SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT
ITN 003-19 STOP LOSS INSURANCE

ATTACHMENT 1
MEDICAL PLAN(S) SUMMARY OF BENEFITS AND COVERAGE

BlueOptions

With Integrated Prescription Drug Coverage Benefit Booklet for the Southwest Florida Water Mgmt. Dist. Group Health Plan

A Self-funded Group Health Benefit Plan

For Customer Service Assistance:
(800) 352-2583

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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 Southwest Florida Water Mgmt. Dist.

The sponsor of your Group Health Plan has contracted with BlueCross 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 Southwest Florida Water Mgmt. Dist.

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 included in this Booklet 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 Benefit 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® (Out-of-State) Program when you receive Services out-of-state?**

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

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

  Read the "Enrollment and Effective Date of Coverage" section.

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

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

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

  Read the "Termination of Coverage" section.

- **what 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, BCBSF or Southwest Florida Water Mgmt. Dist. may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. Neither BCBSF nor Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., 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 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 Southwest Florida Water Mgmt. Dist. 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;
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.

<u>Exclusions:</u>

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

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 as to make it impractical for the individual to receive services in a less intensive setting.

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

Exclusion:

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

Mammograms

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

Benefits for mammograms may not be subject to the 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

1. 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.
2. 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.
3. 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 Southwest Florida Water Mgmt. Dist. 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 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 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. Certain Physician Services can be rendered electronically through a computer via the Internet (E-Visits). E-Visits are covered when rendered in accordance with the Payment Rules below.

Payment Rules for E-Visits

Expenses for E-Visits are covered only if:

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

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

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled E-visit and for telephone consultations (except as indicated as covered under the Preventive Service category of this section).
2. Telemedicine Services, as defined in this Benefit Booklet.
3. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

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 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 Prescription Drugs

The following Self-Administered Drugs are covered:

1. Self-Administered Prescription Drugs used in the treatment of diabetes, cancer,

Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis; and

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

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

    b. Continuation of growth hormone therapy is only covered for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependent peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses. Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

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;

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; and
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery.
6. 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 and the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An “incidental surgical procedure” includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in BCBSF’s or Southwest Florida Water Mgmt. Dist.’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 Southwest Florida Water Mgmt. Dist., 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 (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

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

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

<u>Exclusion:</u>

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Benefit Booklet;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published *Medicare Coverage Issues Manual*;

7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility; or
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

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.

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 **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; 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 BlueScript Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Benefit Booklet.

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.

Exclusion:

Contraceptive injectable Prescription Drugs, 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. Only those OTC Drugs listed in the Medication Guide are covered.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed on our website at www.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.

Exclusion:

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

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.

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.

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

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

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

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

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

23. New Prescription Drugs.

24. We reserve the right not to apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance,

manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

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

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 our agreement with the Pharmacy selected;
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.

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.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your policy, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

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.

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 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 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 web site 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.

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 Southwest Florida Water Mgmt. Dist.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

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

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the 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 COVERED SERVICES 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. Specialty Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. (See "What is Covered?" section for additional information.)
9. New Prescription Drug(s), as defined in the DEFINITIONS section.
10. Convenience Kits, as defined in the DEFINITIONS section of the Booklet.
11. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our 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.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. any Service to diagnose or treat any Condition resulting from or in connection with your job or employment;
3. any Health Care Services not within the Service categories described in the "What is Covered?" or "BlueScript® Pharmacy Program" sections, any rider, or

Endorsement attached hereto, unless such Services are specifically required to be covered by applicable law;

4. any Health Care Service you render to yourself or those renedered by a Physician or other health care Provider related to you by blood or marriage;
5. Any Health Care Service which is not Medically Necessary as determined by us or Southwest Florida Water Mgmt. Dist. and defined in this Booklet . The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service;
6. Any Health Care Services rendered at no charge;
7. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
8. Any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a) war or an act of war, whether declared or not;
    b) your participation in, or commission of, any act punishable by law as a 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;
    e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or
    f) Services that are not patient-specific, as determined solely by us.
9. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
10. Any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

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.

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.

Telemedicine Services, as defined in this Benefit Booklet.

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

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

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

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a

Condition, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

Wigs and/or cranial prosthesis.

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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. Southwest Florida Water Mgmt. Dist. retains ultimate responsibility for determining whether expenses incurred for medical care are covered under this Booklet. In making coverage decisions, neither BCBSF nor Southwest Florida Water Mgmt. Dist. 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 insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

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.

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. This does not apply to Covered Prescription Drugs or Supplies covered under the BlueScript® Pharmacy Program. Please refer to the "BlueScript® Pharmacy Program" section for additional information.

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.

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

Out-of-Pocket Maximums

Individual out-of-pocket maximum

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

Family out-of-pocket 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 the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period. 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 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 Group Master Policy replaces such policy. 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 Group policy. This provision is only applicable for you during the initial Benefit Period of coverage under the Group Master Policy and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage under the Group Master Policy 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 the Group Master Policy, 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 the Group Master Policy, 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 Southwest Florida Water Mgmt. Dist., 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.

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 Southwest Florida Water Mgmt. Dist.

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 (Out-of-State) Traditional Program Providers, in conformity with the "BlueCard (Out-of-State) 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. Although you have the option to select any Provider you choose, you are encouraged to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs. Developing and continuing a relationship with a Family Physician allows the physician to become knowledgeable about you and your family's health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers may result in lower out-of-pocket expenses for you. You should always determine whether a Provider is In-Network or Out-of-Network prior to receiving Services to determine the amount you are responsible for paying out-of-pocket.

Location of Service

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

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

1. 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.

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 (Out-of-State) 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 (Out-of-State) Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.
Can you be billed the difference between what we pay the Provider and the Provider's charge?	• **NO.** You are protected from being billed for the difference in our Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept 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 (Out-of-State) Program, when you receive Services from a BlueCard (Out-of-State) Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.

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

To determine what expenses you are responsible for paying for Covered Prescription Drugs and Supplies, please refer to the "BlueScript® Pharmacy Program" section.

Physicians

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

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

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

Hospitals

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

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

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

This will provide you with information that will help you determine a portion of what your out-of-pocket costs may be in the event you are hospitalized.

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

Specialty Pharmacy

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

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

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 DED will be waived for these Services and are available at a lower cost share of $5 when they are rendered in the Value Choice Provider's office. To find a Value Choice Provider you may access the most recent provider directory at www.floridablue.com. These Providers will be designated under the heading Value Choice Providers. Advanced imaging, maternity and Medical Pharmacy Services will remain at the cost share listed on your Schedule of Benefits.

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 (Out-of-State) PPO Program Provider; 5) is a BlueCard (Out-of-State) Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes* ; or 7) is an Ambulance Provider that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) *Florida Statutes*, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.

Section 8: BlueCard® (Out-of-State) 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 Progam 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 Southwest Florida Water Mgmt. Dist., 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 are responsible for paying under this Benefit Booklet.

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

1. certain **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging;
3. **Autism Spectrum Disorder;** and
4. **other Health Care Services** that are or may become subject to a prior coverage

authorization program or a pre-service notification program as defined and administered by us.

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

In-Network Providers

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

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

Out-of-Network Providers

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

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

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

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

3. In the case of **Autism Spectrum Disorder,** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization will result in denial of coverage for such Services.**

4. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization or provide pre-service notification may result in denial of the claim or application of a financial penalty assessed at the time the claim is presented for payment to us**. The penalty applied will be the lesser of $500 or 20% of the total Allowed Amount of the claim. The decision to apply a penalty or deny the claim will be made uniformly and will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

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

BCBSF will provide you information for any Out-of-Network Health Care Service subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service not already listed here. This information will be provided to you upon enrollment, or at least 30 days prior to such Out-of-Network Services becoming subject to a prior coverage authorization or pre-service notification program.

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

Note:

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, Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist., 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. Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.;
2. The employee's job must fall within a job classification identified by Southwest Florida Water Mgmt. Dist. ;
3. The employee must have completed any applicable Waiting Period identified by Southwest Florida Water Mgmt. Dist.; and
4. The employee must meet any additional eligibility requirement(s) required by Southwest Florida Water Mgmt. Dist.

Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist., provided such companies and Southwest Florida Water Mgmt. Dist. are under common control; and
4. other individuals as determined by Southwest Florida Water Mgmt. Dist. (e.g., members of associations or labor unions).

Southwest Florida Water Mgmt. Dist. 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), from 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not

have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of his own or entitled to benefits under Title XVIII of the Social Security Act. You may be required to provide such proof at least once each year until the end of the calendar year in which the child attains 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 the Covered Plan Participant'**s** sole responsibility to establish that a child meets the applicable requirements for eligibility.

Handicapped Children

In the case of a handicapped dependent child, 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 mental retardation or physical handicap; and
3. chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 30^{th} birthday.

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

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

When making application for coverage, you must elect one of the types of coverage available under Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist.'s health benefit program. The period is established by Southwest Florida Water Mgmt. Dist., occurs annually, and will take place when specified by Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist. 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.

Southwest Florida Water Mgmt. Dist. must be notified, in writing, within 30 days after the birth.

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 Southwest Florida Water Mgmt. Dist. 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.

In the event BCBSF is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Plan Participant provides notice to Southwest Florida Water Mgmt. Dist., and an Enrollment Form is received by BCBSF within 60 days of the birth. In the event BCBSF is not notified within 60 days of the date of birth, the Covered Plan Participant must make application during an Annual Open Enrollment Period in order for the adopted newborn child to be covered.

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., and we receive the Enrollment Form within 60 days of the placement. In the event Southwest Florida Water Mgmt. Dist. is not notified within 60 days of the date of placement, the Covered Plan Participant must make application during an Annual Open Enrollment Period in order for the adopted or Foster Child to be covered.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child. Proof of final adoption must be submitted to BCBSF through Southwest Florida Water Mgmt. Dist. It is the responsibility of the Covered Plan Participant to notify us if the adoption does not take place. Upon receipt of this notification, coverage for the child will be terminated 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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 first of the month following the special enrollment event, unless required by law. 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 Southwest Florida Water Mgmt. Dist. 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, Pre-existing Condition exclusionary period, 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist., prior to the requested termination date or within 30 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, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'s responsibility to notify you of your termination or that of your Covered Dependents for any reason.

Section 13: Continuing Coverage Under COBRA

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

You must contact Southwest Florida Water Mgmt. Dist. to determine if you or your Covered Dependent are entitled to COBRA continuation of coverage. Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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. Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., in writing, within 60 days of any of these events. Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist. 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. Southwest Florida Water Mgmt. Dist. 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.

A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:

- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist. MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you . Also, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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:

Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. or to any individual covered under this Benefit Booklet on account of any nonpayment of primary benefits resulting from any failure of performance of Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. if you have questions relating to your Group Plan's SPD. We are not your Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

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

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

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

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the Provider's name and address;

6. the name of the individual who received the Service; and
7. the Covered Plan Participant's name and contract number as they appear on the Identification Card.

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

Note: Please refer to the "BlueScript® Pharmacy 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® (Out-of-State) Program" section of this Booklet).

The Processing of Post-Service Claims

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

- Payment for Post-Service Claims

When payment is due under the terms of 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:

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

telephone, facsimile or other available expeditious method;

- If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.floridablue.com or by calling the number on the back of your BCBSF ID Card.

Timing of Our Appeal Review on Adverse Benefit Determinations

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

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

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

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

Submit appeals of Adverse Benefit Determinations to:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

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

Southwest Florida Water Mgmt. Dist. 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.

Section 19: Relationships Between the Parties

BCBSF/Southwest Florida Water Mgmt. Dist. and Health Care Providers

Neither BCBSF nor Southwest Florida Water Mgmt. Dist. nor any of their respective officers, directors or employees provides Health Care Services to you. Rather, BCBSF and Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. **In this regard, we and Southwest Florida Water Mgmt. Dist. hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and Southwest Florida Water Mgmt. Dist.

Neither Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. and we will not be liable for any acts or omissions, or those of Southwest Florida Water Mgmt. Dist., its agents, servants, employees, or any person or organization with which Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, BCBSF or Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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 Group Application and/or 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 Southwest Florida Water Mgmt. Dist.:

> To the address indicated by Southwest Florida Water Mgmt. Dist.

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, Southwest Florida Water Mgmt. Dist. 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. Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. Group Health Plan or this Benefit Booklet.

Customer Rewards Programs

From time to time, we may offer programs to our customers that provide rewards for following the terms of the program. We will tell you about any available rewards programs in general mailings, member newsletters and/or on our website. Your participation in these programs is completely voluntary and will in no way affect the coverage available to you under this Benefit Booklet. We reserve the right to offer rewards in excess of $25 per year as well as the right to discontinue or modify any reward program

features or promotional offers at any time without your consent.

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 Southwest Florida Water Mgmt. Dist. 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 (Out-of-State) Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard (Out-of-State) Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard (Out-of-State) Program" section for more details.
5. In the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the

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

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever *Florida Statute* §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular Services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much 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® (Out-of-State) Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the Provider discounts of other participating Blue Cross and/or Blue Shield plans.

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

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

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

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

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

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

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

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 licensed pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state, as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

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

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

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

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

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management program as described in the “Blueprint for Health Programs” section of 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 masters level nurse (ARNP) who operates under a set of clinical protocols that strictly circumscribe the conditions the ARNP can treat. Although no physician is present at the Convenient Care Center, medical oversight is based on a written collaborative agreement between a supervising physician and the ARNP.

Copayment means the dollar amount established solely by Southwest Florida Water Mgmt. Dist. 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.

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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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.

E-Visit, for purposes of the Benefit Booklet, means online assessment and management Services provided to an established patient by a Physician or other qualified health care professional; that does not originate from a related Physician Service rendered within the previous 7 days; using the internet or similar electronic communications network.

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 Southwest Florida Water Mgmt. Dist.:

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 Southwest Florida Water Mgmt. Dist.):

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 (Out-of-State) PPO Program Provider under the Blue Cross and Blue Shield Association's BlueCard (Out-of-State) 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 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 (Out-of-State) PPO Program but was participating, for purposes of the BlueCard (Out-of-State) Program, as a BlueCard (Out-of-State) Traditional Program Provider; or
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue or our Traditional Program; or

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

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient 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 seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

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

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

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

Physician 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.

Telemedicine means the practice of medicine by a licensed Florida Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

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.

Waiting Period means the length of time specified by Southwest Florida Water Mgmt. Dist. 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.

BlueOptions **with Integrated Prescription Drug Coverage**

Schedule of Benefits - Plan 05180 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	$1,500	$3,000
Per Family per Benefit Period	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance - The percentage of the Allowed Amount **you pay** for Covered Services	10%	40%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$3,000	$6,000
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 + 10%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 10%	DED + 40%
Allergy Injections rendered by		
Family Physicians	DED + 10%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 10%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	DED + 10%	DED + 40%
Other health care professionals licensed to perform such Services.	DED + 10%	DED + 40%
E-Visits rendered by		
Family Physicians	DED + 10%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 10%	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 10%	DED + 40%
Convenient Care Centers	DED + 10%	DED + 40%

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 Rendered by		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Well Woman Services Rendered by		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services rendered by		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Service	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopies	$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 + 10%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 10%	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 + 10%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 10%	DED + 10%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	DED + 10%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 10%	In-Network DED + 10%
Physician and other health care professional Services rendered by all other Providers	DED + 10%	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 + 10%	DED + 10%	**DED + 40%
Physician and other health care professional Services	DED + 10%		In-Network DED + 10%
Outpatient			
Facility (per visit)	DED + 10%	DED + 10%	DED + 40%
Physician and other health care professional Services	DED + 10%		In-Network DED + 10%
Therapy Services	DED + 10%	DED + 10%	DED + 40%
Emergency Room Visits			
Facility	DED + 10%		DED + 10%
Physician and other health care professional Services	DED + 10%		In-Network DED + 10%

*****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 areas, including, but 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 (Cost Share amounts listed in the "In-Network" column). If such Covered Services were rendered by a Physician who is not In-Network, or a Physician who is not a Traditional Program Provider, you will be responsible for the difference between what the Plan pays and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

*****Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

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 + $30	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $50	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 + $20	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $60	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $100	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 + $30	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies		
For up to a One-Month Supply	DED + $50	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.

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

- 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) at two times the Cost Share amount you would be required to pay 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 + 10%	In-Network DED + 10%
Hospital	DED + 10%	DED + 40%
Physician Services at Hospital and ER	DED + 10%	In-Network DED + 10%
Physician and other health care professionals licensed to perform such Services rendered at: Family Physician office	DED + 10%	DED + 40%
Specialist office	DED + 10%	DED + 40%
All other locations	DED + 10%	DED + 40%
Inpatient Facility Services	DED + 10%	DED + 40%
Physicians and other health care professionals licensed to perform such Services	DED + 10%	In-Network DED + 10%

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**

Schedule of Benefits - Plan 05181 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) - Shared*		
Per Person per Benefit Period	$3,000	$6,000
Per Family per Benefit Period	$3,000	$6,000
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance - The percentage of the Allowed Amount **you pay** for Covered Services	10%	40%
Out-of-Pocket Maximums - Shared*		
Per Person per Benefit Period	$6,000	$12,000
Per Family per Benefit Period	$6,000	$12,000

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 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 + 10%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 10%	DED + 40%
Allergy Injections rendered by		
Family Physicians	DED + 10%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 10%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	DED + 10%	DED + 40%
Other health care professionals licensed to perform such Services.	DED + 10%	DED + 40%
E-Visits rendered by		
Family Physicians	DED + 10%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 10%	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 10%	DED + 40%
Convenient Care Centers	DED + 10%	DED + 40%

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 Rendered by		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Well Woman Services Rendered by		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services rendered by		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Service	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopies	$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 + 10%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 10%	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 + 10%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 10%	DED + 10%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	DED + 10%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 10%	In-Network DED + 10%
Physician and other health care professional Services rendered by all other Providers	DED + 10%	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 + 10%	DED + 10%	**DED + 40%
Physician and other health care professional Services	DED + 10%		In-Network DED + 10%
Outpatient			
Facility (per visit)	DED + 10%	DED + 10%	DED + 40%
Physician and other health care professional Services	DED + 10%		In-Network DED + 10%
Therapy Services	DED + 10%	DED + 10%	DED + 40%
Emergency Room Visits			
Facility	DED + 10%		DED + 10%
Physician and other health care professional Services	DED + 10%		In-Network DED + 10%

*****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 areas, including, but 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 (Cost Share amounts listed in the "In-Network" column). If such Covered Services were rendered by a Physician who is not In-Network, or a Physician who is not a Traditional Program Provider, you will be responsible for the difference between what the Plan pays and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

*****Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

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 + $30	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $50	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 + $20	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $60	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $100	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 + $30	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies		
For up to a One-Month Supply	DED + $50	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.

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

- 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) at two times the Cost Share amount you would be required to pay 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 + 10%	In-Network DED + 10%
Hospital	DED + 10%	DED + 40%
Physician Services at Hospital and ER	DED + 10%	In-Network DED + 10%
Physician and other health care professionals licensed to perform such Services rendered at:		
Family Physician office	DED + 10%	DED + 40%
Specialist office	DED + 10%	DED + 40%
All other locations	DED + 10%	DED + 40%
Inpatient		
Facility Services	DED + 10%	DED + 40%
Physicians and other health care professionals licensed to perform such Services	DED + 10%	In-Network DED + 10%

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 Southwest Florida Water Mgmt. Dist. Group Health Plan

A Self-funded Group Health Benefit Plan

For Customer Service Assistance:
(800) 352-2583

78159 – Plans 05180 05181
004, C04, R04, 005, C05
1/1/18

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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 Southwest Florida Water Mgmt. Dist.

The sponsor of your Group Health Plan has contracted with BlueCross 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 Southwest Florida Water Mgmt. Dist.

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 included in this Booklet 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 Benefit 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® (Out-of-State) Program when you receive Services out-of-state?**

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

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

  Read the "Enrollment and Effective Date of Coverage" section.

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

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

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

  Read the "Termination of Coverage" section.

- **what 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, BCBSF or Southwest Florida Water Mgmt. Dist. may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. Neither BCBSF nor Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., 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 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 Southwest Florida Water Mgmt. Dist. 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;
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.

<u>Exclusions:</u>

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

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 as to make it impractical for the individual to receive services in a less intensive setting.

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

Exclusion:

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

Mammograms

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

Benefits for mammograms may not be subject to the 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

1. 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.
2. 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.
3. 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 Southwest Florida Water Mgmt. Dist. 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 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 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. Certain Physician Services can be rendered electronically through a computer via the Internet (E-Visits). E-Visits are covered when rendered in accordance with the Payment Rules below.

Payment Rules for E-Visits

Expenses for E-Visits are covered only if:

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

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

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled E-visit and for telephone consultations (except as indicated as covered under the Preventive Service category of this section).
2. Telemedicine Services, as defined in this Benefit Booklet.
3. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

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 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 Prescription Drugs

The following Self-Administered Drugs are covered:

1. Self-Administered Prescription Drugs used in the treatment of diabetes, cancer,

Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis; and

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

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

    b. Continuation of growth hormone therapy is only covered for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependent peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses. Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

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;

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; and
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery.
6. 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 and the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An “incidental surgical procedure” includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in BCBSF’s or Southwest Florida Water Mgmt. Dist.’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 Southwest Florida Water Mgmt. Dist., 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 (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

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

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

<u>Exclusion:</u>

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Benefit Booklet;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published *Medicare Coverage Issues Manual*;

7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility; or
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

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.

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 **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; 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 BlueScript Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Benefit Booklet.

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.

Exclusion:

Contraceptive injectable Prescription Drugs, 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. Only those OTC Drugs listed in the Medication Guide are covered.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed on our website at www.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.

Exclusion:

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

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.

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.

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

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

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

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

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

23. New Prescription Drugs.

24. We reserve the right not to apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance,

manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

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

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 our agreement with the Pharmacy selected;
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.

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.

Note: Prior Coverage Authorizations expire on the earlier of, but not to exceed 12 months:

1. the termination date of your policy, or
2. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Prescription Drug. To request a continuation we must we receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

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.

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 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 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 web site 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.

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 Southwest Florida Water Mgmt. Dist.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

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

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the 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 COVERED SERVICES 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. Specialty Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. (See "What is Covered?" section for additional information.)
9. New Prescription Drug(s), as defined in the DEFINITIONS section.
10. Convenience Kits, as defined in the DEFINITIONS section of the Booklet.
11. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our 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.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. any Service to diagnose or treat any Condition resulting from or in connection with your job or employment;
3. any Health Care Services not within the Service categories described in the "What is Covered?" or "BlueScript® Pharmacy Program" sections, any rider, or

Endorsement attached hereto, unless such Services are specifically required to be covered by applicable law;

4. any Health Care Service you render to yourself or those renedered by a Physician or other health care Provider related to you by blood or marriage;
5. Any Health Care Service which is not Medically Necessary as determined by us or Southwest Florida Water Mgmt. Dist. and defined in this Booklet . The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service;
6. Any Health Care Services rendered at no charge;
7. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
8. Any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a) war or an act of war, whether declared or not;
    b) your participation in, or commission of, any act punishable by law as a 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;
    e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or
    f) Services that are not patient-specific, as determined solely by us.
9. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
10. Any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

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.

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.

Telemedicine Services, as defined in this Benefit Booklet.

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

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

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

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a

Condition, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

Wigs and/or cranial prosthesis.

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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. Southwest Florida Water Mgmt. Dist. retains ultimate responsibility for determining whether expenses incurred for medical care are covered under this Booklet. In making coverage decisions, neither BCBSF nor Southwest Florida Water Mgmt. Dist. 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 insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

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.

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. This does not apply to Covered Prescription Drugs or Supplies covered under the BlueScript® Pharmacy Program. Please refer to the "BlueScript® Pharmacy Program" section for additional information.

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.

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

Out-of-Pocket Maximums

Individual out-of-pocket maximum

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

Family out-of-pocket 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 the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period. 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 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 Group Master Policy replaces such policy. 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 Group policy. This provision is only applicable for you during the initial Benefit Period of coverage under the Group Master Policy and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage under the Group Master Policy 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 the Group Master Policy, 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 the Group Master Policy, 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 Southwest Florida Water Mgmt. Dist., 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.

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 Southwest Florida Water Mgmt. Dist.

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 (Out-of-State) Traditional Program Providers, in conformity with the "BlueCard (Out-of-State) 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. Although you have the option to select any Provider you choose, you are encouraged to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs. Developing and continuing a relationship with a Family Physician allows the physician to become knowledgeable about you and your family's health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers may result in lower out-of-pocket expenses for you. You should always determine whether a Provider is In-Network or Out-of-Network prior to receiving Services to determine the amount you are responsible for paying out-of-pocket.

Location of Service

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

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

1. 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.

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 (Out-of-State) 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 (Out-of-State) Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.
Can you be billed the difference between what we pay the Provider and the Provider's charge?	• **NO.** You are protected from being billed for the difference in our Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept 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 (Out-of-State) Program, when you receive Services from a BlueCard (Out-of-State) Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.

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

To determine what expenses you are responsible for paying for Covered Prescription Drugs and Supplies, please refer to the "BlueScript® Pharmacy Program" section.

Physicians

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

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

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

Hospitals

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

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

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

This will provide you with information that will help you determine a portion of what your out-of-pocket costs may be in the event you are hospitalized.

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

Specialty Pharmacy

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

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

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 DED will be waived for these Services and are available at a lower cost share of $5 when they are rendered in the Value Choice Provider's office. To find a Value Choice Provider you may access the most recent provider directory at www.floridablue.com. These Providers will be designated under the heading Value Choice Providers. Advanced imaging, maternity and Medical Pharmacy Services will remain at the cost share listed on your Schedule of Benefits.

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 (Out-of-State) PPO Program Provider; 5) is a BlueCard (Out-of-State) Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes* ; or 7) is an Ambulance Provider that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) *Florida Statutes*, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.

Section 8: BlueCard® (Out-of-State) 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 Progam 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 Southwest Florida Water Mgmt. Dist., 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 are responsible for paying under this Benefit Booklet.

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

1. certain **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging;
3. **Autism Spectrum Disorder;** and
4. **other Health Care Services** that are or may become subject to a prior coverage

authorization program or a pre-service notification program as defined and administered by us.

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

In-Network Providers

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

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

Out-of-Network Providers

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

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

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

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

3. In the case of **Autism Spectrum Disorder,** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization will result in denial of coverage for such Services.**

4. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization or provide pre-service notification may result in denial of the claim or application of a financial penalty assessed at the time the claim is presented for payment to us**. The penalty applied will be the lesser of $500 or 20% of the total Allowed Amount of the claim. The decision to apply a penalty or deny the claim will be made uniformly and will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

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

BCBSF will provide you information for any Out-of-Network Health Care Service subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service not already listed here. This information will be provided to you upon enrollment, or at least 30 days prior to such Out-of-Network Services becoming subject to a prior coverage authorization or pre-service notification program.

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

Note:

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, Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist., 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. Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.;
2. The employee's job must fall within a job classification identified by Southwest Florida Water Mgmt. Dist. ;
3. The employee must have completed any applicable Waiting Period identified by Southwest Florida Water Mgmt. Dist.; and
4. The employee must meet any additional eligibility requirement(s) required by Southwest Florida Water Mgmt. Dist.

Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist., provided such companies and Southwest Florida Water Mgmt. Dist. are under common control; and
4. other individuals as determined by Southwest Florida Water Mgmt. Dist. (e.g., members of associations or labor unions).

Southwest Florida Water Mgmt. Dist. 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), from 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not

have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of his own or entitled to benefits under Title XVIII of the Social Security Act. You may be required to provide such proof at least once each year until the end of the calendar year in which the child attains 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 the Covered Plan Participant'**s** sole responsibility to establish that a child meets the applicable requirements for eligibility.

Handicapped Children

In the case of a handicapped dependent child, 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 mental retardation or physical handicap; and
3. chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 30^{th} birthday.

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

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

When making application for coverage, you must elect one of the types of coverage available under Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist.'s health benefit program. The period is established by Southwest Florida Water Mgmt. Dist., occurs annually, and will take place when specified by Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist. 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.

Southwest Florida Water Mgmt. Dist. must be notified, in writing, within 30 days after the birth.

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 Southwest Florida Water Mgmt. Dist. 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.

In the event BCBSF is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Plan Participant provides notice to Southwest Florida Water Mgmt. Dist., and an Enrollment Form is received by BCBSF within 60 days of the birth. In the event BCBSF is not notified within 60 days of the date of birth, the Covered Plan Participant must make application during an Annual Open Enrollment Period in order for the adopted newborn child to be covered.

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., and we receive the Enrollment Form within 60 days of the placement. In the event Southwest Florida Water Mgmt. Dist. is not notified within 60 days of the date of placement, the Covered Plan Participant must make application during an Annual Open Enrollment Period in order for the adopted or Foster Child to be covered.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child. Proof of final adoption must be submitted to BCBSF through Southwest Florida Water Mgmt. Dist. It is the responsibility of the Covered Plan Participant to notify us if the adoption does not take place. Upon receipt of this notification, coverage for the child will be terminated 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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 first of the month following the special enrollment event, unless required by law. 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 Southwest Florida Water Mgmt. Dist. 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, Pre-existing Condition exclusionary period, 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist., prior to the requested termination date or within 30 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, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'s responsibility to notify you of your termination or that of your Covered Dependents for any reason.

Section 13: Continuing Coverage Under COBRA

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

You must contact Southwest Florida Water Mgmt. Dist. to determine if you or your Covered Dependent are entitled to COBRA continuation of coverage. Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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. Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., in writing, within 60 days of any of these events. Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist. 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. Southwest Florida Water Mgmt. Dist. 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.

A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:

- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

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 Southwest Florida Water Mgmt. Dist.

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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist. MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you . Also, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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:

Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. or to any individual covered under this Benefit Booklet on account of any nonpayment of primary benefits resulting from any failure of performance of Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. if you have questions relating to your Group Plan's SPD. We are not your Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

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

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

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

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the Provider's name and address;

6. the name of the individual who received the Service; and
7. the Covered Plan Participant's name and contract number as they appear on the Identification Card.

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

Note: Please refer to the "BlueScript® Pharmacy 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® (Out-of-State) Program" section of this Booklet).

The Processing of Post-Service Claims

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

- Payment for Post-Service Claims

When payment is due under the terms of 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:

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

telephone, facsimile or other available expeditious method;

- If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.floridablue.com or by calling the number on the back of your BCBSF ID Card.

Timing of Our Appeal Review on Adverse Benefit Determinations

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

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

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

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

Submit appeals of Adverse Benefit Determinations to:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

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

Southwest Florida Water Mgmt. Dist. 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.

Section 19: Relationships Between the Parties

BCBSF/Southwest Florida Water Mgmt. Dist. and Health Care Providers

Neither BCBSF nor Southwest Florida Water Mgmt. Dist. nor any of their respective officers, directors or employees provides Health Care Services to you. Rather, BCBSF and Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. **In this regard, we and Southwest Florida Water Mgmt. Dist. hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and Southwest Florida Water Mgmt. Dist.

Neither Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. and we will not be liable for any acts or omissions, or those of Southwest Florida Water Mgmt. Dist., its agents, servants, employees, or any person or organization with which Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, BCBSF or Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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 Southwest Florida Water Mgmt. Dist. 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, Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.'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 Group Application and/or 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 Southwest Florida Water Mgmt. Dist.:

> To the address indicated by Southwest Florida Water Mgmt. Dist.

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, Southwest Florida Water Mgmt. Dist. 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. Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. Group Health Plan or this Benefit Booklet.

Customer Rewards Programs

From time to time, we may offer programs to our customers that provide rewards for following the terms of the program. We will tell you about any available rewards programs in general mailings, member newsletters and/or on our website. Your participation in these programs is completely voluntary and will in no way affect the coverage available to you under this Benefit Booklet. We reserve the right to offer rewards in excess of $25 per year as well as the right to discontinue or modify any reward program

features or promotional offers at any time without your consent.

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 Southwest Florida Water Mgmt. Dist. 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 (Out-of-State) Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard (Out-of-State) Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard (Out-of-State) Program" section for more details.
5. In the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the

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

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever *Florida Statute* §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular Services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much 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® (Out-of-State) Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the Provider discounts of other participating Blue Cross and/or Blue Shield plans.

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

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

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

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

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

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

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

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 licensed pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state, as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

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

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

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

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

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management program as described in the “Blueprint for Health Programs” section of 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 masters level nurse (ARNP) who operates under a set of clinical protocols that strictly circumscribe the conditions the ARNP can treat. Although no physician is present at the Convenient Care Center, medical oversight is based on a written collaborative agreement between a supervising physician and the ARNP.

Copayment means the dollar amount established solely by Southwest Florida Water Mgmt. Dist. 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.

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 Southwest Florida Water Mgmt. Dist., 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist.

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.

E-Visit, for purposes of the Benefit Booklet, means online assessment and management Services provided to an established patient by a Physician or other qualified health care professional; that does not originate from a related Physician Service rendered within the previous 7 days; using the internet or similar electronic communications network.

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 Southwest Florida Water Mgmt. Dist.:

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 Southwest Florida Water Mgmt. Dist.):

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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 Southwest Florida Water Mgmt. Dist. 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 (Out-of-State) PPO Program Provider under the Blue Cross and Blue Shield Association's BlueCard (Out-of-State) 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 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 (Out-of-State) PPO Program but was participating, for purposes of the BlueCard (Out-of-State) Program, as a BlueCard (Out-of-State) Traditional Program Provider; or
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue or our Traditional Program; or

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

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient 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 seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

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

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

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

Physician 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.

Telemedicine means the practice of medicine by a licensed Florida Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

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.

Waiting Period means the length of time specified by Southwest Florida Water Mgmt. Dist. 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.

BlueOptions

Schedule of Benefits

Plan 3559

You should carefully review this Schedule of Benefits, which is part of your Benefit Booklet, to be aware of important information concerning your share of the expenses for Covered Services you receive. Your share of the expenses, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **will vary** depending upon the Provider you choose and the setting in which the Services are rendered. 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 Coinsurance Amounts

Benefit Description	**In-Network**	**Out-of-Network**
Individual Deductible (DED) per BP	$500	
Family Deductible (DED) per BP	$1,500	
Amount Payable By the Plan	80% of the Allowed Amount	60% of the Allowed Amount
Individual Out-of-Pocket Maximum per BP	$3,000	
Family Out-of-Pocket Maximum per BP	$6,000	

Note: Out-of-Pocket maximums include the DED amount, any applicable Copayments and Coinsurance amounts. Any non-covered charges or charges in excess of the Allowed Amount are not included. Prescription Drug Copayments, Deductible and/or Coinsurance amounts are not included.

Office Services

Benefit Description	In-Network	Out-of-Network
Office Services Rendered by Family Physicians 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.	$15 Copayment per visit*	60% of the Allowed Amount after DED
Office Services Rendered by: 1. Physicians other than Family Physicians; and 2. Other health care professionals licensed to perform such Services.	$30 Copayment per visit*	60% of the Allowed Amount after DED
Allergy Injections rendered by: 1. Family Physicians	$10 Copayment per visit*	60% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services.	$10 Copayment per visit*	60% of the Allowed Amount after DED
Advanced Imaging Services: CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology rendered by: 1. Family Physicians	$100 Copayment per visit*	60% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services.	$100 Copayment per visit*	60% of the Allowed Amount after DED
E-visit 1. Family Physicians	$10 Copayment per visit*	60% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services.	$10 Copayment per visit*	60% of the Allowed Amount after DED

Benefit Description	In-Network	Out-of-Network
Motorized Wheelchair, Durable Medical Equipment	100% of the Allowed Amount	60% of the Allowed Amount after DED
Prosthetics, and Orthotics 1. Family Physicians 2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services.	$15 Copayment per visit* $30 Copayment per visit*	60% of the Allowed Amount after DED 60% of the Allowed Amount after DED

*These Services are subject to the Copayment only.

Note: You should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office, review the most recent Provider Directory or access the BlueOptions Provider directory on our web-site at www.floridablue.com.

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Preventive Adult Wellness Services rendered by:		
1. Family Physicians	$15 Copayment per visit*	60% of the Allowed Amount
2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such Services.	$30 Copayment per visit*	60% of the Allowed Amount
Preventive Adult Well Woman Services rendered by:		
1. Family Physicians	$15 Copayment per visit*	60% of the Allowed Amount
2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such Services.	$30 Copayment per visit*	60% of the Allowed Amount
Preventive Child Health Supervision Services rendered by;		
1. Family Physicians	$15 Copayment per visit*	60% of the Allowed Amount
2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such Services.	$30 Copayment per visit*	60% of the Allowed Amount
Mammograms	100% of the Allowed Amount	100% of the Allowed Amount
Routine Colonoscopies for Ages 50+	100% of the Allowed Amount	100% of the Allowed Amount

*These Services are subject to the Copayment only.

Outpatient Facility Services (Locations other than Hospital, Psychiatric Facility, Substance Abuse Facility or Physician's Office)

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Services	$100 Copayment per visit*	60% of the Allowed Amount after DED
Physician Services rendered at an Ambulatory Surgical Center by: 1. Radiologists, Anesthesiologists, and Pathologists; 2. all other Providers.	80% of the Allowed Amount after DED 80% of the Allowed Amount after DED	80% of the Allowed Amount after DED 60% of the Allowed Amount after DED
Independent Diagnostic Testing Facility Services 1. Advanced Imaging Services: CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology; 2. All other diagnostic Services	$100 Copayment per visit* $100 Copayment per visit*	60% of the Allowed Amount after DED 60% of the Allowed Amount after DED
Urgent Care Center	$30 Copayment per visit*	$30 Copayment per visit
Independent Clinical Lab Services	100% of the Allowed Amount	60% of the Allowed Amount after DED

*These Services are subject to the Copayment only.

Inpatient/Outpatient Services (Rendered at a Hospital Facility)

Benefit Description	**In-Network**		**Out-of Network**
	Option 1	**Option 2 and Out of State BlueCard® Participating**	
Inpatient Facility Services (Applies per admission)	$500 Copayment*	$1,000 Copayment*	60% of the Allowed Amount
Outpatient Facility Services			
1. Therapy Services	$150 Copayment*	$250 Copayment*	$350 Copayment
2. All Other Services (Applies per visit)	$150 Copayment*	$250 Copayment*	$350 Copayment
Inpatient/outpatient Physician and other health care professional Services	80% of the Allowed Amount after DED		80% of the Allowed Amount after DED
Emergency Room Facility Services (Applies per visit) Copayment waived if admitted	$100 Copayment*		$100 Copayment

*These Services are subject to the Copayment only.

Note: Please refer to your Provider Directory to determine the applicable option for each In-Network Hospital.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Care and Treatment Services		
Outpatient Facility Services rendered at:		
1. Emergency Room	100% of the Allowed Amount	100% of the Allowed Amount
2. Hospital	100% of the Allowed Amount	$350 Copayment
3. Physician Services at Hospital and ER	100% of the Allowed Amount	100% of the Allowed Amount
Physician and other health care professionals licensed to perform such Services rendered at:		
1. Family Physicians Office	100% of the Allowed Amount	60% of the Allowed Amount
2. Specialist Office	100% of the Allowed Amount	60% of the Allowed Amount
3. All other locations	100% of the Allowed Amount	60% of the Allowed Amount
Inpatient		
1. Facility Services	100% of the Allowed Amount	80% of the Allowed Amount
2. Physician and other health care professionals licensed to perform such Services	100% of the Allowed Amount	100% of the Allowed Amount

Other Services

Benefit Description	In-Network	Out-of-Network
Diabetic Equipment and Supplies	100% of the Allowed Amount	60% of the Allowed Amount after DED

Benefit Maximums

Home Health Care Visits Per Person Per BP 20

Inpatient Rehabilitation Days Per Person Per BP 30

Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Visits Per Person per BP 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility Days Per Person Per 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 to the Group, amounts applied to your Benefit Period and lifetime maximums under the prior BCBSF or HOI policy, will be applied toward your Benefit Period and lifetime maximums under the Benefit Booklet.

Prescription Drug Program

The Group purchased optional pharmacy coverage from BCBSF. Please refer to the pharmacy program endorsement issued to the Group.

In-Network Providers

NetworkBlue is the panel of NetworkBlue Providers designated as In-Network for your plan. Refer to your BlueOptions Provider directory for a complete listing of your In-Network Providers. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.

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

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**
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	$20	50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$25	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$25	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$50	50% of the Non-Participating Pharmacy Allowance

	Participating Pharmacy	Non-Participating Pharmacy
Non-Preferred Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$40	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$40	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$80	50% of the Non-Participating Pharmacy Allowance

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.

- 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.