and supplies will be covered in accordance with the terms and conditions of such Pharmacy Program Endorsement.

Diagnostic Services

Diagnostic Services when ordered by a Physician are limited to the following:

1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);
2. laboratory and pathology Services;
3. Services involving bones or joints of the jaw (e.g., Services to treat temporomandibular joint [TMJ] dysfunction) or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. approved machine testing (e.g., electrocardiogram [EKG], electroencephalograph [EEG], and other electronic diagnostic medical procedures); and
5. genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

Dialysis Services

Dialysis Services including equipment, training, and medical supplies, when provided at any location by a Provider licensed to perform dialysis including a Dialysis Center are covered.

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, limited to the most cost effective equipment as determined by BCBSF or Suwannee County Board of Public Instruction is covered.

Payment Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Payment for Durable Medical Equipment will be based on the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) the Allowed Amount. The Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of Durable Medical Equipment due to growth of a child or significant change in functional status is a Covered Service.

Exclusion:

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used are excluded.

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.

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 when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period are covered.

Coverage to treat inherited diseases of amino acid and organic acids, for you up to your 25th birthday, shall include coverage for food products modified to be low protein.

Eye Care

Coverage includes the following Services:

1. Physician Services, soft lenses or sclera shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician Services to treat an injury to or disease of the eyes.

Exclusion:

Health Care Services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercises or visual training; eye glasses and contact lenses and their fitting are excluded. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK) are excluded.

Home Health Care

The Home Health Care Services listed below are covered when the following criteria are met:

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan which has been reviewed and renewed by the prescribing Physician every 30 days. In order to determine whether such Services are covered under this Booklet, you may be required to provide a copy of any written treatment plan;
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide Services;

2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
3. medical social Services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen); and
6. Physical Therapy by a Physical Therapist, Occupational Therapy by a 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 a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is:

1. approved by your Physician; and
2. your doctor has certified to us in writing that your life expectancy is 12 months or less.

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. Drugs and medicines administered (except for take home Drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the “What Is Not Covered?” section);
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;

12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, and Cardiac Therapies; and
14. transplants as described in the Transplant Services subsection.

Exclusion:

Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital: 1) room and board provided during the admission; 2) Physician visits provided while you were an inpatient; 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and 4) other Services provided while you were an inpatient.

In addition, expenses for the following and similar items are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home Drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

Inpatient Rehabilitation

Inpatient Rehabilitation Services are covered when the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Inpatient Rehabilitation Services are subject to the inpatient facility Copayment, if applicable, and the benefit maximum set forth in the Schedule of Benefits.

Exclusion:

All Substance Dependency, drug and alcohol related diagnoses, Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening are Covered Services.

Benefits for mammograms may not be subject to the Deductible, Coinsurance, or Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by you and your attending Physician are covered. Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Services

Health Care Services, including prenatal care, delivery and postpartum care and assessment, provided to you, by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife may be Covered Services. Care for the mother includes the postpartum assessment.

In order for the postpartum assessment to be covered, such assessment must be provided at a Hospital, an attending Physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in care for a mother. Coverage under this Booklet for the postpartum assessment includes coverage for the physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards.

Under Federal law, your Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Pharmacy

Physician-administered Prescription Drugs which are rendered in a Physician's office may be subject to a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug and does not include the administration of the Prescription Drug.

Your plan may also include a maximum monthly amount you will be required to pay out-of-pocket for Medical Pharmacy, when such Services are provided by an In-Network Provider or Specialty Pharmacy. If your plan includes a Medical Pharmacy out-of-pocket monthly maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

Please refer to your Schedule of Benefits for the additional Cost Share amount and/or monthly maximum out-of-pocket applicable to Medical Pharmacy for your plan.

Note: For purposes of this benefit, allergy injections and immunizations are not considered Medical Pharmacy.

Newborn Care

A newborn child will be covered from the moment of birth provided that the newborn child is eligible for coverage and properly enrolled. Covered Services shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment:

An assessment of the newborn child is covered provided the Services were rendered at a Hospital, the attending Physician's office, a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These Services are not subject to the Deductible.

Ambulance Services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn child's Condition, as determined by us and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child, are covered.

Under Federal law, your Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Orthotic Devices

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets are covered when prescribed by a Physician and designed and fitted by an Orthotist.

Benefits may be provided for necessary replacement of an Orthotic Device which is owned by you when due to irreparable damage, wear, a change in your Condition, or when necessitated due to growth of a child.

Payment for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six-month period unless a more frequent replacement is determined by BCBSF or Suwannee County Board of Public Instruction to be Medically Necessary.

Exclusion:

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease;
2. Expenses for orthotic appliances or devices which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets), except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
3. Expenses for devices necessary to exercise, train, or participate in sports, e.g. custom-made knee braces.

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;

3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulation Services

Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

Cardiac Therapy Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.

Occupational Therapy Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition are covered.

Speech Therapy Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition are covered.

Physical Therapy Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition are covered.

Massage Therapy Services provided by a Physician, Massage Therapist, or Physical Therapist when the Massage is prescribed as being Medically Necessary by a Physician licensed pursuant to Florida Statutes Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Physician's prescription must specify the number of treatments.

Payment Guidelines for Massage and Physical Therapy

1. Payment for covered Massage Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
2. Payment for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
3. Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day not to exceed fifteen (15) minutes in length.

Spinal Manipulations: Services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered.

Payment Guidelines for Spinal Manipulation

1. Payment for covered spinal manipulation is limited to no more than 26 spinal manipulations per Benefit Period, **or** the maximum benefit listed in the Schedule of Benefits, whichever occurs first.
2. Payment for covered Physical Therapy Services rendered on the same day as a spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

Your Schedule of Benefits sets forth the maximum number of visits covered under this plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example,

even if you may have only been administered two (2) of the spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy visit maximum with other Services.

Oxygen

Expenses for oxygen, the equipment necessary to administer it, and the administration of oxygen are covered.

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility.

Exclusion:

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

Preventive Health Services

Preventive Services are covered for both adults and children based on prevailing medical standards and recommendations which are explained further below. Some examples of preventive health Services include, but are not limited to, periodic routine health exams, routine gynecological exams, immunizations and related preventive Services such as Prostate Specific Antigen (PSA), routine mammograms and pap smears. In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. with respect to infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph number one as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

More detailed information, such as medical management programs or limitations, on Services that are covered under the Preventive Health 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 Health 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 Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

For example, if the USPSTF adds a new recommendation for a preventive Service that we do not cover and you are already covered under this Benefit Booklet; that new Service will not be a Covered Service under this category right away. The coverage for a new Service will start on your Group's Anniversary Date one year after the new recommendation goes into effect.

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph one above.

Prosthetic Devices

The following Prosthetic Devices are covered when prescribed by a Physician and designed and fitted by a Prosthetist:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers and prosthetic devices incident to a Mastectomy;
2. appliances needed to effectively use artificial limbs or corrective braces; or
3. penile prosthesis.

Covered Prosthetic Devices (except cardiac pacemakers, and Prosthetic Devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessitated due to growth of a child.

Exclusion:

Expenses for cosmetic enhancements to artificial limbs

Self-Administered Injectable Prescription Drugs

Unless otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet, only Self-Administered Injectable Prescription Drugs used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when you are an inpatient in a Skilled Nursing Facility:

1. room and board;
2. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered while an inpatient (except take-home Drugs);
4. intravenous solutions;
5. Administration of, including the cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;

8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease; and
10. Physical, Speech, and Occupational Therapies.
11. A treatment plan from your Physician may be required in order to determine coverage and payment.

Exclusion:

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other Service primarily for the convenience of you and/or your family members or the Provider are excluded. Expenses for any inpatient days beyond the per person maximum number of days per Benefit Period listed on the Schedule of Benefits are also excluded.

Surgical Assistant Services

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary are covered.

Surgical Procedures

Surgical procedures performed by a Physician may be covered including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;
4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and
6. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Exclusions:

   The following Services, which are considered cosmetic in nature, are not covered when used to improve the gender-specific appearance of an individual. Examples of Services which are considered cosmetic include, but are not limited to:

   a) reduction thyroid chondroplasty;
   b) liposuction;
   c) rhinoplasty;
   d) facial bone reconstruction;
   e) face lift;
   f) blepharoplasty;
   g) voice modification surgery;
   h) hair removal/hairplasty; or

i) breast augmentation.

Payment Guidelines for Surgical Procedures

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed. In addition the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits will apply. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in BCBSF's or Suwannee County Board of Public Instruction's opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example).
3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

Transplant Services

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to BCBSF or Suwannee County Board of Public Instruction, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge Services, and treatment of complications after transplantation. Benefits will only be paid for Services, care and treatment received or provided in connection with a:

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. Coverage will be provided for the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

Coverage will be provided for donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

You may call the customer service phone number indicated in this Booklet or on your Identification Card in order to determine which Bone Marrow Transplants are covered under this Booklet.

Exclusion:

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Benefit Booklet;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant; and
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.

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

Virtual Visits between you and a Virtual Care Provider that is designated by us and under contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion:

1. Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

Section 3: What Is Not Covered?

Introduction

Your Booklet expressly excludes expenses for the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the "What Is Covered?" section or any other section of the Booklet.

Abortions which are elective.

Arch Supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Assisted Reproductive Therapy (Infertility) including, but not limited to, associated Services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; and infertility treatment medication.

Autopsy or postmortem examination Services, unless specifically requested by BCBSF or Suwannee County Board of Public Instruction.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered under the Preventive Health Services category of the "What Is Covered?" section.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants,or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, breast augmentation.

Costs related to telephone consultations (except as indicated as covered under the Preventive Health Services category of the "What Is Covered?" section), failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial Care and any Service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home

parents; domestic maid services; respite care; and provision of Services which are for the sole purposes of allowing a family member or caregiver of a Covered Person to return to work.

Dental Services or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to an Accidental Dental Injury or the Child Cleft Lip and Cleft Palate Treatment Services category as described in the "What Is Covered?" section.

Diabetic Equipment and Supplies used for the treatment of diabetes which are otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet.

Drugs

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All Drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to Drugs dispensed to you when:
    a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
    b) you are in the outpatient department of a Hospital;
    c) dispensed to your Physician for administration to you in the Physician's office:
        i. by a Specialty Pharmacy under contract with us to provide such medications; and
        ii. prior coverage authorization has been obtained (if required); and
        iii. is indicated as covered in the Medication Guide; or
    d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for Self-Administered Prescription Drugs in connection with a nursing visit.
3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods, except as described in the Preventive Health Services category of the "What Is Covered?" section.
4. Any Drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction Drugs excluded under this paragraph.
5. Any Self-Administered Prescription Drug except when covered under the "BlueScript® Pharmacy Program" section or the "What Is Covered?" section of this Benefit Booklet.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
    a) emergency stabilization;

b) during a covered inpatient stay, or

c) when proximately related to a surgical procedure.

The exceptions to the exclusion for Drugs purchased or dispensed by a pharmacy described in subparagraph number two do not apply to hemophilia Drugs excluded under this subparagraph.

7. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.
8. New Prescription Drug(s), as defined in the Definitions section.
9. Convenience Kits, as defined in the Definitions section of the Booklet.
10. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Medical Policy Committee or any other nationally recognized source.

Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category.

Food and Food Products whether prescribed or not, except as covered in the Enteral Formulas subsection of the "What Is Covered?" section.

Foot Care which is routine, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to: non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails corns, or calluses.

Genetic screening, including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition, except as provided under the Preventive Health Services category of the "What Is Covered?" section.

Hearing Aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair.

Immunizations except those covered under the Preventive Health Services category of the "What Is Covered?" section.

Motor Vehicle Accidents Injuries and Services you incur due to an accident involving any motor vehicle for which no-fault insurance is available.

Oral Surgery except as provided under the "What Is Covered?" section.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Oversight of a medical laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion shall, include, but is not limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. the calibration of laboratory machines or testing of laboratory equipment;
3. the preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and
4. laboratory equipment or laboratory personnel for any reason.

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to your treatment including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;

3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the "What Is Covered?" section of this Booklet.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations categories of the "What Is Covered?" section. Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.

Reversal of Voluntary, Surgically-Induced Sterility including the reversal of tubal ligations and vasectomies.

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCBSF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Smoking Cessation Programs including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.), except as indicated as covered under the Preventive Health Services category of the "What Is Covered?" section.

Sports-Related devices and Services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

Training and Educational Programs, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation, except as provided under the "Diabetes Outpatient Self Management" category of the "What Is Covered?" section.

Travel or vacation expenses even if prescribed or ordered by a Provider.

Virtual Visits, except as described in the "What Is Covered?" section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and/or does not have a contract with us to provide access to Virtual Visits under this Booklet.

Volunteer Services or Services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment (if applicable) requirements which are waived by a health care Provider.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, 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. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a) a licensed outdoor youth program, and/or
    b) a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

Section 4: Medical Necessity

In order for Health Care Services to be covered under this Booklet, such Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as defined by this Benefit Booklet.

It is important to remember that any review of Medical Necessity BCBSF or Suwannee County Board of Public Instruction undertakes is solely for the purposes of determining coverage, benefits, or payment under the terms of this Booklet and not for the purpose of recommending or providing medical care. In conducting a review of Medical Necessity, BCBSF or Suwannee County Board of Public Instruction may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining whether a Health Care Service provided or proposed meets the definition of Medical Necessity in this Booklet. In applying the definition of Medical Necessity in this Booklet to a specific Health Care Service, coverage and payment guidelines then in effect may be applied by BCBSF or Suwannee County Board of Public Instruction.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. Suwannee County Board of Public Instruction retains ultimate responsibility for determining whether expenses incurred for medical care are covered under this Booklet. In making coverage decisions, neither BCBSF nor Suwannee County Board of Public Instruction will be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to:

1. staying in the Hospital because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;
3. staying in the Hospital because supervision in the home, or care in the home, is not available or 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 Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by this Benefit Booklet) or a Covered Service. Please refer to the "Definitions" section for the definitions of "Medically Necessary" or "Medical Necessity".

Section 5: Understanding Your Share of Health Care Expenses

This section explains what your share of the health care expenses will be for Covered Services you receive. In addition to the information explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

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 you 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.

Deductible Requirement

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by us. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount. Please see your Schedule of Benefits for more information.

Family Deductible

If your plan includes a family Deductible, after the family Deductible has been met by your family, neither you nor your Covered Dependents will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible, if applicable, is the amount applied toward the individual Deductible. Please see your Schedule of Benefits for more information.

Copayment Requirements

Covered Services rendered by certain Providers or at certain locations or settings will be subject to a Copayment requirement. This is the dollar amount you have to pay when you receive these Services. Please refer to your Schedule of Benefits for the specific Covered Services which are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your plan. If the Allowed Amount or the Provider’s actual charge for a Covered Service rendered is less than the Copayment amount, you must pay the lesser of the Allowed Amount or the Provider’s actual charge for the Covered Service.

1. Office Services Copayment:

   If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office (when applicable) must be satisfied by you, for each office Service before any payment will be made. The office Services Copayment applies regardless of the reason for the office visit and applies to all

Covered Services rendered in the office, with the exception of Durable Medical Equipment, Medical Pharmacy, Prosthetics, and Orthotics.

Generally, if more than one Covered Service that is subject to a Copayment is rendered during the same office visit, you will be responsible for a single Copayment which will not exceed the highest Copayment specified in the Schedule of Benefits for the particular Health Care Services rendered.

2. Inpatient Facility Copayment:

   The Copayment for inpatient facility Services, if applicable to your plan, must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions to a Hospital, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals for inpatient admissions.

   Note: Copayments for inpatient facility Services vary depending on the facility chosen. Please see the Schedule of Benefits for more information.

3. Outpatient Facility Copayment:

   The Copayment for outpatient facility Services, if applicable to your plan, must be satisfied by you, for each outpatient visit to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Facility, Psychiatric Facility or Substance Abuse Facility, before any payment will be made for any claim for outpatient Covered Services. The Copayment for outpatient facility Services, if applicable to your plan, applies regardless of the reason for the visit, and applies to all outpatient visits to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Facility, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other healthcare professionals.

   Note: Copayments for outpatient facility Services vary depending on the facility chosen. Please see the Schedule of Benefits for more information.

4. Copayment for Emergency Room Facility Services:

   The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit.

   - If you are admitted to an In-Network Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.
   - If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the Out-of-network Deductible, In-Network Coinsurance and/or Emergency Room Copayment will apply to that admission. Please see your Schedule of Benefits for the applicable Cost Share.

Coinsurance Requirements

All applicable Deductible or Copayment amounts must be satisfied before any portion of the Allowed Amount will be paid for Covered Services. For Services that are subject to Coinsurance, the Coinsurance percentage of the applicable Allowed Amount you are responsible for is listed in the Schedule of Benefits.

Note: The Deductible, any applicable Copayments and Coinsurance amounts will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums. If the Group has purchased Prescription Drug coverage, any applicable Cost Share under the Prescription Drug coverage, will only apply to the out-of-pocket maximums under this Booklet.

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Deductible and Coinsurance maximums met by you under a prior group insurance, blanket insurance, franchise insurance or group Health Maintenance Organization (HMO) policy maintained by the Group if the coverage provided hereunder replaces such a policy or plan. This provision only applies if the prior group insurance, blanket insurance, franchise insurance or HMO coverage purchased by the Group was in effect immediately preceding the Effective Date of this Benefit Booklet. This provision is only applicable for you during the initial Benefit Period of coverage under this Benefit Booklet and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage under this Benefit Booklet only, charges credited by the Group's prior insurer, toward your Deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of this Benefit Booklet, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

Charges credited by the Group's prior insurer, toward your Coinsurance maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of this Benefit Booklet, will be credited to your out-of-pocket maximum under this Booklet.

Prior coverage credit toward the Deductible or out-of-pocket maximums will only be given for Health Care Services, which would have been Covered Services under this Booklet.

Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group. You and/or the Group are responsible for providing us with any information necessary for us to apply this prior coverage credit.

Benefit Maximum Carryover

If immediately before the Effective Date of coverage under this Benefit Booklet, you were covered under a prior group policy issued by BCBSF to Suwannee County Board of Public Instruction, amounts applied to your benefit maximums under the prior BCBSF policy, will be applied toward your benefit maximums under this Booklet, unless otherwise specified on your Schedule of Benefits.

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

Additional Expenses You Must Pay

In addition to your share of the expenses described above, you are also responsible for:

1. any applicable Copayments;
2. expenses incurred for non-covered Services;

3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., the Benefit Period maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept the Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any contribution amount required by Suwannee County Board of Public Instruction.

Special Payment Rules

Emergency Services in an Emergency Room

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

Additionally, payments for Emergency Services by an Out-of-Network Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center; and
- you do not have the ability and opportunity to choose an In-Network Provider at the In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center who is available to treat you; and,
- section 627.64194(3) of the Florida Statutes is applicable to the Services rendered.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

How Benefit Maximums Will Be Credited

Only amounts actually paid for Covered Services will be credited towards any applicable benefit maximums. The amounts paid which are credited towards your benefit maximums will be based on the Allowed Amount for the Covered Services provided.

Section 6: Physicians, Hospitals and Other Provider Options

Introduction

It is important for you to understand how the Provider you select and the setting in which you receive Health Care Services affects how much you are responsible for paying under this Booklet. This section, along with the Schedule of Benefits and BCBSF's Provider Directory, describes the health care Provider options available to you and the payment rules for Services you receive.

As used throughout this section "out-of-pocket expenses" or "out-of-pocket" refers to the amounts you are required to pay including any applicable Copayments, the Deductible and/or Coinsurance amounts for Covered Services.

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard Traditional Program Providers, in conformity with the "BlueCard Program" section of this Benefit Booklet.

Provider Participation Status

With BlueOptions, you may choose to receive Services from any Provider. However, you may be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider.

Family Physician Program

We encourage you to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians).

- Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs.
- Developing and continuing a relationship with a Family Physician allows the Physician to become knowledgeable about you and your family's health history.
- A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs.
- Care rendered by Family Physicians usually results in lower out-of-pocket expenses for you.

We will check our records periodically to see if you have visited a Family Physician. If not, we may provide your name and contact information to an In-Network Family Physician who will call you and offer to schedule a wellness visit. This program is completely voluntary and although we encourage you to schedule this visit, you are not obligated to do so. The applicable Family Physician Cost Share will apply to this visit.

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-Network, refer to the current Provider directory at www.floridablue.com or call the customer service phone number on your ID Card.

Location of Service

In addition to the participation status of the Provider, the location or setting where you receive Services can affect the amount you pay. For example, the amount you are responsible for paying out-of-pocket will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. Please refer to your Schedule of Benefits for specific information regarding your out-of-pocket expenses for such situations. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the "What Is Covered?" section and your Schedule of Benefits to find out if the specific Health Care Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

To verify if a Provider is In-Network for your plan you can:

1. review your current BlueOptions Provider Directory;
2. access the BlueOptions Provider directory at BCBSF's web-site at www.floridablue.com; and/or
3. call the customer service phone number in this Booklet or on your Identification Card.

In-Network Providers

When you use In-Network Providers, your out- of-pocket expenses for Covered Services will be lower. Payment will based on the Allowed Amount and your share of the cost will be at the In-Network benefit level listed in the Schedule of Benefits.

Please remember that changes to Provider network participation can occur at any time. Consequently, it is your responsibility to determine whether a specific Provider is In-Network at the time you receive Covered Services.

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. Payment will be based on the Allowed Amount and will be 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, payment to such Provider may be under the terms of that Provider's contract. If your Schedule of Benefits and BlueOptions Provider directory do not include a Provider as In-Network under your Benefit Plan, the Provider is considered Out-of-Network.

	In-Network	Out-of-Network
What expenses are you responsible for paying?	• Any applicable Copayments, Deductible(s) and/or Coinsurance requirements; • Expenses for Services which are not covered; • Expenses for Services in excess of any benefit maximum limitations; • Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and • Expenses for Services which are excluded.	
Who is responsible for filing your claims?	• The Provider will file the claim for you and payment will be made directly to the Provider.	• You are responsible for filing the claim and payment will be made directly to the Covered Plan Participant. If you receive Services from a Provider who participates in our Traditional Program or is a BlueCard Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.
Can you be billed the difference between what we pay the Provider and the Provider's charge?	• **NO.** You are protected from being billed for the difference in our Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept the Allowed Amount as payment in full for Covered Services except as otherwise permitted under the terms of the Provider's contract and this Booklet.	• **YES.** You are responsible for paying the difference between the Allowed Amount and the Provider's charge. However, if you receive Services from a Provider who participates in BCBSF's Traditional Program, the Provider will accept the Allowed Amount as payment in full for Covered Services since such Traditional Program Providers have agreed not to bill you for the difference. Further, under the BlueCard Program, when you receive Services from a BlueCard Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.

Note: You are solely responsible for selecting a Provider when obtaining Health Care Services and for verifying whether that Provider is In-Network or Out-of-Network at the time Health Care Services are rendered. You are also responsible for determining the corresponding payment options, if any, at the time the Health Care Services are rendered.

Value Choice Providers

Some Providers, designated by us, may provide Services other than advanced imaging, maternity and Medical Pharmacy at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office. The chart below lists the Services included and the Cost Share amounts:

Value Choice Provider Type	Services Included	Cost Share
Dietician / Nutritionist	Covered Services such as Diabetic Education	$0

To find a Value Choice Provider, access the most recent provider directory at www.floridablue.com and look for Providers with "Value Choice Providers" under "Programs".

Other Providers

With BlueOptions you have access to other Providers in addition to the ones previously described in this section. Other Providers include facilities that provide alternative outpatient settings or other persons and entities that specialize in a specific Service(s). While these Providers may be recognized for payment, they may not be included as In-Network Providers for your plan. Additionally, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Booklet. Please refer to the "What Is Covered?" and "What Is Not Covered?" sections of this Booklet and your Schedule of Benefits to determine your out-of-pocket expenses for Covered Services rendered by these Providers.

You may be able to receive certain outpatient Services at a location other than a Hospital. The amount you are responsible for paying for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Remember that the location of Service can impact the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs. When Services are rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense for the facility Provider as well as an out-of-pocket expense for other types of Providers.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, any of the following assignments, or attempted assignments, by you to any Provider will not be honored:

- an assignment of the benefits due to you for Covered Services under this Benefit Booklet;
- an assignment of your right to receive payments for Covered Services under this Benefit Booklet; or
- an assignment of a claim for damage resulting from a breach, or an alleged breach, of the terms of this Benefit Booklet.

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard PPO Program Provider; 5) is a BlueCard Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, Florida Statutes ; or 7) is an Ambulance Provider that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) Florida Statutes, first occurred to

a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, Florida Statutes. A written attestation of the assignment of benefits may be required.

Section 7: BlueCard® Program

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

BlueCard Program

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees

that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

Blue Cross Blue Shield Global Core® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these Services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Section 8: Blueprint for Health Programs

Introduction

BCBSF has established (and from time to time establishes) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. Under the terms of the ASO Agreement between BCBSF and Suwannee County Board of Public Instruction, BCBSF has agreed to make these programs available to you. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health; 2) help facilitate the management and review of coverage and benefits provided under this Booklet; and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services.

Admission Notification

The admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network.

In-Network

Under the admission notification requirement, we must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric Facilities, Substance Abuse Facilities or Skilled Nursing Facilities. While it is the sole responsibility of the In-Network Provider located in Florida to comply with the admission notification requirements, you should ask the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) if we have been notified of your admission. For an admission outside of Florida, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) may notify us of your admission by calling the toll free customer service number on your Identification card.

Out-of-Network

For admissions to an Out-of-Network Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility should notify BCBSF of the admission. Notifying BCBSF of your admission will enable BCBSF to provide you information about the Blueprint for Health Programs available to you. You or the Hospital may notify BCBSF of your admission by calling the toll free customer service number on your ID card.

Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, 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. The review is conducted solely to determine whether we should provide coverage and/or payment for a particular admission or Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals, including in advance of a transfer from one inpatient facility to another. We will provide notification to your Physician when inpatient coverage criteria are no longer

met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

Provider Focused Utilization Management Program

Certain NetworkBlue Providers have agreed to participate in our focused utilization management program. This pre-service review program is intended to promote the efficient delivery of medically appropriate Health Care Services by NetworkBlue Providers. Under this program we may perform focused prospective reviews of all or specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit to us specific medical information relating to Health Care Services proposed for you. These NetworkBlue Providers have agreed not to bill, or collect, any payment whatsoever from you or us, or any other person or entity, with respect to a specific Health Care Service if:

1. they fail to submit the Health Care Service for a focused prospective review when required under the terms of their agreement with us; or
2. we perform a focused review under the focused utilization management program and we determine that a Health Care Service is not Medically Necessary in accordance with our Medical Necessity criteria or inconsistent with our benefit guidelines then in effect unless the following exception applies.

Exception for Certain NetworkBlue Physicians

Certain NetworkBlue Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only may bill you for Services determined to be not Medically Necessary by BCBSF under this focused utilization management program if, before you receive the Service:

a) they give you a written estimate of your financial obligation for the Service;

b) they specifically identify the proposed Service that BCBSF has determined not to be Medically Necessary; and

c) you agree to assume financial responsibility for such Service.

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you will have to pay under this Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for Covered Services listed below. You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

For details on how to obtain prior coverage authorization for these Services, please call the customer service phone number on your ID Card.

Services that Require Prior Authorization

Advanced Diagnostic Imaging Services

You must obtain an authorization for advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, when rendered or referred by a Provider **before** the advanced diagnostic

imaging Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Applied Behavioral Analysis

You must obtain an authorization for Applied Behavioral Analysis for Autism Spectrum Disorder or Down Syndrome, **before** the Services are provided. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Approved Clinical Trials

You must obtain an authorization for Services rendered in connection with Approved Clinical Trials, 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 this plan will not make any payment for such Services**.

Prescription Drugs

In the case of Prescription Drugs, it is your sole responsibility to obtain prior coverage authorization **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, this plan will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

All Prescription Drugs covered under the Medical Pharmacy category in the "What Is Covered?" section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

Other Health Care Services

In the case of other Health Care Services under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

Additional Information

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.

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 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.

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
   a) the termination date of your plan, or
   b) the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

Member Focused Programs

The Blueprint for Health Programs may include voluntary programs for certain members. These programs may address health promotion, prevention and early detection of disease, chronic illness management programs, case management programs and other member focused programs.

Personal Case Management Program

The personal case management program focuses on members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, BCBSF may, in its sole discretion, assign a personal case manager to you to help coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the personal case management program, you may be offered alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available on a case-by-case basis when you meet BCBSF's case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing. In addition, Suwannee County Board of Public Instruction will be required to specifically agree to such treatment plan and the alternative benefits or payments.

The fact that certain Health Care Services under the personal case management program have been provided or payment has been made in no way obligates BCBSF, Suwannee County Board of Public Instruction, or the Group Health Plan to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of our right to enforce this Benefit Booklet in strict accordance with its terms. The terms of this Booklet will continue to apply, except as specifically modified in writing in accordance with the personal case management program rules then in effect

Health Information, Promotion, Prevention and Illness Management Programs

These Blueprint for Health Programs may include health information that supports member education and choices for healthcare issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help members with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include prenatal educational programs and illness management programs for conditions such as diabetes, cancer and heart disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll free customer service number on your Identification card for more information. Your participation in this program is completely voluntary.

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and the responsibility of your Physicians and other health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. Suwannee County Board of Public Instruction is ultimately responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Booklet. In fulfilling this responsibility, neither BCBSF nor Suwannee County Board of Public Instruction will be deemed to participate in or override the medical decisions of your health care Provider.

Please note that the hospital admission notification requirement and any Blueprint for Health Program may be discontinued or modified at any time without notice to you or your consent.

Section 9: Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Group Health Plan, and who meets and continues to meet the eligibility requirements described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members. No changes in the eligibility requirements will be permitted except as permitted by Suwannee County Board of Public Instruction. Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Covered Plan Participant as the legal guardian or appropriate adoption documentation described in the "Enrollment and Effective Date of Coverage" section.

Eligibility Requirements for Covered Plan Participants

In order to be eligible to enroll as a Covered Plan Participant, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. The employee must be a bona fide employee of Suwannee County Board of Public Instruction;
2. The employee's job must fall within a job classification identified by Suwannee County Board of Public Instruction;
3. The employee must have completed any applicable Waiting Period identified by Suwannee County Board of Public Instruction; and
4. The employee must meet any additional eligibility requirement(s) required by Suwannee County Board of Public Instruction.

Suwannee County Board of Public Instruction's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of Suwannee County Board of Public Instruction provided such companies and Suwannee County Board of Public Instruction are under common control; and
4. other individuals as determined by Suwannee County Board of Public Instruction (e.g., members of associations or labor unions).

Suwannee County Board of Public Instruction shall have sole discretion concerning the expansion of eligibility classifications.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Plan Participant's spouse under a legally valid existing marriage.
2. The Covered Plan Participant's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Plan Participant 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 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Plan Participant, whether the

dependent child resides with the Covered Plan Participant, or whether the dependent child is eligible for or enrolled in any other group health plan.

Section 10: Enrollment and Effective Date of Coverage

Eligible Employees and Eligible Dependents may enroll for coverage according to the provisions below.

Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Booklet. Neither BCBSF nor Suwannee County Board of Public Instruction will have any obligation whatsoever to any individual who is not properly enrolled.

Any Employee or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage according to the provisions set forth below.

Enrollment Forms/Electing Coverage

To apply for coverage, you as the Eligible Employee must:

1. complete and submit, through Suwannee County Board of Public Instruction, the Enrollment Form;
2. provide any additional information needed to determine eligibility, at the request of BCBSF or Suwannee County Board of Public Instruction;
3. pay any required contribution; and
4. complete and submit, through Suwannee County Board of Public Instruction an Enrollment Form to add Eligible Dependents.

When making application for coverage, you must elect one of the types of coverage available under Suwannee County Board of Public Instruction's program. Such types may include:

Employee Only Coverage - This type of coverage provides coverage for the Employee only.

Employee/Spouse Coverage - This type of coverage provides coverage for the Employee and the employee's spouse under a legally valid existing marriage.

Employee/Child(ren) Coverage - This type of coverage provides coverage for the Employee and the employee's covered child(ren) only.

Employee/Family Coverage - This type of coverage provides coverage for the Employee and the employee's Covered Dependents.

There may be additional contribution amounts for each Covered Dependent based on the coverage selected by Suwannee County Board of Public Instruction.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee’s or Eligible Dependent’s initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in Suwannee County Board of Public Instruction’s health benefit program. The period is established by Suwannee County Board of Public

Instruction, occurs annually, and will take place when specified by Suwannee County Board of Public Instruction.

Special Enrollment Period is the 30-day period of time immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for coverage. Special circumstances are described in the "Special Enrollment Period" subsection.

Employee Enrollment

1. An Eligible Employee must enroll during the Initial Enrollment Period in order to become covered as of the Effective Date of Suwannee County Board of Public Instruction. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) will be the same as the Covered Plan Participant's Effective Date.
2. An individual who becomes an Eligible Employee after Suwannee County Board of Public Instruction's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will begin on the date specified in writing by Suwannee County Board of Public Instruction.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Plan Participant. Below are special rules for certain Eligible Dependents.

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must submit an Enrollment Form to BCBSF through Suwannee County Board of Public Instruction during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

If timely notice is given, no additional contribution will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child if the Covered Plan Participant provides notice to Suwannee County Board of Public Instruction and an Enrollment Form is received within the 60-day period of the birth of the child and any applicable contribution is paid back to the date of birth.

If the newborn is not enrolled within sixty days of the date of birth, the newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

Note: Coverage for a newborn child of a Covered Dependent will automatically terminate 18 months after the birth of the newborn child.

Adopted Newborn Child – To enroll an adopted newborn child, the Covered Plan Participant must submit an Enrollment Form through Suwannee County Board of Public Instruction to BCBSF during the 30-day period immediately following the date of birth. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents, which are deemed necessary in order to administer this provision.

If timely notice is given, no additional contribution will be charged for coverage of the adopted newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable

contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for an adopted newborn child if the Covered Plan Participant provides notice to Suwannee County Board of Public Instruction and an Enrollment Form is received within the 60-day period of the birth of the adopted newborn child and any applicable contribution is paid back to the date of birth.

If the adopted newborn child is not enrolled within sixty days of the date of birth, the adopted newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Plan Participant, there shall be no coverage for the adopted newborn child. It is your responsibility as the Covered Plan Participant to notify Suwannee County Board of Public Instruction within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

Adopted/Foster Children – To enroll an adopted or Foster Child, the Covered Plan Participant must submit an Enrollment Form during the 30-day period immediately following the date of placement. The Effective Date for an adopted or Foster Child (other than an adopted newborn child) will be the date such adopted or Foster Child is placed in the residence of the Covered Plan Participant in compliance with Florida law. The Covered Plan Participant may be required to provide any information and/or documents deemed necessary, in order to properly administer this section.

In the event Suwannee County Board of Public Instruction is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as Covered Plan Participant provides notice to Suwannee County Board of Public Instruction, and we receive the Enrollment Form within 60 days of the placement. If the adopted or Foster Child is not enrolled within sixty days of the date of placement, the adopted or Foster Child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted Child. Proof of final adoption must be submitted to BCBSF through Suwannee County Board of Public Instruction. It is the responsibility of the Covered Plan Participant to notify BCBSF through Suwannee County Board of Public Instruction if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Plan Participant to notify BCBSF through Suwannee County Board of Public Instruction that the Foster Child is no longer in the Covered Plan Participant's care. Upon receipt of this notification, coverage for the child will be terminated on the date the Covered Plan Participant's status as a foster parent terminated.

Marital Status –The Covered Plan Participant may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered Plan Participant must complete the Enrollment Form through Suwannee County Board of Public Instruction and forward it to BCBSF. The Covered Plan Participant must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Plan Participant may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under their plan. To apply for coverage, the Covered Plan Participant must complete an Enrollment Form through Suwannee County Board of Public Instruction and forward it to BCBSF. The Covered Plan Participant must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Enrollment Form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the date established by Suwannee County Board of Public Instruction.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee or the Eligible Dependent is enrolled due to a special circumstance as outlined in the "Special Enrollment Period" subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependent(s) must complete the applicable Enrollment Form and forward it to the Group within the time periods noted below for each special enrollment event.

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage if one of the following special enrollment events occurs and the applicable Enrollment Form is submitted to the Group within the indicated time periods:

1. If you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Program (CHIP) or Medicaid, see #3 below), or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:

   a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

   b) you lost your other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and

   c) you submit the applicable Enrollment Form to the Group within 30 days of the date your coverage was terminated

   Note: Loss of coverage for failure to pay your required contribution/premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

   or

2. If when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption and you submit the applicable Enrollment Form to the Group within 30 days of the date of the event.

or

3. If you or your Eligible Dependent(s) lose coverage under a CHIP or Medicaid due to loss of eligibility for such coverage or become eligible for the optional state premium assistance program and you submit the applicable Enrollment Form to the Group within 60 days of the date such coverage was terminated or the date you become eligible for the optional state premium assistance program.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees or Eligible Dependents who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Plan Participant).

Other Provisions Regarding Enrollment and Effective Date of Coverage

Rehired Employees

Individuals who are rehired as employees of Suwannee County Board of Public Instruction are considered newly hired employees for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Group Health Plan (which includes this Booklet), which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, and Waiting Period) are applicable to rehired employees and their Eligible Dependents if the employee does not qualify for the federal exception.

Section 11: Termination of Coverage

Termination of a Covered Plan Participant's Coverage

A Covered Plan Participant's coverage will automatically terminate at 12:01 a.m.:

1. on the date the Group Health Plan terminates;
2. on the date the Administrative Services Only Agreement between BCBSF and Suwannee County Board of Public Instruction terminates;
3. on the last day of the first month that the Covered Plan Participant fails to continue to meet any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause (see the "Termination of an Individual Coverage for Cause" subsection); or
5. on the date specified by Suwannee County Board of Public Instruction that the Covered Plan Participant's coverage terminates.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage will automatically terminate at 12:01 a.m. on the date:

1. the Group Health Plan terminates;
2. the Covered Plan Participant's coverage terminates for any reason;
3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group Health Plan;
4. last day of the Calendar Year that the Covered Dependent child no longer meets any of the applicable eligibility requirements;
5. the Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

In the event you as the Covered Plan Participant wish to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to BCBSF through Suwannee County Board of Public Instruction prior to the termination date requested.

In the event you as the Covered Plan Participant wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit an Enrollment Form to Suwannee County Board of Public Instruction, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

Termination of an Individual's Coverage for Cause

In the event any of the following occurs, Suwannee County Board of Public Instruction may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits; or
2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed, by or on your behalf.

Notice of Termination

It is Suwannee County Board of Public Instruction's responsibility to immediately notify you of your termination or that of your Covered Dependents for any reason.

Section 12: Continuing Coverage Under COBRA

Federal Continuation of Coverage Law

A Federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to your Group Health Plan. If COBRA applies, you or your Covered Dependents may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

You must contact Suwannee County Board of Public Instruction to determine if you or your Covered Dependent are entitled to COBRA continuation of coverage. Suwannee County Board of Public Instruction is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Covered Persons of their rights under COBRA. If you fail to meet your obligations under COBRA and this Benefit Booklet, Suwannee County Board of Public Instruction will not be liable for any claims incurred by you or your Covered Dependent(s) after termination of coverage.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below.

The following is a summary of what you may elect, if COBRA applies to Suwannee County Board of Public Instruction and you are eligible for such coverage:

1. You may elect to continue this coverage for a period not to exceed 18 months* in the case of:
   a) termination of employment of the Covered Plan Participant other than for gross misconduct; or
   b) reduced hours of employment of the Covered Plan Participant.

   ***Note:** You and your Covered Dependents are eligible for an 11-month extension of the 18-month COBRA continuation option above (to a total of 29 months) if you or your Covered Dependent is totally disabled, as defined by the Social Security Administration (SSA) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Person must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.
2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
   a) the Covered Plan Participant's entitlement to Medicare;
   b) divorce or legal separation of the Covered Plan Participant;
   c) death of the Covered Plan Participant;
   d) the employer filing bankruptcy (subject to bankruptcy court approval); or
   e) a Dependent child may elect the 36-month extension if the Dependent child ceases to be an Eligible Dependent under the terms of Suwannee County Board of Public Instruction's coverage.

Children born to, or placed for adoption with, the Covered Plan Participant during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

Additional requirements applicable to continuation of coverage under COBRA are set forth below:

1. Suwannee County Board of Public Instruction must notify you of your continuation of coverage rights under COBRA within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify Suwannee County

Board of Public Instruction, in writing, within 60 days of any of these events. Suwannee County Board of Public Instruction's 14-day notice requirement runs from the date of receipt of such notice.

2. You must elect to continue the coverage within 60 days of the later of:
   a) the date that the coverage terminates; or
   b) the date the notification of continuation of coverage rights is sent by Suwannee County Board of Public Instruction.
3. COBRA coverage will terminate if you become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the Social Security Administration that you are no longer disabled. You must inform Suwannee County Board of Public Instruction of the Social Security Administration's determination within 30 days of such determination.
6. You must meet all contribution requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in the Group Health Plan.
7. Suwannee County Board of Public Instruction must continue to provide group health coverage to its employees.

An election by a Covered Plan Participant or Covered Dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that Covered Plan Participant or Covered Dependent spouse, unless otherwise specified in the election form.

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Benefit Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to Suwannee County Board of Public Instruction.

Section 13: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for a BCBSF individual policy (hereinafter referred to as a "converted policy" or "conversion policy") if:

1. you were continuously covered for at least three months under the Group Health Plan, and/or under another group policy that provided similar benefits immediately prior to the Group Health Plan; and
2. your coverage was terminated for any reason, including discontinuance of the Group Health Plan in its entirety and termination of continued coverage under COBRA.

Notify us in writing or by telephone if you are interested in a conversion policy. Within 14 days of such notice, we will send you a conversion policy application, premium notice and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

We must receive a completed application for a converted policy, and the applicable premium payment, within the 63-day period beginning on the date the coverage under the Group Health Plan terminated. If coverage has been terminated due to the non-payment of employee contribution by Suwannee County Board of Public Instruction, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Health Plan terminated.

In the event we do not receive the converted policy application and the initial premium payment within such 63-day period, your converted policy application will be denied and you will not be entitled to a converted policy.

Additionally, you are not entitled to a converted policy if

1. you are eligible for or covered under the Medicare program;
2. you failed to pay, on a timely basis, the contribution required for coverage under this Group Health Plan;
3. the Group Health Plan was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under this Booklet; or
4. a) you fall under one of the following categories and meet the requirements of 4.b. below:
    i. you are covered under any hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Booklet; or
    ii. you are eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Booklet; or
    iii. benefits similar to the benefits provided under this Booklet are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and

    b) the benefits provided under the sources referred to in paragraph 4.a.i or the benefits provided or available under the source referred to in paragraph 4.a.ii. and 4.a.iii. above, together with the benefits

provided by our converted policy would result in over insurance in accordance with our over insurance standards, as determined by us.

Neither Suwannee County Board of Public Instruction nor BCBSF has any obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial premium payment to us within 63 days of the termination of your coverage under this Benefit Booklet. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under this Benefit Booklet is terminated.

Note: Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Booklet. When applying for our converted policy, you have two options:
1) a converted policy providing major medical coverage meeting the requirements of 627.6675(10) Florida Statutes or 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) Florida Statutes. In any event, we will not be required to issue a converted policy unless required to do so by Florida law. We may have other options available to you. Call the telephone number on your Identification card for more information.

Section 14: Extension of Benefits

Extension of Benefits

In the event the Group Health Plan is terminated, coverage will not be provided under this Benefit Booklet for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire Group Health Plan is terminated. The extension of benefits described in this section does not apply when your coverage terminates, if the Group Health Plan remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is your sole responsibility to provide acceptable documentation showing that you are entitled to an extension of benefits.

1. In the event you are totally disabled on the termination date of the Group Health Plan as a result of a specific Accident or illness incurred while you were covered under this Booklet, as determined by us, a limited extension of benefits will be provided under this Benefit Booklet for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. In any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

   For purposes of this section, you will be considered “totally disabled” only if, in our opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. You are totally disabled only if, in our opinion, you are unable to perform those normal day-to-day activities which you would otherwise perform and you require regular care and attendance by a Physician.

2. In the event you are receiving covered dental treatment as of the termination date of the Group Health Plan, a limited extension of such covered dental treatment will be provided under this Benefit Booklet if:

   a) a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while you were covered under the Group Health Plan;

   b) the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic Services; and

   c) the dental procedures were performed within 90 days after the Group Health Plan terminated.

3. This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Group Health Plan or on the date you become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. You are not required to be totally disabled in order to be eligible for this extension of benefits.

   Please refer to the “Dental Care” category of the “What Is Covered?” section for a description of the dental care Services covered under this Booklet.

4. In the event you are pregnant as of the termination date of the Group Health Plan, a limited extension of the maternity expense benefits will be available, provided the pregnancy commenced while the pregnant individual was covered under the Group Health Plan, as determined by us. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. You are not required to be totally disabled in order to be eligible for this extension of benefits.

Section 15: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When you become covered under Medicare and continue to be eligible and covered under this Benefit Booklet, coverage under this Benefit Booklet will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, coverage under this Benefit Booklet will be secondary to any Medicare benefits. To the extent the benefits under this Benefit Booklet are primary, claims for Covered Services should be filed with BCBSF first.

Under Medicare, Suwannee County Board of Public Instruction MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you . Also, Suwannee County Board of Public Instruction MAY NOT induce you to decline or terminate your group health insurance coverage and elect Medicare as primary payer.

If you become 65 or become eligible for Medicare due to End Stage Renal Disease ("ESRD"), you must notify Suwannee County Board of Public Instruction.

Individuals With End Stage Renal Disease

If you are entitled to Medicare coverage because of ESRD, coverage under this Benefit Booklet will be provided on a primary basis for 30 months beginning with the earlier of:

1. the month in which you became entitled to Medicare Part A ESRD benefits; or
2. the first month in which you would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the time you became eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health insurance coverage will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, coverage will be provided, as described in this section, on a primary basis for 30 months.

Disabled Active Individuals

If you are entitled to Medicare coverage because of a disability other than ESRD, Medicare benefits will be secondary to the benefits provided under this Benefit Booklet provided that:

Suwannee County Board of Public Instruction employed at least 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year. If the Group Health Plan is a multi-employer plan, as defined by Medicare, Medicare benefits will be secondary if at least one employer participating in the plan covered 100 or more employees under the plan on 50% or more of its regular business days during the previous Calendar Year.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Benefit Booklet.
2. BCBSF will not be liable to Suwannee County Board of Public Instruction or to any individual covered under this Benefit Booklet on account of any nonpayment of primary benefits resulting from any

failure of performance of Suwannee County Board of Public Instruction's obligations as described in this section.

Section 16: Duplication of Coverage Under Other Health Plans/Programs

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided under this Benefit Booklet.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is your responsibility to provide BCBSF and Suwannee County Board of Public Instruction with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify BCBSF and Suwannee County Board of Public Instruction in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies which may be subject to COB include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage in which the law permits us to coordinate benefits;
4. Medicare, as described in "The Effect of Medicare Coverage/Medicare Secondary Payer Provisions" section; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of our payment, if any, when benefits are coordinated under this section, is based on whether or not the benefits under this Benefit Booklet are primary. When primary, payment will be made for Covered Services without regard to coverage under other plans. When the benefits under this Benefit Booklet are not primary, payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event you receive Covered Services from a NetworkBlue Provider or an Out-of-Network Provider who participates in our Traditional Program, "total reasonable expenses" shall mean the amount required to be paid to the Provider pursuant to the applicable agreement BCBSF has with such Provider. **In the event that the primary payer's payment exceeds the Allowed Amount, no payment will be made for such Services.**

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. 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 Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
   a) the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;

b) if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.

4. When we cover a dependent child whose parents are not married, or are separated or divorced:
   a) the plan of the parent with custody is primary;
   b) the plan of the remarried parent with custody is primary; the step-parent's plan is secondary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; and
   c) the plan of the parent without custody is last;
   d) regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:
   a) the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:
   a) first, the plan covering the person as an employee, or as the employee's dependent; and
   b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.
7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.
8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

We will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare Supplement policy.

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Booklet shall not duplicate any benefits to which you or your Covered Dependents are entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 17: Claims Processing

Introduction

This section is intended to:

- help you understand what you or your treating Providers must do, under the terms of this Benefit Booklet, in order to obtain payment for expenses for Covered Services they have rendered or will render to you; and
- provide you with a general description of the applicable procedures we will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying you when we deny benefits.

Under no circumstances will we be held responsible for, nor will we accept liability relating to, the failure of your Group Plan's sponsor or plan administrator to: 1) comply with applicable disclosure requirements; 2) provide you with a Summary Plan Description (SPD) or 3) comply with any other legal requirements. You should contact Suwannee County Board of Public Instruction if you have questions relating to your Group Plan's SPD. We are not your Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

The Processing of Post-Service Claims

We will use our best efforts to pay, contest, or deny all Post-Service Claims for which we have all of the necessary information, as determined by us. Post-Service Claims will be paid, contested, or denied within the timeframes described below.

- Payment for Post-Service Claims

When payment is due under the terms of this Benefit Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more or additional information, we may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. Our notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- Denial of Post-Service Claims

In the event we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and

the reason(s) for denial. It is your responsibility to ensure that we receive all information determined by us as necessary to adjudicate a Post-Service Claim. **If we do not receive the necessary information, the claim or a portion of the claim may be denied.**

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Additional Processing Information for Post-Service Claims

In any event, we will use our best efforts to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by us or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by us within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

We will investigate any allegation of improper billing by a Provider upon receipt of written notification from you. If we determine that you were billed for a Service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due solely to the notification from you, we will pay you 20 percent of the amount of the reduction, up to a total of $500.

Pre-Service Claims

How to File a Pre-Service Claim

This Benefit Booklet may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the “What Is Covered?” section and other applicable sections of your Benefit Booklet. You may also call the customer service number on your Identification card for assistance.
We are not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to you unless the terms of this Benefit Booklet require (or condition payment upon) approval by us for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, we will use our best efforts to provide notice of our determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, we will use our best efforts to provide notice within 24 hours of:
1) the need for additional information; 2) the specific information that you or your Provider may need to provide; and 3) the date that we reasonably expect to provide notice of the decision. If we request additional information, we must receive it within 48 hours of our request. We will use our best efforts to provide notice of the decision on your Pre-Service Claim within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period you were afforded to provide the specified additional information as described above.

Benefit Determinations on Pre-Service Claims that Do Not Involve Urgent Care

We will use our best efforts to provide notice of a decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. This 15-day determination period may be extended by us one time for up to an additional 15 days. If such an extension is necessary, we will use our best efforts to provide notice of the extension and

reasons for it. We will use our best efforts to provide notification of the decision on your Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by us.

If additional information is necessary to make a determination, we will use our best efforts to: 1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; 2) identify the specific information that you or your Provider may need to provide; and 3) inform you of the date that we reasonably expect to notify you of our decision. If we request additional information, we must receive it within 45 days of our request for the information. We will use our best efforts to provide notification of the decision on your Pre-Service Claim within 15 days of receipt of the requested information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

A reduction or termination of coverage or benefits for Services will be considered an Adverse Benefit Determination when:

- we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of Services; and
- the reduction or termination of coverage or benefits by us was not due to an amendment of this Benefit Booklet or termination of your coverage as provided by this Benefit Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of your request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: 1) we need additional information; or 2) you or your representative failed to follow proper procedures in your request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination:

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

1. the date the Service or supply was provided;

2. the Provider's name;
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;
7. a description of the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
8. a description of any additional information that might change the determination and why that information is necessary;
9. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures;
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; and
11. You have the right to an independent external review through an external review organization for certain appeals, as provided in the Patient Protection and Affordable Care Act of 2010.

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 three days after the oral notification.

How to Appeal an Adverse Benefit Determination

Except as described below, only you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the review process described below. Your appeal must be submitted to us in writing for an internal appeal within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

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. We must receive your appeal of an Adverse Benefit Determination in person or in writing.
4. 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.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the

final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.

6. 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 the Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.
10. 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.
11. 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.
12. 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.
13. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.
14. 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.
15. 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 Decision subsection below.

Appeals must be sent to the address below:

Blue Cross and Blue Shield of Florida
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:

- Pre-Service Claims: within 30 days of the receipt of your appeal; or
- Post-Service Claims: within 60 days of the receipt of your appeal; or

- Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

Note: The nature of a claim for Services (i.e. whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements ("Deemed Exhaustion") and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

How to Request External Review of Our Appeal Decision

If we deny your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational, you are entitled to request an independent, external review of our decision. Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

Blue Cross and Blue Shield of Florida
Attention: Member External Reviews DCC9-5
Post Office Box 44197
Jacksonville, FL 32231-4197

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

If the External Reviewer decides to overturn our decision, we will provide coverage or payment for your health care item or Service.

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.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

   In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

   In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a health care Provider of our choice as often as is reasonably necessary while a claim is pending. Failure by you to fully cooperate with such examination shall result in a denial of the pending claim and we shall have no liability for such claim.

3. Legal Actions:

   No legal action arising out of or in connection with coverage under this Benefit Booklet may be brought against BCBSF or Suwannee County Board of Public Instruction within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

   The information provided on the itemized statement and the claim form is relied upon by BCBSF 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 available legal remedy, in denial of the claim or cancellation or rescission of your coverage.

5. Explanation of Benefits Form:

   All claims decisions, including denial and claims review decisions, will be communicated to you in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

   a) The specific reason or reasons for the Adverse Benefit Determination;

   b) Reference to the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

   c) A description of any additional information that would change the initial determination and why that information is necessary;

   d) A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

e) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond Our Control:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Services, taking into account the impact of the event. For purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

ERISA Civil Action Provision

If a federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, applies to your Group Benefit Plan. You or your Covered Dependents may be entitled, after exhaustion of the appeal procedures provided for in this section, to pursue a civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Section 18: Relationships Between the Parties

BCBSF/Suwannee County Board of Public Instruction and Health Care Providers

Neither BCBSF nor Suwannee County Board of Public Instruction nor any of their respective officers, directors or employees provides Health Care Services to you. Rather, BCBSF and Suwannee County Board of Public Instruction are engaged in making coverage and benefit decisions under this Booklet. By accepting the Group health care coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those Services are not employees or agents of BCBSF or Suwannee County Board of Public Instruction. **In this regard, we and Suwannee County Board of Public Instruction hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and Suwannee County Board of Public Instruction 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 under the Group Health Plan concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. Neither BCBSF nor Suwannee County Board of Public Instruction will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and Suwannee County Board of Public Instruction

Neither Suwannee County Board of Public Instruction nor any person covered under this Booklet is BCBSF's agent or representative, and neither shall be liable for any acts or omissions by BCBSF's agents, servants, employees, or us. Additionally, neither BCBSF nor Suwannee County Board of Public Instruction will be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. BCBSF is not your agent, servant, or representative nor is BCBSF an agent, servant, or representative of Suwannee County Board of Public Instruction and we will not be liable for any acts or omissions, or those of Suwannee County Board of Public Instruction, its agents, servants, employees, or any person or organization with which Suwannee County Board of Public Instruction has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical Services or supplies, must be made solely by your family and your treating Physician in accordance with the patient/physician relationship. It is possible that you or your treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 19: General Provisions

Access to Information

BCBSF and Suwannee County Board of Public Instruction have the right to receive, from you and any health care Provider rendering Services to you, information that is reasonably necessary, as determined by BCBSF and Suwannee County Board of Public Instruction, in order to administer the coverage and benefits provided, subject to all applicable confidentiality requirements listed below. By accepting coverage, you authorize every health care Provider who renders Services to you, to disclose to BCBSF and Suwannee County Board of Public Instruction 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 BCBSF and/or Suwannee County Board of Public Instruction to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, BCBSF or Suwannee County Board of Public Instruction may, without the consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to any person covered under this Booklet or applicant for enrollment which BCBSF or Suwannee County Board of Public Instruction deems to be necessary.

Right to Recovery

Whenever the Group Health Plan has made payments in excess of the maximum provided for under this Booklet, BCBSF or Suwannee County Board of Public Instruction will have the right to recover any such payments, to the extent of such excess, from you or any person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Benefit Booklet shall be deemed to have been modified and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or Services under this Booklet. Further, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

BCBSF's arrangements with a Provider may require that we release certain claims and medical information about persons covered under this Booklet to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any such Provider to evaluate your financial responsibility under this Booklet.

Benefit Booklet

You have been provided with this Benefit Booklet and an Identification Card as evidence of coverage under Suwannee County Board of Public Instruction's Group Health Plan.

Modification of Provider Network and the Participation Status

NetworkBlue, and the participation status of individual Providers available under this Booklet, are subject to change at any time by BCBSF without prior notice to you or your approval or that of Suwannee County Board of Public Instruction. Additionally, BCBSF may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to you or your approval, or that of, Suwannee County Board of Public Instruction. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time the Health Care Service is rendered. Under this Booklet, your financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of You and Your Covered Dependents

You must cooperate with BCBSF and Suwannee County Board of Public Instruction, and must execute and submit to us any consents, releases, assignments, and other documents requested in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause (See the "Termination of an Individual's Coverage for Cause" subsection in the "Termination of Coverage" section).

Non-Waiver of Defaults

Any failure by BCBSF or Suwannee County Board of Public Instruction at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect BCBSF's or Suwannee County Board of Public Instruction's right at any time to enforce any terms or conditions under this Benefit Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

If to BCBSF:

To the address printed on the Identification Card.

If to you:

To the latest address provided by you or to your latest address on Enrollment Forms actually delivered to us.

You must notify us immediately of any address change.

If to Suwannee County Board of Public Instruction:

To the address indicated by Suwannee County Board of Public Instruction.

Our Obligations upon Termination

Upon termination of your coverage for any reason, there will be no further liability or responsibility to you under the Group Health Plan, except as specifically described herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Booklet.

Florida Agency for Health Care Administration Performance Data

The performance outcome and financial data published by the Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute, located at the web site address www.floridahealthfinder.gov, may be accessed through the link provided on the Blue Cross and Blue Shield of Florida corporate web site at www.floridablue.com.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its

representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of, Suwannee County Board of Public Instruction and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Suwannee County Board of Public Instruction hereby specifically expresses its intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the terms of the Suwannee County Board of Public Instruction Group Health Plan or this Benefit Booklet.

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Section 20: Definitions

The following definitions are used in this Benefit Booklet. Other definitions may be found in the particular section or subsection where they are used.

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Administrative Services Only Agreement or **ASO Agreement** means an agreement between Suwannee County Board of Public Instruction and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to BCBSF's NetworkBlue and BCBSF's network of Traditional Insurance Providers.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Benefit Booklet with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in the Claims Processing section, shall also constitute an Adverse Benefit Determination.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard 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 BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by BCBSF that may be based on several factors including (but not necessarily limited to): (i) payment for such Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating providers in other provider networks of third-party payers which may include, for

example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by BCBSF, with BCBSF's provider network strategies (e.g., does not result in payment that encourages Providers participating in a BCBSF network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the Allowed Amount for the specific Covered Services provided to you may be based upon the amount provided to BCBSF by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating Providers in its geographic area for such Services.

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular Services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What Is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much will be paid.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between such Allowed Amount and the amount billed for such Services by any such Out-of-Network Provider.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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:

i. The Department of Veterans Affairs.

ii. The Department of Defense.

iii. 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.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;
2. Asperger's syndrome;
3. Pervasive developmental disorder not otherwise specified; and
4. Childhood Disintegrative Disorder.

Benefit Period means a consecutive period of time, specified by BCBSF and the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your Benefit Period is listed on your Schedule of Benefits, and will not be less than 12 months unless indicated as such.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the Florida Statutes, or a similar applicable law of another state, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.

BlueCard® Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. 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 PPO Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard 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 Traditional Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard

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 PPO Program Provider means a Provider designated as a BlueCard PPO Program Provider by the Host Blue.

BlueCard Traditional Program Provider means a Provider designated as a BlueCard Traditional Program Provider by the Host Blue.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary Services).

Calendar Year begins January 1st and ends December 31st.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or 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 your share of health care expenses for Covered Services. After your Deductible requirement is met, a percentage of the Allowed Amount will be paid for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or

a specific number of treatments, if we had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management program as described in the “Blueprint for Health Programs” section of the Benefit Booklet.

Condition means a disease, illness, ailment, injury, or pregnancy.

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

Convenient Care Center means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one master’s level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

Copayment means the dollar amount established solely by Suwannee County Board of Public Instruction which is required to be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to Coinsurance, Copayment, Deductible and/or Per Admission Deductible (PAD) amounts. Applicable Cost Share amounts are identified in your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Plan Participant (See the “Eligibility Requirements for Dependent(s)” subsection of the “Eligibility for Coverage” section).

Covered Person means a Covered Plan Participant or a Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under this Benefit Booklet other than as a Covered Dependent.

Covered Services means those Health Care Services which meet the criteria listed in the “What Is Covered?” section.

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Booklet, before payment for Covered Services begins.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) and the Florida Agency for Health Care Administration or a similar regulatory agency of another state to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services.

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent;
5. the Covered Plan Participant has submitted acceptable proof of evidence of common residence and joint financial responsibility to the Group; and
6. the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law or a similar applicable law of another state to provide home medical equipment, oxygen therapy Services, or dialysis supplies in the patient’s home under a Physician’s prescription.

Effective Date means, with respect to Suwannee County Board of Public Instruction, 12:01 a.m. on the date the ASO Agreement went into effect. With respect to individuals covered under this Benefit Booklet, 12:01 a.m. on the date Suwannee County Board of Public Instruction specifies that the coverage will commence as further described in the “Enrollment and Effective Date of Coverage” section of this Benefit Booklet.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section in this Benefit Booklet, and is eligible to enroll as a Covered Dependent.

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the "Eligibility Requirements for Covered Plan Participants" subsection of the "Eligibility for Coverage" section in this Benefit Booklet and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Plan Participant until such individual has actually enrolled with, and been accepted for coverage as a Covered Plan Participant by Suwannee County Board of Public Instruction.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

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 an amendment to the Group Health Plan or this Benefit Booklet.

Enrollment Date means the date of enrollment of the individual under the Group Health Plan or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under this Benefit Booklet..

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by BCBSF or Suwannee County Board of Public Instruction:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or
4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently

published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific evidence" shall mean (as determined by BCBSF or Suwannee County Board of Public Instruction):

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services which are determined by BCBSF or Suwannee County Board of Public Instruction to be Experimental or Investigational are excluded (see the “What Is Not Covered?” section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF or Suwannee County Board of Public Instruction 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.

FDA means the United States Food and Drug Administration.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with Florida Statutes or by a similar regulatory agency of another state in compliance with that state’s applicable laws.

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Group means the employer, labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits are provided, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or Group Plan means the plan established and maintained by Suwannee County Board of Public Instruction for the provision of health care coverage and benefits to the individuals covered under this Benefit Booklet.

Health Care Services or Services includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds, and other Services rendered or supplied, by or at the direction of, Providers.

Home Health Agency means a properly licensed agency or organization which provides Health Care Services in the home pursuant to Chapter 400 of the Florida Statutes, or a similar applicable law of another state.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization which is duly licensed by the state of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Identification Card means the card(s) issued to Covered Plan Participants. The card is not transferable to another person. Possession of such card in no way guarantees that a particular individual is eligible for, or covered under, this Benefit Booklet.

Independent Clinical Laboratory means a laboratory properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Facility means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all

applicable Florida law or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an Independent Diagnostic Testing Facility.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on the Schedule of Benefits under the heading “In-Network”. Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Benefit Booklet.

In-Network Provider means any health care Provider who, at the time Covered Services were rendered to you, was under contract with BCBSF to participate in BCBSF’s NetworkBlue and included in the panel of providers designated by BCBSF as “In-Network” for your specific plan. (Please refer to your Schedule of Benefits). For payment purposes under this Benefit Booklet only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard 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 a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statues, or a similar applicable law of another state.

Massage Therapist means a person properly licensed to practice Massage, pursuant to Chapter 480 of the Florida Statutes, or a similar applicable law of another state.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Benefit Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means 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, or 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 Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Benefit Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Medication Guide for the purpose of this Benefit Booklet means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

Note: The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card for current information.

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 ICD 10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state.

NetworkBlue means, or refers to, the preferred provider network established and so designated by BCBSF which is available to individuals covered under this Benefit Booklet. Please note that BCBSF's Preferred Patient Care (PPC) preferred provider network is not available to individuals covered under this Benefit Booklet.

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Occupational Therapist means a person properly licensed to practice Occupational Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on the Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of this Benefit Booklet.

Out-of-Network Provider means a Provider who, at the time Health Care Services were rendered:

1. did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or
2. did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard PPO Program but was participating, for purposes of the BlueCard Program, as a BlueCard Traditional Program Provider; or
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue or our Traditional Program; or
5. did not have a contract with a Host Blue to participate for purposes of the BlueCard Program as a BlueCard Traditional Program Provider.

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; outpatient Cardiac Therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet BCBSF's criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, Florida Administrative Code or the similar law or laws of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 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.

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the Florida Statutes, or a similar applicable law of another state.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

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 this Benefit Booklet.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of the Benefit Booklet condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of the Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

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".

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Health Services covered under your plan. **Note:** The Preventive Services Guide is subject to change Please refer to our website at www.floridablue.com/healthresources for the most current guide.

Prosthetist/Orthotist means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide Services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

Provider means any facility, person or entity recognized for payment by BCBSF under this Booklet.

Provider Incentive means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

Registered Nurse First Assistant (RNFA) means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

Rehabilitation Services means Services for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to cardiac rehabilitation, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage Therapy.

Rehabilitative Therapies means therapies, the primary purpose of which, is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

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.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Skilled Nursing Facility means an institution or part thereof which meets BCBSF's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by BCBSF.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

Specialty Drug means an FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs 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.

Speech Therapy means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy Services.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

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: 1) the United States Pharmacopoeia Drug Information; 2) the American Medical Association Drug Evaluation; or 3) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the

purposes of this Booklet, a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's use of alcohol or any other substance injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Traditional Program means, or refers to, BCBSF's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS).

Traditional Program Providers means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, have entered into a contract, then in effect, to participate in BCBSF's Traditional Program as applicable in Florida or in certain counties outside of Florida when such programs exist.

Urgent Care Center means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For purposes of this Benefit Booklet, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

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.

Virtual Care Provider is a licensed Provider that is designated by us to provide care and treatment options by way of Virtual Visits. An In-Network Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications. Virtual Visits shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

Waiting Period means the length of time specified by Suwannee County Board of Public Instruction which must be met by an individual before that individual becomes eligible for coverage under this Benefit Booklet.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

BlueScript® Pharmacy Program Endorsement

This Endorsement and the BlueScript Pharmacy Program Schedule of Benefits are to be attached to, and made a part of, your Benefit Booklet. The Benefit Booklet is hereby amended by adding the following BlueScript Pharmacy Program provisions.

References to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise.

References to "we", "us", and "our" throughout refer to BCBSF.

Introduction

This Endorsement provides coverage for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this Endorsement, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as applicable, indicated on the BlueScript Pharmacy Program Schedule of Benefits.

In the Medication Guide, you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. You may be able to reduce your out-of-pocket expenses by: 1) using Participating Pharmacies; 2) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com, call the customer service phone number on your Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

Covered Prescription Drugs and Supplies and Covered OTC Drugs

A Prescription Drug, Covered OTC Drug or Self-Administered Injectable Prescription Drug is covered under this Endorsement **only** if it is:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
2. dispensed by a Pharmacist;
3. Medically Necessary, as defined in this Booklet 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 by us as indicated with a unique identifier in the Medication Guide, then in effect;
8. not specifically or generally limited or excluded herein or by the Benefit Booklet;
9. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs;

[Internal Identifier]

10. reviewed by our Pharmacy and Therapeutics Committee; and
11. within the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs category listed in this Endorsement.

A Supply is covered under this Endorsement **only** if it is:

1. a Covered Prescription Supply;
2. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license;
3. Medically Necessary; and
4. not specifically or generally limited or excluded herein or by the Benefit Booklet.

Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs

The benefit guidelines set forth below, may be applied to coverage under this Endorsement, as well as any other applicable payment rules specific to particular Covered Services listed in the Benefit Booklet.

Contraceptive Coverage

Prescription diaphragms, oral contraceptives and contraceptive patches are covered under this Endorsement unless indicated as not covered on the BlueScript Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Endorsement.

The following are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

   Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the your Physician.

   You can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or you may call the customer service phone number on your Identification Card and one will be mailed to you upon request.
2. Diaphragms indicated as covered in the Medication Guide; and
3. Emergency contraceptives indicated as covered in the Medication Guide.

<u>Exclusion</u>

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide), and implants (e.g., Norplant, IUD, etc.) inserted for any purpose are excluded from coverage under this Endorsement.

Prescription diaphragms, oral contraceptives and contraceptive patches are covered under this Endorsement unless indicated as not covered on the BlueScript Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Endorsement.

The following are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

4. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the your Physician.

You can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or you may call the customer service phone number on your Identification Card and one will be mailed to you upon request.

5. Diaphragms indicated as covered in the Medication Guide; and
6. Emergency contraceptives indicated as covered in the Medication Guide.

Exclusion

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants (e.g., Norplant, IUD, etc.) inserted for any purpose are excluded from coverage under this Endorsement.

Covered Over-the-Counter (OTC) Drugs

Select OTC Drugs, listed in the Medication Guide, may be covered when you obtain a Prescription for the OTC Drug from your Physician. In order for there to be coverage under this Endorsement for OTC Drugs, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the Preferred Generic Prescription Drug Copayment or percentage of the Participating Pharmacy Allowance or the Non-Participating Pharmacy Allowance, as applicable, indicated on the BlueScript Pharmacy Program Schedule of Benefits. Only those OTC Drugs listed in the Medication Guide are covered.

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed on our website at www.floridablue.com, or you may call the customer service phone number on your Identification Card and one will be mailed to you upon request.

Diabetic Coverage

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this Endorsement.

Insulin is **only** covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting insulin are covered only when prescribed in conjunction with insulin.

The following Supplies and equipment used in the treatment of diabetes are covered under this Endorsement: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and syringes and needles.

Exclusion:

All Supplies used in the treatment of diabetes except those that are Covered Prescription Supplies are excluded from coverage under this Endorsement.

Mineral Supplements, Fluoride or Vitamins

The following Drugs are covered only when state or federal law requires a Prescription and when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license:

1. prenatal vitamins;
2. oral single-product fluoride (non-vitamin supplementation);

3. sustained release niacin;
4. folic acid;
5. oral hematinic agents;
6. dihydrotachysterol; or
7. calcitriol.

Exclusion:

Prescription vitamin or mineral supplements not listed above, non-prescription mineral supplements and non-prescription vitamins are excluded from coverage.

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the cost share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

Preventive Medications

Certain medications may be available at no Cost Share when purchased from a Participating Pharmacy if they are considered a Preventive Service as outlined in the WHAT IS COVERED? section of the Benefit Booklet . Please see the Medication Guide for a list of these medications.

Specialty Pharmacy: Split Fill Option

Some types of medication may be difficult to tolerate for patients who are new to certain forms of treatment, such as oral oncology medication. To reduce waste and help avoid cost for medications that will go unused, the Specialty Pharmacy may split the first fill for certain medications identified in the Medication Guide. The applicable Cost Share would also be split between the two fills.

Limitations and Exclusions

Limitations

Coverage and benefits for Covered Prescription Drugs and Supplies and Covered OTC Drugs are subject to the following limitations in addition to all other provisions and exclusions of your Benefit Booklet:

1. This Endorsement does not cover more than the Maximum supply, as set forth in the BlueScript Pharmacy Program Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs.
2. Prescription refills beyond the time limit specified by state and/or federal law are not covered.
3. Certain Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
4. Specialty Drugs (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., 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

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific subsection of the "What Is Covered?" section of your Benefit Booklet, which this Endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a Hospital).
2. Except as covered in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for emergency contraceptives, insulin and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this Endorsement.
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes); regardless of the intended use (except for Covered Prescription Supplies).
7. Prescription Drugs and Supplies and OTC Drugs that are:
    a) in excess of the limitations specified in this Endorsement or on the BlueScript Pharmacy Program Schedule of Benefits;
    b) furnished to you without cost;
    c) Experimental or Investigational;
    d) indicated or used for the treatment of infertility;
    e) used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova;
    f) prescribed by a Pharmacist;
    g) used for smoking cessation (e.g., Zyban), except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section in the Booklet;
    h) listed in the Homeopathic Pharmacopoeia;
    i) not Medically Necessary;
    j) indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number 11 does not apply to sexual dysfunction Drugs excluded under this paragraph;
    k) purchased from any source (including a pharmacy) outside of the United States;
    l) prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America; and
    m) OTC Drugs not listed in the Medication Guide.
8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.
9. Any appetite suppressant, Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control.
10. Immunization agents, biological sera, blood and blood plasma, 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 that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good

quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce.
13. Drugs that do not have a valid National Drug Code.
14. Drugs that are compounded except those that have at least one active ingredient that is an FDA-approved Prescription Drug with a valid National Drug Code.
15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:

    a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

    b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by: 1) American Medical Association; 2) National Heart Lung and Blood Institute; 3) American Cancer Society; 4) American Heart Association; 5) National Institutes of Health; 6) American Gastroenterological Association; 7) Agency for Health Care Policy and Research; or

    c. BCBSF or Suwannee County Board of Public Instruction, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.
16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by:

    a) American Medical Association;

    b) National Heart Lung and Blood Institute;

    c) American Cancer Society;

    d) American Heart Association;

    e) National Institutes of Health;

    f) American Gastroenterological Association; or

    g) Agency for Health Care Policy and Research;

    unless, BCBSF or Suwannee County Board of Public Instruction, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.
17. Any amount you are required to pay under this Endorsement as indicated on the BlueScript Pharmacy Program Schedule of Benefits.
18. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance.
19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.
20. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.
21. Food or medical food products, whether prescribed or not.

[Internal Identifier]

22. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a) the Drug is a Repackaged Drug;

    b) the Drug is no longer marketed;

    c) the Drug has been shown to have excessive adverse effects and/or safer alternatives;

    d) the Drug, 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 Endorsement.

23. New Prescription Drugs.

Payment Rules

Under this Endorsement, the amount you must pay for Covered Prescription Drugs and Supplies or Covered OTC Drugs may vary depending on:

1. the participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. the terms of the Pharmacy's agreement with us or our Pharmacy Benefit Manager;
3. whether you have satisfied the Pharmacy Deductible, if any, and the amount of Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance set forth in the BlueScript Pharmacy Program Schedule of Benefits;
4. whether the Prescription Drug is a Generic Prescription Drug or a Brand Name Prescription Drug or Covered OTC Drug;
5. whether the Prescription Drug is on the Preferred Medication List;
6. whether the Prescription Drug is purchased from the Mail Order Pharmacy; and
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug.

A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Non-Preferred Prescription Drugs are subject to a higher Cost Share amount, as set forth in the BlueScript Pharmacy Program Schedule of Benefits.

We reserve the right to add, remove or reclassify any Prescription Drug in the Medication Guide at any time.

Pharmacy Alternatives

For purposes of this Endorsement, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

Participating 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 Participating Pharmacy, you may refer to the provider directory then in effect at www.floridablue.com or call the customer service phone number on your ID Card.

Prior to purchase, you must pay your Cost Share amount as listed in the Schedule of Benefits and present your ID Card and the Pharmacy must be able to verify that you are, in fact, covered by us.

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by a Participating Pharmacy are less than the required Copayment, the amount you pay will depend on the agreement then in effect between the Pharmacy and us or our Pharmacy Benefit Manager, and will be one of the following:

1. the usual and customary charge of such Pharmacy as if it were not a Participating Pharmacy;
2. the charge under the Pharmacy's agreement with us or our Pharmacy Benefit Manager; or
3. the Copayment, if less than the usual and customary charge of such Pharmacy.

Specialty Pharmacy

Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions are typically more difficult to maintain, administer and monitor when compared to traditional Drugs. Specialty Drugs may require frequent dosage adjustments, special storage and handling and may not be readily available at local pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require.

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications, while helping to preserve your benefits.

The Specialty Pharmacies designated, solely by us, are the only "In-Network" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueScript Pharmacy Program.

For additional details on how to obtain Covered Prescription Specialty Drugs from a Specialty Pharmacy, refer to the Medication Guide.

Mail Order Pharmacy

For details on how to obtain Covered Prescription Drugs and Supplies and OTC Drugs from the Mail Order Pharmacy, refer to the Medication Guide or the Mail Order Pharmacy Brochure.

Note: Specialty Drugs are not available through the Mail Order Pharmacy.

Non-Participating Pharmacies

Payment to you for Covered Prescription Drugs and Supplies and Covered OTC Drugs is based upon our Non-Participating Pharmacy Allowance. Non-Participating Pharmacies have **not** agreed to accept our Participating Pharmacy Allowance or our Pharmacy Benefit Manager's Participating Pharmacy Allowance as payment in full less any applicable Cost Share amounts due from you.

You may be responsible for paying the full cost of the Covered Prescription Drugs and Supplies and Covered OTC Drugs at the time of purchase and must submit a claim to us for reimbursement. Our reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs will be based on the Non-Participating Pharmacy Allowance less the Pharmacy Deductible, if any, and the Copayment or percentage of the Non-Participating Pharmacy Allowance set forth in the "Non-Participating Pharmacy" Cost Share column in the BlueScript Pharmacy Program Schedule of Benefits.

In order to be reimbursed for Covered Prescription Drugs and Supplies and Covered OTC Drugs purchased at a Non-Participating Pharmacy, you must obtain an itemized paid receipt and submit it with a properly completed claim form (with any required documentation) to:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Prescription Drug Program
P. O. Box 1798
Jacksonville, Florida 32231

Pharmacy Utilization Review Programs

Our pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and Supplies and OTC Drugs.

We may, at our sole discretion, require that Prescriptions for select Prescription Drugs and Supplies or OTC Drugs be reviewed under our pharmacy utilization review programs, then in effect, in order for there to be coverage for them. Under these programs there may be limitations or conditions on coverage for select Prescription Drugs and Supplies and OTC Drugs, depending on the quantity, frequency or type of Prescription Drug, Supply or OTC Drug Prescribed.

Note: If coverage is not available, or is limited, this does not mean that you cannot obtain the Prescription Drug, Supply or OTC Drug from the Pharmacy. It only means that we will not cover or pay for the Prescription Drug, Supply or OTC Drug. You are always free to purchase the Prescription Drug, Supply or OTC Drug at your sole expense.

Our pharmacy utilization review programs include the following:

Responsible Steps

Under this program, we may exclude from coverage certain Prescription Drugs and OTC Drugs unless you have first tried designated Drug(s) identified in the Medication Guide in the order indicated. In order for there to be coverage for such Prescription Drugs and OTC Drugs prescribed by your Physician, we must receive written documentation from you and your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Prior to filling your Prescription, your Physician may, but is not required to, contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

Dose Optimization Program

Under this program, we may exclude from coverage any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

Prior Coverage Authorization Program

You are required to obtain prior coverage authorization from us in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **Failure to obtain authorization will result in denial of coverage.** Prescription Drugs and Supplies and OTC Drugs requiring prior coverage authorization are designated in the Medication Guide.

[Internal Identifier]

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your plan, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

For additional details on how to obtain prior coverage authorization refer to the Medication Guide.

Information on our pharmacy utilization review programs is published in the Medication Guide at www.floridablue.com, or you may call the customer service phone number on your Identification Card. Your Pharmacist may also advise you if a Prescription Drug requires prior coverage authorization.

Ultimate Responsibility for Medical Decisions

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the applicable terms of the Benefit Booklet. Ultimately, the final decision concerning whether a Prescription Drug, Supply or OTC Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us in authorizing coverage are made only to determine whether coverage or benefits are available under the Benefit Booklet and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug, Supply or OTC Drug, must be made solely by you and your treating Physician in accordance with the patient/Physician relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug, Supply or OTC Drug is needed, appropriate, or desirable, even though such Prescription Drug, Supply or OTC Drug may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if we have indicated that coverage and payment will not be made for such Prescription Drug, Supply or OTC Drug.

Definitions

Certain important terms applicable to this Endorsement are set forth below. For additional applicable definitions, please refer to the definitions in the Benefit Booklet that this Endorsement amends.

Average Wholesale Price ("AWP") means the average wholesale price of a Prescription Drug at the time a claim is processed as established by BCBSF based upon its utilization of a national drug database as determined by BCBSF, provided that any such national drug database must be accepted in the industry as a provider of average wholesale price, or similar pricing, data on a national scale.

Biosimilar Prescription Drug is a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (know 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.

Brand Name Prescription Drug means a Prescription Drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

Covered OTC Drug means an Over-the-Counter Drug that is designated in the Medication Guide as a Covered OTC Drug.

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered by this Endorsement.

Covered Prescription Drug(s) and Supply(ies) means Covered Prescription Drugs and Covered Prescription Supplies.

Covered Prescription Supply(ies) means only the following Supplies:

1. Prescription diaphragms as covered in the Medication Guide;
2. syringes and needles prescribed in conjunction with insulin, or a covered Self-Administered Injectable Prescription Drug which is covered under this Endorsement;
3. syringes and needles prescribed in conjunction with a Prescription Drug covered under this Endorsement;
4. syringes and needles which are 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.

Day Supply means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

Dispensing Fee means the fee a Pharmacy is paid for filling a Prescription in addition to payment for the Drug.

Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

FDA means the United States Food and Drug Administration.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either: 1) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or 2) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of BCBSF, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic 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.

Mail Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug and Covered Prescription Supply as set forth in the BlueScript Pharmacy Program Schedule of Benefits.

Mail Order Pharmacy means the Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide mail order services.

Maximum means the amount designated in our Medication Guide as the Maximum, including but not limited to, frequency, dosage and duration of therapy.

Medication Guide means the guide then in effect issued by us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Preferred Brand Name

Prescription Drugs; and Non-Preferred Prescription Drugs. The Medication Guide does not list all Non-Preferred Prescription Drugs due to space limitations, but some Non-Preferred Prescription Drugs and potential alternatives are provided for your information. **Note:** The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card for current information.

National Drug Code (NDC) means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

National Network Pharmacy means a Pharmacy located outside of Florida that is part of the national network of Pharmacies established by our contracting Pharmacy Benefit Manager.

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. 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 for the Prescription Drug;

   or

2. December 31st of the following Calendar Year.

Non-Participating Pharmacy means a Pharmacy that has not agreed to participate in the network for this Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Non-Participating Pharmacy Allowance means the amount upon which payment in such situations will be based for Covered Prescription Drugs and Supplies and Covered OTC Drugs:

1. In the case of Generic Prescription Drugs and Supplies and OTC Drugs, the Non-Participating Pharmacy Allowance shall be approximately 33 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable Drug is less, the amount billed.
2. In the case of Brand Name Prescription Drugs and Supplies, the Non-Participating Pharmacy Allowance shall be approximately 82 percent of AWP plus a $1.00 Dispensing Fee or, if the amount billed for the applicable Drug is less, the amount billed.

It is further provided, however, that if either: 1) a national drug database then used by BCBSF makes a "material modification" to its AWP data (as determined by BCBSF), or; 2) BCBSF elects to utilize a new national drug database, BCBSF may modify the 33 percent of AWP figure and/or the 82 percent of AWP figure set out above so that the applicable modified figure sets out a replacement percent figure that is between: 1) the percent figure calculated to approximate the applicable Non-Participating Pharmacy Allowance in effect immediately prior to the applicable AWP database change, and; 2) the 33 percent of AWP figure or the 82 percent of AWP figure, whichever is applicable.

Non-Preferred Prescription Drug means a compound drug or Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect. New Prescription Drugs are not a Non-Preferred Prescription Drug.

One-Month Supply means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's dosing recommendations. Certain Drugs, e.g. Specialty Drugs, may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

Over-the-Counter (OTC) Drug means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

Participating Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to participate in the network for this Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

Participating Pharmacy Allowance means the maximum amount allowed to be charged by a Participating Pharmacy per Prescription for a Covered Prescription Drug, Covered Prescription Supply or Covered OTC Drug under this Endorsement.

Pharmacist means a person properly licensed to practice the profession of Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state that regulates the profession of Pharmacy.

Pharmacy means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state, where a Pharmacist dispenses Prescription Drugs.

Pharmacy Benefit Manager means an organization that has established, and manages, Pharmacy networks and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

Pharmacy Deductible means the amount of allowed charges for Covered Prescription Drugs and Supplies and Covered OTC Drugs you must actually pay per Benefit Period, in addition to any applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, to a Pharmacy, who is recognized for payment under this Endorsement, before our payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs begins.

Pharmacy Out-of-Pocket Maximum means the maximum amount you will be required to pay per Benefit Period for Covered Prescription Drugs and Supplies and Covered OTC Drugs. Any benefit penalty reductions, non-covered charges or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance will not accumulate toward the pharmacy out-of-pocket maximum.

Preferred Brand Name Prescription Drug means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug.

Preferred Generic Prescription Drug means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide.

Preferred Medication List means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which we provide coverage and benefits, subject to the exclusions and limitations of this Endorsement. The Preferred Medication List is contained within the Medication Guide.

Preferred Prescription Drug means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained within the Medication Guide.

Prescription means an order for Drugs, or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or Supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of this Endorsement, insulin and emergency contraceptives are considered a Prescription Drug because, in order to be covered, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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.

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding insulin. Covered Self-Administered Injectable Prescription Drugs are denoted with a symbol in the Medication Guide.

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy. Specialty Drugs are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed an agreement with us or our Pharmacy Benefit Manager to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

Supply(ies) means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, bandages, cotton swabs, and similar items and any birth control device.

Three-Month Supply means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer's dosing recommendations.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent as expressed herein.

Serviced by
Blue Cross and Blue Shield of Florida, Inc.

Templates Included

Compliance/Notices/Meaningful Access Notice.jld
Compliance/Notices/Prior Authorization (Preapproval) of Medical and Pharmacy Services Notice.jld
Compliance/Notices/Privacy Notice - Breast Reconstruction Notice.jld

78170-05781--Schedule-Of-Benefits-1
78170-05781--Rx-Schedule-Of-Benefits-1
78170-05781--Benefit-Booklet-1
78170-05781--RXE-1

MATCHING CRITERIA

Record Number	947
Request Type	M
Health Product	BLUEOPTIONS
Small Group	N
Rx Product	BLUESCRIPT
Rx Plan	164
Health Plan	05781
IRX	N
Generic Choices	N
Generic Only	N
Closed Formulary	N
HSA	N
HSA-BRX	N
Standard	N
Basic	N
ACA	N
RX CoIns	N
ICC	N
CP-GF-BEN-IND	N
CP-GF-STATUS-IND	N
CP-GROUP-SUB	G
CP-GENERATION-IND	3
CP-EXCHANGE-IND	N
CP-RX-DED-IND	N

CP-RX-NGF-2012-HCR-IND	Y
CP-RX-GF-2012-HCR-IND	N
TAG-RX-SUFFIX	RX
AON	N
CP-ASO-IND	Y
ROUTE	GROUP
EFF-YEAR	21
PMT_KEY	021135023257120007020002947
GRP-PKG-EFF-YEAR	21
GRP-NO	78170
DIV-NO	C13
PKG-NO	01
FEEDER1	0
FEEDER2	0
FEEDER3	0
FEEDER4	0
FEEDER5	0
FEEDER6	0
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DATE	6/5/21 11:25 AM

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **SUWANNEE COUNTY BOARD OF PUBLIC INSTRUCTION**
SUWANNEE COUNTY SCHOOLS

Policy Number **160-157141** **Insured Person**

Plan Effective Date **May 1, 2018** **Certificate Effective Date**
Refer to Exceptions on 9070

Class Number 2

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-547-9515.

STANDARD INSURANCE COMPANY

J. Greg Ness
President

FLORIDA - IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629
	Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2580

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Office of Insurance Regulation with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 2	Eligible Employee Electing High Dental

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$150

Coinsurance Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	$1,250

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on April 30, 2018, and
b. on May 1, 2018 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

DEFINITIONS

COMPANY: refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

POLICYHOLDER: refers to the Policyholder named on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child less than 30 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each child age 30 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a “Network Provider.” The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider’s contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an “Out-of-Network Provider.” Members are required to pay the difference between the plan payment and

the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a Member of the Eligible Class for Insurance is any eligible employee electing high dental working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is defined by the Policyholder.

Retirees are included in the Eligible Class for Insurance as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing high dental working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are included in the Eligible Class for Dependent Insurance as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage.

If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before thedate on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.

2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.

3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.

4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.

5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and

2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth unless the insured person is covered on May 1, 2018. For those Insureds covered on May 1, 2018, see b.

b. Limitation a. will be waived for those Insureds whose coverage was effective on May 1, 2018 and

i. the person has the tooth extracted while insured under the prior contract: and

ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

3. for appliances, restorations, or procedures to:

a. alter vertical dimension;
b. restore or maintain occlusion; or
c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is paid benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per benefit period.

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.
D0230 Intraoral - periapical each additional radiographic image.
D0240 Intraoral - occlusal radiographic image.
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.
D0272 Bitewings - two radiographic images.
D0273 Bitewings - three radiographic images.
D0274 Bitewings - four radiographic images.
D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per benefit period.

D0277, also contribute(s) to this limitation.

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 3 year(s).

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PRE-DIAGNOSTIC TEST

TYPE 1 PROCEDURES

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

TESTS: D0431

Coverage is limited to 1 of any of these procedures per 2 year(s).

Benefits are considered for persons from age 35 and over.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 2 of any of these procedures per benefit period.

Benefits are considered for persons age 14 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per benefit period.

D4346, D4910, also contribute(s) to this limitation.

An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per benefit period.

Not allowed when done on the same date as periodontal services.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.
D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 3 year(s).

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per lifetime.

Benefits are considered for persons age 14 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cement or re-bond space maintainer.
D1555 Removal of fixed space maintainer.
D1575 Distal shoe space maintainer - fixed - unilateral.

SPACE MAINTAINER: D1510, D1515, D1520, D1525, D1575

Benefits are considered for persons age 14 and under.

Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.

TYPE 2 PROCEDURES

D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.
D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2929 Prefabricated porcelain/ceramic crown - primary tooth.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).

TYPE 2 PROCEDURES

D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.

TYPE 2 PROCEDURES

D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

Each quadrant is limited to 2 of any of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.

FULL MOUTH DEBRIDEMENT: D4355

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER PERIODONTAL SERVICES

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
D4910 Periodontal maintenance.

OTHER PERIODONTAL SERVICES: D4346, D4910

Coverage is limited to 2 of any of these procedures per benefit period.

D1110, D1120, also contribute(s) to this limitation.

Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

TYPE 2 PROCEDURES

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Coverage is limited to dates of service more than 6 months after placement date.

DENTURE REPAIR

D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken clasp-per tooth.
D5640 Replace broken teeth - per tooth.

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES

D5730 Reline complete maxillary denture (chairside).
D5731 Reline complete mandibular denture (chairside).
D5740 Reline maxillary partial denture (chairside).
D5741 Reline mandibular partial denture (chairside).
D5750 Reline complete maxillary denture (laboratory).
D5751 Reline complete mandibular denture (laboratory).
D5760 Reline maxillary partial denture (laboratory).
D5761 Reline mandibular partial denture (laboratory).

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

TYPE 2 PROCEDURES

D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.

TYPE 3 PROCEDURES

D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

VENEERS

D2960 Labial veneer (resin laminate) - chairside.
D2961 Labial veneer (resin laminate) - laboratory.
D2962 Labial veneer (porcelain laminate) - laboratory.

LABIAL VENEERS: D2960, D2961, D2962

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Benefits are considered on anterior teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

TYPE 3 PROCEDURES

D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).

TYPE 3 PROCEDURES

D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.

TYPE 3 PROCEDURES

D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

TYPE 3 PROCEDURES

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured. We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on April 30, 2018 and are both:

    a. insured under this policy; and
    b. currently undergoing a Treatment Program on May 1, 2018.

2. in the first 12 months that a person is insured if the person is a Late Entrant.

3. before the Insured has been insured under this section for at least 12 consecutive months unless the Insured is covered on May 1, 2018.

4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

5. if the Insured's insurance under this section terminates.

6. for which the Insured is paid benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

10. To replace lost, missing or stolen orthodontic appliances.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan.** The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense.**

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

HIPAA Notice of Privacy Practices

To: All Insureds covered under a Dental Insurance policy ("Health Plan") with Standard Insurance Company

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at **www.standard.com/hipaa.**

Permitted Uses and Disclosures of Your Health Information

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

Treatment. This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

Payment. This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

Health Care Operations. This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

Public Health Activities. We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners and Medical Examiners. We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes. We may disclose health information for research purposes.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement and National Security and Intelligence Activities. We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

To Avert a Serious Threat to Health or Safety. We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Disclosure to your Plan Sponsor. Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

Sale of Protected Health Information. We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes require your authorization.

Marketing. We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

Other Uses and Disclosures of Your Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. To inspec or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

Right to Breach Notification. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

Your Right to File a Complaint. If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company
Attn: Quality Assurance Specialist
PO Box 82629
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Privacy Contact

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **SUWANNEE COUNTY BOARD OF PUBLIC INSTRUCTION**
SUWANNEE COUNTY SCHOOLS

Policy Number **160-157141** **Insured Person**

Plan Effective Date **May 1, 2018** **Certificate Effective Date**
Refer to Exceptions on 9070

Class Number 1

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-547-9515.

STANDARD INSURANCE COMPANY

J. Greg Ness
President

FLORIDA - IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629
	Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2580

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Office of Insurance Regulation with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Eligible Employee Electing Low Dental

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$150

Coinsurance Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	$750

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on April 30, 2018, and
b. on May 1, 2018 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

DEFINITIONS

COMPANY: refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

POLICYHOLDER: refers to the Policyholder named on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child less than 30 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each child age 30 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a “Network Provider.” The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider’s contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an “Out-of-Network Provider.” Members are required to pay the difference between the plan payment and

the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a Member of the Eligible Class for Insurance is any eligible employee electing low dental working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is defined by the Policyholder.

Retirees are included in the Eligible Class for Insurance as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing low dental working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are included in the Eligible Class for Dependent Insurance as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage.

If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before thedate on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.

2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.

3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.

4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.

5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and

2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth unless the insured person is covered on May 1, 2018. For those Insureds covered on May 1, 2018, see b.

b. Limitation a. will be waived for those Insureds whose coverage was effective on May 1, 2018 and

i. the person has the tooth extracted while insured under the prior contract: and

ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

3. for appliances, restorations, or procedures to:

a. alter vertical dimension;
b. restore or maintain occlusion; or
c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is paid benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.
- Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per benefit period.

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.
D0230 Intraoral - periapical each additional radiographic image.
D0240 Intraoral - occlusal radiographic image.
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.
D0272 Bitewings - two radiographic images.
D0273 Bitewings - three radiographic images.
D0274 Bitewings - four radiographic images.
D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per benefit period.

D0277, also contribute(s) to this limitation.

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 3 year(s).

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PRE-DIAGNOSTIC TEST

TYPE 1 PROCEDURES

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

TESTS: D0431

Coverage is limited to 1 of any of these procedures per 2 year(s).

Benefits are considered for persons from age 35 and over.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 2 of any of these procedures per benefit period.

Benefits are considered for persons age 14 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per benefit period.

D4346, D4910, also contribute(s) to this limitation.

An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per benefit period.

Not allowed when done on the same date as periodontal services.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.
D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 3 year(s).

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per lifetime.

Benefits are considered for persons age 14 and under.

Benefits are considered on permanent molars only.

Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cement or re-bond space maintainer.
D1555 Removal of fixed space maintainer.
D1575 Distal shoe space maintainer - fixed - unilateral.

SPACE MAINTAINER: D1510, D1515, D1520, D1525, D1575

Benefits are considered for persons age 14 and under.

Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.

TYPE 2 PROCEDURES

D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.
D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2929 Prefabricated porcelain/ceramic crown - primary tooth.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Coverage is limited to dates of service more than 6 months after placement date.

TYPE 2 PROCEDURES

DENTURE REPAIR
- D5511 Repair broken complete denture base, mandibular.
- D5512 Repair broken complete denture base, maxillary.
- D5520 Replace missing or broken teeth - complete denture (each tooth).
- D5611 Repair resin partial denture base, mandibular.
- D5612 Repair resin partial denture base, maxillary.
- D5621 Repair cast partial framework, mandibular.
- D5622 Repair cast partial framework, maxillary.
- D5630 Repair or replace broken clasp-per tooth.
- D5640 Replace broken teeth - per tooth.

DENTURE REBASES
- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.

DENTURE RELINES
- D5730 Reline complete maxillary denture (chairside).
- D5731 Reline complete mandibular denture (chairside).
- D5740 Reline maxillary partial denture (chairside).
- D5741 Reline mandibular partial denture (chairside).
- D5750 Reline complete maxillary denture (laboratory).
- D5751 Reline complete mandibular denture (laboratory).
- D5760 Reline maxillary partial denture (laboratory).
- D5761 Reline mandibular partial denture (laboratory).

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS
- D7111 Extraction, coronal remnants - primary tooth.
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

OTHER ORAL SURGERY
- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
- D7280 Exposure of an unerupted tooth.
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
- D7283 Placement of device to facilitate eruption of impacted tooth.
- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.

TYPE 2 PROCEDURES

D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.

TYPE 3 PROCEDURES

D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

VENEERS

D2960 Labial veneer (resin laminate) - chairside.
D2961 Labial veneer (resin laminate) - laboratory.
D2962 Labial veneer (porcelain laminate) - laboratory.

LABIAL VENEERS: D2960, D2961, D2962

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Benefits are considered on anterior teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.

TYPE 3 PROCEDURES

D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.

TYPE 3 PROCEDURES

D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

Each quadrant is limited to 1 of each of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

Each quadrant is limited to 2 of any of these procedures per 3 year(s).

Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.

FULL MOUTH DEBRIDEMENT: D4355

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER PERIODONTAL SERVICES

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
D4910 Periodontal maintenance.

OTHER PERIODONTAL SERVICES: D4346, D4910

Coverage is limited to 2 of any of these procedures per benefit period.

D1110, D1120, also contribute(s) to this limitation.

Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.

TYPE 3 PROCEDURES

D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

TYPE 3 PROCEDURES

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.

TYPE 3 PROCEDURES

D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

SURGICAL EXTRACTIONS

- D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
- D7220 Removal of impacted tooth - soft tissue.
- D7230 Removal of impacted tooth - partially bony.
- D7240 Removal of impacted tooth - completely bony.
- D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
- D7250 Removal of residual tooth roots (cutting procedure).
- D7251 Coronectomy-intentional partial tooth removal.

ANESTHESIA-GENERAL/IV

- D9219 Evaluation for deep sedation or general anesthesia.
- D9222 Deep sedation/general anesthesia - first 15 minutes.
- D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
- D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
- D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

TYPE 3 PROCEDURES

Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured. We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on April 30, 2018 and are both:

    a. insured under this policy; and
    b. currently undergoing a Treatment Program on May 1, 2018.

2. in the first 12 months that a person is insured if the person is a Late Entrant.

3. before the Insured has been insured under this section for at least 12 consecutive months unless the Insured is covered on May 1, 2018.

4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

5. if the Insured's insurance under this section terminates.

6. for which the Insured is paid benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

10. To replace lost, missing or stolen orthodontic appliances.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan.** The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense.**

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

HIPAA Notice of Privacy Practices

To: All Insureds covered under a Dental Insurance policy ("Health Plan") with Standard Insurance Company

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at **www.standard.com/hipaa.**

Permitted Uses and Disclosures of Your Health Information

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

Treatment. This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

Payment. This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

Health Care Operations. This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

Public Health Activities. We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners and Medical Examiners. We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes. We may disclose health information for research purposes.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement and National Security and Intelligence Activities. We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

To Avert a Serious Threat to Health or Safety. We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Disclosure to your Plan Sponsor. Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

Sale of Protected Health Information. We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes require your authorization.

Marketing. We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

Other Uses and Disclosures of Your Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. To inspec or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

Right to Breach Notification. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

Your Right to File a Complaint. If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company
Attn: Quality Assurance Specialist
PO Box 82629
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Privacy Contact

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE
GROUP EYE CARE INSURANCE

The Policyholder **SUWANNEE COUNTY BOARD OF PUBLIC INSTRUCTION**
SUWANNEE COUNTY SCHOOLS

Policy Number **160-157141** **Insured Person**

Plan Effective Date **May 1, 2018** **Certificate Effective Date**
Refer to Exceptions on 9070

Class Number 3

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-877-7195.

STANDARD INSURANCE COMPANY

J. Greg Ness
President

FLORIDA - IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Assurance
Address:	P.O. Box 82629
	Lincoln, NE 68501-2629
Phone:	888-418-6811
Fax:	402-309-2580

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Office of Insurance Regulation with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 3	Eligible Employee Electing Vision

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

When a Participating Provider is used:	
Exams - Each Benefit Period	$10
Contact Lens Fitting and Evaluation - Each Benefit Period	$60
Frames, Lenses and Medically Necessary Contacts - Each Benefit Period	$10
When a Non-Participating Provider is used:	
Exams - Each Benefit Period	$10
Frames, Lenses and Medically Necessary Contacts - Each Benefit Period	$10

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY: refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

POLICYHOLDER: refers to the Policyholder named on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child through the end of the year in which they turn 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, newborn adopted children from the date of placement for adoption, any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code and, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

c. each child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of developmental disability or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred

to as an “Out-of-Network Provider.” Members are required to pay the difference between the plan payment and the provider’s actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a Member of the Eligible Class for Insurance is any eligible employee electing vision working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is defined by the Policyholder.

Retirees are included in the Eligible Class for Insurance as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Eye Care expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing vision working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are included in the Eligible Class for Dependent Insurance as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage.

If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on theend of the month falling on or next following the day before thedate on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

AMOUNT PAYABLE
The Amount Payable for Covered Expenses is the lesser of the provider's charge, or the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services below.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING PROVIDERS
A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDER
A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.

COVERED EXPENSES
Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS
If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED
An expense is incurred at the time a service is rendered or a supply item furnished.

PROOF OF LOSS
Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS
This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS
This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE *Participating Provider*	*Non-Participating Provider**
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to $ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to $ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to $ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to $ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to $100.00
Frames			
Single Frame	Once every 24 months	Up to $150.00	Up to $ 75.00
Contact Lenses (in lieu of Complete Pair of Spectacles) Includes allowance for Contact Lens Fitting & Evaluation			
Elective	Once every 12 months	Up to $150.00	Up to $120.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to $210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

**The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan.** The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense.**

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

HIPAA Notice of Privacy Practices

To: All Insureds covered under a Eye Care Insurance policy ("Health Plan") with Standard Insurance Company

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at **www.standard.com/hipaa.**

Permitted Uses and Disclosures of Your Health Information

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

Treatment. This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

Payment. This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

Health Care Operations. This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

Public Health Activities. We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners and Medical Examiners. We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes. We may disclose health information for research purposes.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement and National Security and Intelligence Activities. We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

To Avert a Serious Threat to Health or Safety. We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Disclosure to your Plan Sponsor. Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

Sale of Protected Health Information. We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes require your authorization.

Marketing. We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

Other Uses and Disclosures of Your Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. To inspec or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

Right to Breach Notification. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

Your Right to File a Complaint. If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company
Attn: Quality Assurance Specialist
PO Box 82629
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Privacy Contact

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.